NATIONAL REPRODUCTIVE HEALTH STRATEGY

Ministry of Health
Timor-Leste

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Appreciation

The Ministry of Health recognizes the assistance received in developing this National Reproductive Health Strategy and particularly extends appreciation to UNFPA, WHO and the technical advisers who supported the MoH in identifying appropriate strategies from international sources and working with local staff to adapt these principles and strategies to meet the needs of reproductive health interventions in Timor-Leste.

Reproductive health has the highest priority of the Government of Timor-Leste as the country grapples with the highest fertility rate in the world and unacceptable maternal and child mortality rates while attempting to raise the strings of human capital through public health interventions. This National Reproductive Health Strategy will provide a significant input and sense of direction into addressing these issues.

Special thanks are also extended to all those who participated in the policy consultation process, for without this valuable input, many important issues may have been overlooked.

1. Background

The right to understand matters of reproductive health and how they relate to the overall health of the individual as well as access to services and public health interventions should be available to all women, men and adolescents worldwide. Service access and interventions include family planning and safe motherhood and protection against sexually transmitted infections such as HIV/AIDS.

ICPD, Cairo, 1994 established the brand new concept of "reproductive health", as follows: "Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life.

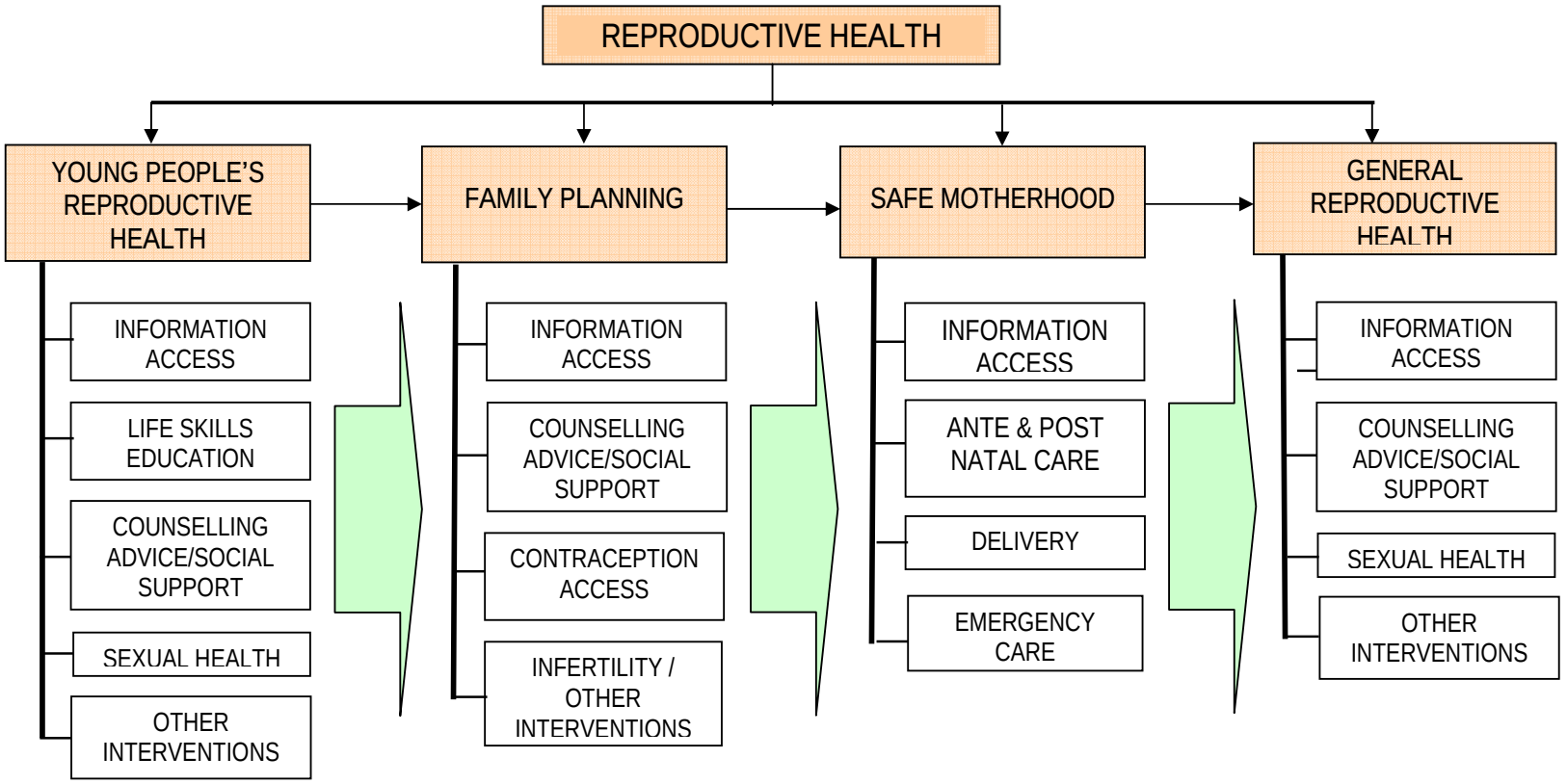
Reproductive health implies that people are able to have responsible, satisfying and safe sex lives and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." (Programme of Action paragraph 7.2)

The ICPD Programme of Action and the Beijing Platform for Action recognize sexual and reproductive rights as inalienable, integral and indivisible parts of universal human rights. The most important sexual and reproductive rights include:

- Reproductive and sexual health as a component of overall health, throughout the life cycle, for both men and women.
- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children; and the right to have access to the information and means needed to exercise voluntary choice.
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender.
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

Sexual and reproductive rights are based on the premise that all individuals have the right to attain the highest standards of sexual and reproductive health and to make reproductive choices free from coercion. The "reproductive health package" is designed to meet that goal, consisting of family planning, sex education, safe motherhood and protection against sexually transmitted infections including HIV/AIDS. Reproductive health is a lifetime concern for both women and men, from infancy to old age. This strategy supports programming tailored to the different challenges they face at different times in life. The life-cycle approach (Table 1) illustrates the links between young people's health, family planning, safe motherhood and general reproductive health of mature population.

Table 1: Life Cycle Approach to Reproductive Health



1.1. Problems and constraints:

1.1.1. Maternal mortality

Timor-Leste has one of the highest maternal mortality rates in the region with estimated rates of up to 860 mothers dying every 100 000 live births of problems related to pregnancy, delivery or early post-delivery. One of the reasons for such high level of maternal problems is the low utilization of skilled assistance for antenatal care, delivery, and postpartum care services (East Timor Health Policy Framework, 2002) however more recent research suggests that more than 60% of delivery complications cannot be detected prior to birthing with shock and excessive bleeding being unpredictable and requiring well organized referral systems to higher level emergency care facilities.

1.1.2. Perinatal and neonatal mortality

The 2002 Multiple Indicator Cluster Survey (MICS), UNICEF found that eight to nine out of every 100 children born die before reaching their first birthday. Another 3 to 4 die before reaching age 5. Risk of dying is markedly higher in rural than in urban areas and particularly in highland regions of the country. While specific data has yet to be gathered smaller studies indicate that the causes are similar to those experienced in similar developing countries – newborn babies die or are damaged because of birth asphyxia, trauma or infections.

1.1.3. Antenatal care and delivery assistance

The MICS showed that 53% of women giving birth within the past year said they had availed themselves of antenatal consultation services. Of these 81% or total **43%** of all women (**61%** TL-DHS 2003) said they had received services from skilled personnel. The main variation across strata was between rural and urban and highland and lowland areas (with rural and upland areas being worse off) supporting a view that isolation and difficulty of access to modern health facilities or personnel is a significant constraint in maternal health service delivery. The TL-DHS 2003 showed that **13.9%** of mothers in Timor-Leste meet the recommended schedule for number and timing of ANC visits. 41% (43% TL-DHS 2003) of women giving birth within the past 12 months were protected against neonatal tetanus.

According to the MICS data, 82% of births during the year preceding the survey were assisted in some fashion, but trained medical personnel assisted in only about 33 percent of these cases or only for about **24%** (**19%** TL-DHS 2003) of all births. As with antenatal care, the main medical source of assistance was from nurses or midwives. The majority of births (TL-DHS 2003) were assisted by relatives or friends (61%). Interestingly, traditional birth attendants do not appear to be particularly widely used, but there may also be some confusion between this category and the one containing relatives or friends. In any case, access is particularly constrained in highland areas where only about 12% of women had a trained attendant at birth, as well as in rural areas generally. In fact, in both of there strata a higher percentage of women apparently gave birth without any assistance (i.e. entirely on their own) and with not even a relative or neighbor in attendance. Conditions are less deficient in urban areas, and particularly in the major urban centers (mainly Dili). There, a majority (65-70% in Dili) of women are getting antenatal care via medical personnel.

And even use of skilled personnel at delivery is not that much under 50% (MICS). It is when one gets outside of these areas of concentration that the system to break down. In more isolated rural and upland regions only a minority of women are getting access to medical services or adequate protection against neonatal tetanus. The interventions to bring services to closer to these women and to stimulate demand for their use need to be given a high priority.

In the TL-DHS 2003, the vast majority of women (85%) did not receive a postnatal check up. Women in urban areas and lowland areas were more likely to receive a post natal check up, as were women with higher levels of education.

1.1.4. Fertility

The TL-DHS 2003 estimated that at current age patterns of fertility each woman in Timor-Leste will give birth to 8 children during her lifetime.

This level of fertility is consistent with extremely short birth intervals of well under 3 years over much of this age range and this clearly poses a significant problem for the health not only of mothers, but also of their children. Children born after a short birth interval are at greater risk of illness and death than children born after a long interval. And duration of breastfeeding for older children may be shortened due to the need to breastfeed the younger child. The immediate impact of such high reproduction rates is on the mother; higher risk of pregnancy complications plus the inability to develop and control their own lives as individuals, mothers and partners.

There are the primary danger signals as well for children in such a high fertility regime which suggest that programs to provide appropriate means and education for potential mothers regarding the benefits of sound reproductive practices could have a marked impact both on the health of the woman and on that of their children.

1.1.5. Contraception

Timor-Leste now has the highest fertility rate in the world (7.77). Fertility regulation through the use of family planning is very low by any standards. Over 60 percent of women and 70 percent of men failed to recognize any method of common contraception methods. Along with a general lack of knowledge of methods of birth spacing and birth limiting, 75 percent of women, when asked, had no knowledge of where to obtain a method (TL-DHS, 2003).

The levels of knowledge of the small group who did recognize at least one method varied by age group of women, but even among those in the prime reproductive ages (20-34), less than 9% are protected. Two methods, injections and contraceptive pills cover the great majority of use and use is highest among women 25-44 years of age. Men knew even less about contraception than women. Planning family sizes was noted as almost absent from inner-family discussion.

The TL-DHS, 2003 showed that only three-quarters of the total demand for family planning is being met in Timor-Leste. Women in the older age groups with already large sized families proved the demanding of information regarding possibilities for contraception services which suggest that there is a need for increased provision of family planning services, particularly in the urban regions.

1.1.6. Adolescent sexual and reproductive health

Following the national surveys in 2002 and 2003, evidence indicates that issues of sexuality and reproductive health in general are not currently a common consideration. This is despite concerns over suggested trends of younger marriages, premature marriages due to teenage pregnancies and teenage women seeking termination of pregnancy.

The population of late adolescent and young adults will increase by 50% over the next 5 years. Social pressures will increase as the exposure to international influences raises awareness, concerns and expectations for individuals and relationships between couples. The growing threat of sexually transmitted infections (STI) and human immunodeficiency virus (HIV) must be understood with healthy lifestyle decisions being made. Awareness of their sexuality, and their rights, along with the challenge of entering into relationships should they choose, will require sensitive public health responses to enable these young adults to enter society as maturing adults in a responsible manner.

1.1.7. Sexually transmitted infection (STIs) and HIV/AIDS

Only 16% of women aged 15-49 in Timor-Leste have heard of HIV/AIDS and only a fraction of these can correctly identify all three major ways of preventing HIV/AIDS transmission or the three major misconceptions about the disease. In fact, even among those who have heard of HIV/AIDS, only about 1% have "sufficient knowledge" defined by being able to correctly identify both ways of preventing transmission and misconceptions about the disease.

In 2002, the Ministry of Health requested Family Health International in collaboration with local NGOs and others to carry out a survey of the levels of HIV and STI infection and associated risk behaviors among small groups at risk for HIV infection in Timor-Leste. The results of the survey showed significant levels of risk behavior. Only 1% of clients said they used condoms in commercial sex, and not a single sex worker reported always using condoms with clients. Indeed, fully 40% of sex workers did not even recognize a condom when shown one. Overwhelmingly the most common reason for not using condoms was that condoms are simply not easily available.

However, STI/HIV/AIDs is not merely a concern for 'high risk groups.' Spouses/partners are susceptible, blood storage and transfer systems vulnerable and health workers must be able to work in safe conditions. Social and service systems must be put in place to ensure harm reduction for all the population along with management of those living with these diseases.

1.1.8. Health system

The Timor-Leste Ministry of Health has the responsibility of maintaining the health and well being of the Peoples of Timor-Leste community. Currently the infrastructure and systems to identify and address key public health priorities and provide care are being constructed and developed. The infrastructure is almost complete with facilities now covering around 90% of the population. Health systems to provide services and interventions continue to be developed and implemented. All districts have ambulances, CHCs have radios, and roads are in varying conditions for

travel across the country. During the rainy season roads are often impossible to travel in rural areas.

Within these services, maternal and child health are priorities along with communicable diseases. Reproductive health sits across these priority areas along with the additional areas of non-communicable disease and environmental health.

Human resources to deliver services and instigate health initiatives are being recruited, trained and deployed across the health facility network. A greater prominence is being given to primary health care at the community level. This entails working with communities to identify local health priorities, options for sound interventions and a combined provider/community response to implementing interventions. Given the number of aspects within the reproductive health continuum, ranging from young people's specific needs through to the needs of the community as they move beyond the reproductive period of their lives, reproductive health interventions require a high level diverse range of skills and competencies for the health worker. In particular, and with the emphasis on the health of women as mothers and individuals, midwives play a key role in providing these services.

The Ministry of Health has employed 363 midwives who are now stationed in health posts, health centers and hospitals across the country. These midwives have a preservice education of 3 years of basic nursing school and 1 year of midwifery school. The majority of midwives (about 300) had competency based training in safe and clean delivery and review of national standards from 2000 - 2004. Many CHC nurses have also received training in antenatal care and emergency obstetrics. Recently the new midwifery school, which provides 1 year of midwifery preservice education to nurses, has opened at the MoH Institute of Health Sciences. Further training is planned with a National Institute of Health Sciences (NIHS) capable of induction training for new health workers and midwives being scheduled for development over the next five years. Reproductive health will be a significant focus of expected curriculum for this program. However, with the incredibly high fertility rates of Timor-Leste, there is an expected 44,000 babies being born each year. The current staffing rate of health posts and health centres will see a demand of as much as 5 births a week for all midwives in addition to their antenatal and post natal care responsibilities. It is therefore important for the health system to adopt human resource plans and appropriate systems to ensure that reproductive health is guaranteed for all young people, birthing mothers, and other adults in Timor-Leste.

There is an active private sector working within the health field in Timor-Leste. A number of faith based organisations, non-government organisations, including Café Timor, are responding to both the market for private services in conjunction with complimenting government services in areas where there has been an agreement to do so. Reproductive health services across the non-government sector varies according to the philosophy and service pattern of each agency however service can range from antenatal care, deliveries and postnatal care through to reproductive health counseling and family planning services. A number of staff from within this sector have been given training opportunities such as training in safe motherhood for midwives.

1.2. Healthy responses

The Ministry of Health (MoH) is developing a health care system based on founding principles stemming from those of comprehensive primary health care. In essence,

and as applicable to reproductive health, public health responses will address the personal vulnerabilities of the population. That is health services will be provided to address ill-health and disease including the provision of care to expectant mothers and prevention interventions for all ages and sexes. In addition, the Ministry of Health will also increase the scope of the community to respond to the demands of life. Health promotion is a fine example of increasing the skills and knowledge of community members on health issues that could effect their well-being.

In keeping with the primary health model the MoH is also assisting the community by provision of a number of resources for priority groups in order that they can put in place the new health knowledge they have learned. Mosquito bed nets for mothers along with prophylactics (condoms) for family planning as another. The development of social support systems that empower specific groups to meet the health demands they experience has started. Health planning has now been taken down to the community level.

The broadening of healthy interventions has recently been introduced. Through the development of community and intersectorial mechanisms, forums to identify and plan interventions to address some of the determinants of health in priority areas have commenced. These will form the foundation of the district health planning process and will included representatives of key groups where in the case of reproductive health will include women, mothers, youth and possibly high risk groups.

This reproductive health strategy has been developed to address these health needs and building on current responses by focusing first on high priority groups and conditions the expanding as competencies and resources allow.

The National Reproductive Health Strategy will be an integral part of the Primary Health Care approach and will be considered in that context. It will promote:

- the assessment and review of RH programs and services at all levels, in particular at the primary health care level, and the undertaking of the necessary changes to improve the quality of services;
- the training of skilled health personnel to improve their reproductive health knowledge, practice, and skills at all levels;
- the accessibility, availability and affordability of reproductive health services to women, men and young people, especially adolescents.

Inherent within this strategic approach are the components of the human capital framework for reproductive health (Annex 1). In viewing social interventions from a development perspective, the human capital framework identifies actions through to impact on individuals and society and eventually economic growth.

In keeping with the goal of developing an integrated health service, this strategy will be read and interpreted in conjunction with associated strategies of the MoH, namely the National Nutrition Strategy, Integrated Management of Childhood Illnesses (IMCI) Strategy, National Immunisation Strategy, National strategy for Health Promotion along with policies currently under development (National Primary Health Care Policy, National STI/HIV/AIDS Policy) and future policies, strategies and protocols.

2. Goals

The overall goal of the strategy is to ensure that people can exercise….

- experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfillment;
- achieve their desired number of children safely and healthily, when and if they decide to have them:
- avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed;
- be free from violence and other harmful practices related to sexuality and reproduction.

The National Reproductive Health Strategy (NRHS) outlines the following priority actions to set up an enabling environment to meet the objectives:

- Coordinating stakeholders and efforts
- Strengthening partnerships
- Integrating systems
- Advocating resource priority
- Focusing national and political commitment
- Designing national standards, protocols and guidelines
- Promoting regulatory frameworks
- Improving quality

2.1. Objectives

Objective 1: To substantially increase the level of knowledge in the general population on issues related to sexuality and reproductive health.

Objective 2: To promote family planning to stabilize population growth rate and reduce the incidence of unintended, unwanted and mistimed pregnancies.

Objective 3: To ensure that all women and men have access to basic reproductive health care services, health promotion and information on issues related to reproduction.

Objective 4: To reduce the level of maternal mortality and morbidity.

Objective 5: To reduce the level of perinatal and neonatal mortality and morbidity.

Objective 6: To reduce the burden of STIs/HIV.

Objective 7: To meet changing reproductive health need over life cycle and to improve the health status of reproductive age people.

2.2. Targets to be achieved by the end of 2015

1. Reduce the maternal mortality ratio by 40% from 2004 levels.
2. Reduce the perinatal and neonatal mortality ratio by 40% from 2004 levels.

3. Increase the contraceptive prevalence rate of married and unmarried couples to 40%.
4. Reduce the percentage of all births that occur to adolescents by 30%.
5. Increase the coverage of antenatal and postnatal care to 80%, the rate of deliveries assisted by skilled attendants to 50% from 2004.
6. Reduce the level of STI by 40% from 2004 levels.
7. Reduce the incidence of STI/HIV among young people by 30%.

See Annex 3

3. Components

Component 1. Young people's sexual and reproductive health

Preamble:

The term "child" is defined as someone between the ages of 5 and 18 years. "Adolescence" has been defined as including those aged between 10 and 19, and "youth" as those between 15 and 24. "Young people" is a term that covers parts of or all of these three age groups; more specifically, it address individuals between the ages of 10 and 24.

Adolescence is a period of rapid personal development, when young people acquire new capacities and are faced with many new situations that create not only opportunities for progress, but also risks to health and wellbeing. It is a time when growth is accelerated, major physical changes take place and differences between boys and girls are accentuated.

The rapid growth that occurs in adolescence demands extra nutritional requirements. The nutritional status of young girls, prior to pregnancy, is important and impacts on the course and outcome of their pregnancy. Entering motherhood in a deficient nutritional state places both the mother and the newborn at risk of an adverse outcome. Foundations of adequate growth and development are laid during childhood and adolescence.

Adolescence is also a time of mental and psychological adjustment. Involvement with groups of the same sex as well as to mixed groups. Sexual pairing may take place during this period. In traditional societies, the earlier maturation of girls has been acknowledged by early marriage. However, in Timor-Leste the mean age of marriage is rising while the age of puberty in both sexes appears to be falling, creating a longer period during which premarital sexual relationships may occur. Adolescent behaviour during these years could range from exploring sexual relationships to experimenting with alcohol, tobacco and substance abuse. Lack of knowledge and peer pressure may lead to risk-taking behaviour, with inadequate access to services and lack of a supportive environment further affecting health and development outcomes. The support and understanding from family members during this phase is therefore crucial in enabling young people to meet these challenges.

The 1994 International Conference on Population and Development (ICPD), Cairo, Egypt, emphasized and highlighted the needs of adolescents. The young people of today are the adults of tomorrow. While today‘s world offers remarkable opportunities for adolescents it also threatens their health. Therefore, it is of paramount importance that an environment be created in which adolescents can realize their full potential and grow to healthy and responsible adulthood.

The health of children and adolescents is acknowledged as an important concern in the Convention on the Rights of the Child (CRC):

Article 24

1. *States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*
2. *States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*
    - *(a) To diminish infant and child mortality;*
    - *(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
    - *(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;*
    - *(d) To ensure appropriate pre-natal and post-natal health care for mothers;*
    - *(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
    - *(f) To develop preventive health care, guidance for parents and family planning education and services.*
3. *States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.*
4. *States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.*

The government of Timor-Leste has agreed to this along with a number of other international conventions. The following are references to education in the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and its Five-Year Review in 1999, which has been accepted by the Government of Timor-Leste:

> *“Governments and non-government organizations should generate social support for the enforcement of law on the minimum legal age at marriage, in particular by providing educational and employment opportunities.” ICPD, para 4.21*
>
> *“There is a close and complex relationship among education, marriage age, fertility, mortality, morbidity and activity. The increase in the education of women and girls contributes to greater empowerment of women, to a postponement of the age of marriage and to a reduction in the size of families. When mothers are better educated, their children’s survival rate tends to increase.” ICPD, para 11.3*
>
> *“To introduce and improve the content of the curriculum so as to promote greater responsibility and awareness on the interrelationships between population and sustainable*

> *development; health issues, including reproductive health; and gender equity." ICPD, para 11.5*
>
> *"Include at all levels, as appropriate, of formal and non-formal schooling, education about population and health issues, including sexual and reproductive issues." ICPD+5, para 35*
>
> *"With due respect for the rights, duties and responsibilities of parents and in a manner consistent with the evolving capacities of the adolescent and their cultural values and religious belief, ensure that adolescents, both in and out of school, receive the necessary information, including information on prevention, education, counseling and health services to enable them to make responsible and informed choices and decisions regarding their sexual and reproductive health needs, in order, to reduce the number of adolescent pregnancies." ICPD +5, para 73 (e)*

The ICPD Programme of Action also emphasizes the need for reproductive heath education especially for young people who need accurate information and skills to make responsible choices. This is important for their healthy development and enables them to choose healthy lifestyles, to prevent HIV/AIDS and violence.

Experience in many countries shows education to be an essential factor in developing health-seeking behaviors and decision making on reproductive health along with exercising the right to make use of these health services where available.

Policy statement

The Government of the Democratic Republic of Timor-Leste guarantees the rights of young people as outlined in the UN Convention on the Rights of the Child.

The Government will develop interventions and action plans which address identified problems, with involvement of young people at all stages of development and implementation.

The Government will ensure that young people receive accurate, culturally acceptable, gender-sensitive, age-appropriate information to enable them to cope with their health and development, to make responsible and informed choices and decisions regarding their sexual and reproductive health needs. All channels of communication including young people's organizations, schools, peer and other inter-personal communication, mass media, and relevant institutions will be utilized for dissemination of accurate, culturally acceptable, gender-sensitive information on young people's health and development.

The Government will ensure that youth friendly health services are accessible, equitable, acceptable, appropriate, comprehensive, confidential, effective and efficient and available in both public and private sectors where the latter compliment government services. General private services will also be encouraged to adhere to the general policy direction of young people's reproductive health services where appropriate. These services will address each adolescent's physical, social and psychological health and development needs, provide a comprehensive package of health care and counseling services for healthy development, gender equality, healthy sexuality, desired reproductive behavior and healthy relationships; will be guided by evidence-based protocols and guidelines.

The Government will build and strengthen national capacity through appropriate training, emphasizing training on aspects of adolescent health and development and develop inter-personal communication skills in those responsible for providing information or counseling to young people.

The Government will monitor, evaluate and conduct operations research for programme improvement and community action, promote qualitative research on adolescent behaviours and motivational patterns.

Strategic approach

Approach 1:

Strengthen the provision of information and skills to young people, families and communities in order to achieve an optimal level of health and development in young people.

An informational package be developed by young people consisting of information on growth and development, nutrition, sexual maturation, positive behavior including safe sex, gender equity, substance abuse, rights and responsibilities and services for young people, for use by young people, parents, teachers and the community at large.

Formulate and use specifically targeted, clear, consistent messages developed by youth to promote health and development of young people.

Develop and provide life-skills training that is age-appropriate and culturally acceptable, enabling young people to cope with their health and development including reproductive health.

Ensure that the concept of reproductive rights has been included in school curricula and out-of-school programmes for young persons through the activities of youth groups and other community organizations. Young people need to be educated on issues related to reproduction and human sexuality, including family planning methods, STIs and HIV/AIDS prevention.

Support young people by providing them with communication skills, negotiation skills, skills for management of emotions and stress and other relevant skills as are necessary.

Mobilize family and community resources for young people health concerns and development programs together with the active participation of young people themselves.

Approach 2:

Increase easy access to a broad range of young person-friendly services.

Essential care standards and practice guides for YPRH care will be adapted and translated to national conditions and needs.

Develop training programs for service providers on YPRH issues, especially related to counseling and service provision.

Provide skills training to service providers to deal with young people’s health and development problems. This includes skills to create empathy, listening skills and interpersonal communication.

Provide training to service providers on technical aspects of YPRH and also appropriate interpersonal communication and counseling skills.

Reorient the existing primary health care services to be young person-friendly. These services to include basic reproductive health services (information on

sexuality and reproductive health, access to family planning services, prenatal and postnatal care, safe delivery, treatment of complications of abortions, diagnosis and treatment of STIs) as well as services for protection from sexual abuse, culturally appropriate psychosocial counseling and mental health services, substance abuse/smoking and alcohol use, negotiating skills, nutrition and control of endemic disease.

Work with young people to identify and address the health needs of young people in disadvantaged circumstances, such as those with disabilities, street children/adolescents.

Establish counseling services, which would encompass young people's health and development concerns.

Behavior change communication (BCC) for sexual and reproductive health and HIV/AIDS that is evidence-based and sensitive to culture and gender. Promotion of joint and individual responsibility for protection against HIV and unintended/unwanted pregnancy

Component 2. Reproductive choice (Family planning)

Preamble

A family planning policy has been developed and approved by the Counsel of Ministers in 2002 however reproductive choice remains a relatively new concept for families in Timor-Leste. This situation stems from history where during the Indonesian occupation the community experienced a family planning program that was felt by the general community to be coercive and politically motivated. This led to some reluctance to participate and to participation that was not seen as individual choice.

Current research now suggests that the fertility rate of ever married women in Timor-Leste is the highest in the world. This has immediate and serious implications for child-bearing women and the health system.

For the individual there is the growing possibility of health implications as the woman ages and produces more children. As the body uses energy in the production of a child, short-spaced conception does not enable the body to fully recuperate. The development of the mother, as a person in her own right, is compromised. Higher aged siblings also feel the impact of high family births in their personal development, sharing of resources, including meaningful time with either parent, and eventually competition within the social and economic arenas for quality education and employment, housing and the like.

From a public health viewpoint, the total fertility rate of the country will result in a doubling of the population in 18 years. The ability to provide the promised range of quality services will be severely compromised as matters of access and equity circum to prioritization of scare resources.

Timor-Leste has adopted a number of international conventions and declarations including signing of all UN treaties many containing significant definitions of the rights of populations and population groups. The rights of women are of particular relevance to reproductive health and reproductive choice.

According to the ICPD Program of Action, the aim of family planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children; to have the information and means to do so; to ensure informed choices; and to make available a full range of safe and effective family planning methods.

> *"All countries should, over the next several years, assess the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services, which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice".*
>
> *Excerpt from the ICPD Program of Action 1994, paragraph 7.16*

Policy statement

The Government of the Democratic Republic of Timor-Leste recognizes the importance of spacing births and reducing the extremely high birth rate as a means of reaching its goals of eradicating poverty, reducing the country's high levels of maternal and infant and child mortality, and improving the health of mothers and children in line with the goals and targets set out in the United Nations Millennium Declaration.

The Government subscribes to the principles enunciated in the Program of Action agreed upon by the countries of the world at the International Conference on Population and Development (ICPD) held in Cairo from 5-13 September 1994, and in the Key Actions for the Further Implementation of the ICPD Program of Action adopted by the twenty-first special session of the United Nations General Assembly held in New York from 30 June-2 July 1999.

In particular, the Government endorses Principle 8 of the ICPD Program of Action, which states:

> *"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programs should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."*

In order to ensure that all couples and individuals in Timor-Leste have the means and information needed to make informed and free choices about the number and spacing of their children, the Government undertakes to make accessible at all levels of the public health system, with technical and financial assistance from the international community if necessary, family planning, including natural family planning, information, counseling and services. To ensure that such information, counseling and services are client-centered and adhere to the highest professional standards, the Government undertakes to provide ongoing training and information to relevant health-care professionals.

The Government undertakes to provide through the public health system, with technical and financial assistance from the international community if necessary, a

secure supply and effective distribution of the widest possible range of contraceptives in order to ensure that the choices and needs of couples and individuals in Timor-Leste are met. These services will be available through both the public as well as registered private services linking with the sub-district distribution and planning.

Public promotion of family planning will be carried out within the context of safeguarding family health and of promoting overall reproductive health and will stress the freedom of choice available to all couples and individuals. Such promotion will encourage accessing family planning information, counseling and services through trained professionals.

For further reference refer to Family Planning Policy, 2003

Strategic approach

Approach 1:

Increase the knowledge of individuals and couples on their right to make free and informed choices on the number and timing of children and to promote the goal of every child being a wanted child.

Develop IEC material focusing on birth spacing as the key to improvement in the health of mother and child. Community level IEC interventions are essential as is the targeting and involvement of men in all campaigns. Information, Education and Communication activities related to family planning should be cultural-religious sensitive, should respect people's individual choices and should be devised in the context of 'Responsible Parenthood'.

Ensure that the concept of reproductive rights has been included in school curricula and out-of-school programmes for young persons through the activities of youth groups and other community organizations. Young people need to be educated on issues related to reproduction and human sexuality, including family planning methods.

Seek to increase awareness that dual protection (from pregnancy and infection) is understood and practiced by all those who could expose themselves to risk.

Ensure that couples and individuals at the risky pregnancy stages (too young, too old, too close, too many) have access to comprehensive family planning services through an informed-choice approach that provides full disclosure of information in conjunction with offering family planning services.

Advocate for and support legislation that provides for free exercise of the reproductive rights of Timor-Leste citizens as detailed in international conventions and agreements signed by the Government.

Approach 2:

Improve the accessibility of contraceptive services and widen the range of contraceptive options offered to all who want to use them.

Family planning services will be integrated into the delivery of reproductive health services and will be universally accessible, convenient and available as required at every health facility. Planning in relation to routine services will be part of long-term strategies within the MoH resource management plan

including the needs of recurring budgets, human resources, supplies and facilities.

Essential care standards and practice guides for fertility regulation will be adapted to national conditions and needs and translated.

National guidelines will be put in place and monitored, based on international evidence based research, regarding contra-indications to the use of each contraceptive method.

Protocols that guarantee confidentiality and anonymity of contraceptive and other family planning services will be formulated and adopted into practice.

Training of health care providers will include not only the technical and managerial aspects of contraception but also appropriate interpersonal communication and counseling skills.

Contraceptive services will be provided as part of primary health care. Advice on natural methods along with condoms, oral and injectable contraceptives will be made available at Health Post level, while contraceptive subdermal implants and IUDs will be added at CHC-2 centers, and sterilization will be available at referral hospitals and higher level health centres with appropriate equipment and trained staff.

Each contraceptive service point (CSP) will be able to explain and offer a choice of at least three different modern methods of contraception, or (in case of surgical contraception) know where to refer clients. Supply chains will be strengthened to ensure a continuity of supplies. Complete and accurate information about all methods will be offered, thus contributing to informed choices.

A referral system to family planning services for methods not available on-site (IUD, implants, sterilization) will be established.

All health services providing contraception will support family planning methods with availability of, or referral for, treatment of adverse reactions or side effects to clients as a result of the use of contraception.

Appropriate arrangements will be made guaranteeing that age (e.g. adolescents), gender, marital status, ethnicity, knowledge of languages, income level, and other criteria do not make services inaccessible to those who need them.

Specific strategies will be developed to cover areas of unmet demand of family planning particularly for older aged mothers still of child bearing age.

Approach 3:

Provide a basic service for individuals and families for the prevention and treatment infertility, which are integrated into high-quality family planning services.

Provide confidential counseling services for women and men on conception techniques and practices at all levels of health system.

Evidence-based tools and guidelines for infertility diagnosis, management and basic treatment adapted and used at district hospitals level.

Approach 4:

Increase the active participation and responsibility of men in informed decision-making on RH issues and to promote use of male contraceptive methods.

RH services for men will be made available such as male family planning methods, information and services on STIs/HIV, infertility.

BCC will be developed, in conjunction with critical reference group, on matters of sexual violence, coerced sex, equitable decision-making and gender issues within families on sexual matters.

Explore the potential for development of advocacy forums and mechanisms for men who require support in living with anti-social behaviours on sexual matters.

Approach 5:

Integrate effective management of STI cases in Family Planning Services and prevent/reduce sexual transmission of STI and HIV/AIDS

Develop culturally appropriate IEC messages on STIs and HIV/AIDS, safer sexual behavior, correct use of condoms, attitudes to and care of people with AIDS.

Train staff in syndromic case management (syndromic diagnosis, treatment, confidentiality, education and counseling, condom notification and follow-up) and in referral of complicated cases.

Screen all family planning clients and provide confidential STI case management if needed through all health facilities. Ensure that services are accessible and acceptable to all groups. Standardized nationally accepted STI treatment protocols will be used.

Ensure a confidential, voluntary, non-coercive system for partner notification.

Ensure an adequate and consistent supply of medical supplies, drugs and barrier protection.

For further reference refer to STI/HIV/AIDS Policy, 2004

Component 3. Safe motherhood

Preamble

Making pregnancy safer is an initiative launched by WHO to reduce the global burden of unnecessary death, illness and disability associated with pregnancy, childbirth and the neonatal period.

The central objective of the Making Pregnancy Safer strategy is to ensure safe pregnancy and childbirth through the availability, access and use of quality ***skilled care*** for all women and their newborns. As a priority, skilled care should be ensured at every birth. Skilled care in maternal and newborn health refers to the process by which a pregnant woman and her newborn are provided with the necessary care, which must include, apart from care in normal (uncomplicated) birth, timely referral and management of complications if they arise. The essential component of skilled care is the presence of a ***skilled attendant*** and other key skilled professionals supported by an appropriate environment with access to basic supplies, drugs and

relevant emergency services. As a core operational principle, skilled care should be provided within a continuum of care. This continuum extends from care and support in the home, to care by a skilled attendant throughout pregnancy, childbirth and the postnatal period, to the care needed in case of complications.

Making Pregnancy Safer, Strategic direction, WHO, 2004-2015

Definition of a skilled attendant

A skilled attendant is a health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period and in the identification, management and referral of complications in women and newborns.

(FIGO/ICM/WHO Joint Statement on Skilled Attendants, 2004)

Maternal death is a tragedy for individual women, for families, and for their communities. Maternal death has implications for the whole family and an impact that rebounds across generations. The complications that cause the death and disabilities of mothers also damage the infants they are carrying. Significant reductions in infant mortality can be achieved with interventions designed to improve the health of the mother and her access to care during labour, birth, and the critical hours immediately afterwards.

A maternal death is the death of woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes.

World Health Organization

Maternal deaths are subdivided into direct and indirect obstetric deaths. Direct obstetric deaths result from obstetric complications of pregnancy, labor, or the postpartum period. They are usually due to one of five major causes – hemorrhage, sepsis, eclampsia, obstructed labour, and complications of unsafe abortion. Indirect obstetric deaths (20%) result from previously exiting diseases or from diseases arising during pregnancy (but without direct obstetric causes), which were aggravated by the physiological effects of pregnancy. The most important indirect causes are malnutrition, anaemia, malaria, hepatitis, heart diseases, tuberculosis or HIV.

Deaths in newborn during the first week of life are largely the result of inadequate, or inappropriate care during pregnancy, childbirth, or the first critical hours after birth. The causes are similar around the world – newborn babies die or are damaged because of birth asphyxia, trauma or infections.

The factors underlying the direct causes of maternal deaths operate at several levels. Health and reproductive behavior affect maternal mortality through health status, pregnancy and complications. The relationships between maternal mortality and characteristics of reproductive behavior (age, pregnancy order, birth spacing, wantedness of pregnancy) are among the best documented in the literature.

The low social and economic status of girls and women is a fundamental determinant of maternal mortality. Low social status of women limits their access to economic resources and basic education and thus their ability to make decisions related to their health nutrition. Violence against women is also considered an underlying and predisposing factor for maternal ill-health.

There is a growing understanding that, while certain pregnancy complications can be prevented, a large proportion that occur particularly around the time of birth can be neither prevented nor predicted. Thus, the presence of skilled attendants is crucial for

the early detection and appropriate, timely management of such complications. It is critical to have well coordinated emergency obstetrical care system to identify complications and ensure their management with immediate first aid and/or referral.

There are three types of delays that can occur when it comes to obstetric complications. Delays in obtaining help may be at the community level, en route to the referral facility, or on arrival at the referral facility. Access to health facilities implies not only that the facilities exist, but people have the information they need to use them properly, that the facilities can be reached by the people who need them, that the cost of care is reasonable, that the supplies and equipment are adequate and that services are provided in a manner acceptable to patients and families. Providing skilled attendants able to prevent, detect, and manage the major obstetric complications, together with the equipment, drugs and other supplies essential for their effective management, is the single most important factor in preventing maternal deaths.

Policy statement

The Government of the Democratic Republic of Timor-Leste recognizes the importance of the availability of good-quality basic and comprehensive essential services to all women during pregnancy and childbirth to reduce levels of maternal and neonatal mortality and morbidity in the country.

The government also guarantees that all pregnant women, whatever the circumstances of their pregnancy and delivery, will have access to basic and comprehensive maternity care, comprising quality antenatal care, clean and safe delivery and postpartum care including newborn care free of charge.

The Government undertakes to develop information, education and communication (IEC) strategies to enable women and their families to recognize complications and to encourage health-promoting behaviors before, during and after pregnancy and delivery. Community based health posts and community based health care providers will be important resources in such efforts.

The Government will improve access to effective maternal and newborn care and fertility regulation services through promoting increased investments in public health and the development of arrangements (such as contracting) to maximize the contribution of the private health sector to the national goals. In order to ensure that health services are available as close as possible to people’s homes the Government will continue in its plan of upgrading of peripheral facilities and improving the quality of care provided through district-based implementation of intervention.

To ensure that a skilled attendant is available to provide care to every pregnant women along with the presence at birth, the Government will develop human resources through in-service, competency based training as well as through initial preservice midwifery education. Priority will be given to the development of core midwifery skills needed to provide routine maternal care and to respond to obstetric complications.

Following the integrated approach of service delivery adopted by the Ministry of Health, antenatal care will be used as an opportunity to detect and manage nutritional deficiencies and to treat endemic diseases such as malaria and STI, as well as to offer prophylactic care such as tetanus toxoid immunization and iron/folate supplementation, to plan the place of birth and inform women and their families about

when and were to seek care. Postpartum care will include breastfeeding support and counseling, the prevention or early detection of maternal or newborn complications, as well as contraceptive advice and vitamin A supplement as required to permit adequate maternal recuperation before the next pregnancy.

The MoH will strengthen the referral system through supportive supervision, further developing communication mechanisms, and logistic support, including ensuring the availability of essential drugs and supplies.

In order to monitor and evaluate quality of care, the Government will undertake to establish and use standards care at each level and monitor standards for practice in maternity services (See Annex 2).

Strategic approach

Approach 1:

Substantially increase the level of knowledge in the general population on issues related to pregnancy and childbirth.

The special needs of pregnant and lactating women in terms of nutrition, rest, antenatal, delivery and postpartum care will be disseminated to all women, families and communities through IEC materials and during maternal service provision.

Signs and symptoms of complications and the need to plan for emergency transport to the health center or hospital will be disseminated to the general community to ensure appropriate care is available for mothers experiencing difficult births.

Antenatal care sessions will be used as an opportunity to provide information to women and their families about danger signs and symptoms during pregnancy and delivery.

Mechanisms to ensure involvement of and collaboration between skilled attendants (private and public) and informal health care providers, such as TBAs, traditional healers will be established.

Provide leadership and direction on maternal and newborn health and the role of skilled attendants within national public health promotion and information efforts, including through specialist and popular journalists and the media.

Approach 2:

Improve quality and coverage of prenatal, delivery, postnatal and perinatal health care.

Ensure adequate number of skill health attendants are recruited, deployed and managed to enable delivery of quality maternal and newborn care.

Ensure that the National Mid term Human Resource Plan provides for adequate numbers of health professionals trained to proficiency in the skills needed to manage normal pregnancies, childbirth, and the immediate post natal period and in the identification, management and referral of complications in women and newborns.

Provide an effective, skilled, and appropriately trained workforce to strengthen reproductive health care delivery.

National and regional trainers' network will be developed to provide up to date information on maternal and perinatal health. Undertake national-level monitoring and evaluation of educational institutions to ensure curricula are competency based and national-level monitoring of implementation of best practice.

Essential care standards and practice guides for maternal and newborn care will be adapted and translated to national conditions and needs and will be used in all sectors (public and private).

National rules, regulations and frameworks for practice will be established, including national ethical codes of professional practice.

Establish mechanisms to ensure the smooth functioning and coordination of the maternal health care team, including links with the private sector.

Develop quality-enhancement procedures that link maternal health care providers with other members of the health care team, including blood bank, laboratory and other diagnostic technicians, maintenance and transport workers, etc.

Strengthen existing links between the community and the health care system. Further develop the concept of establishing and equipping community level maternity waiting homes.

Establish sound monitoring and evaluation strategies including appropriate case notes and other records, surveillance of adverse events, and feedback on progress for all health care providers in both public and private sectors.

Develop mechanisms for regular audit and enquiries and ensure "no name – no blame" mentality to investigate adverse events affecting pregnant women and their newborns.

Research undertaken to develop and introduce effective interventions to reduce maternal and perinatal ill-health and mortality.

Provide skilled care within a continuum of care. This continuum extends from care and support in the home, to care by a skilled attendant throughout pregnancy, childbirth, and the post natal period, to the care needed in case of complications.

Approach 3:

Improve emergency obstetric care through recognition, early detection and management or referral of complications of pregnancy and delivery.

Ensure a policy framework is in place to permit the delivery of clinical interventions at the appropriate levels, from the community level up, as is consistent with practice recognized in procedures and protocols.

Develop competencies and technical support systems for first line maternal health workers in health posts and community health centres to recognize and stabilize cases of birthing complications.

Review and strengthen emergency referral systems for management of complications.

Equip health posts and health centres to enable initial management of complications and the provision of obstetric first aid before referral.

Ensure that national essential drugs lists include key commodities needed by skilled attendants and others to implement the core interventions.

Ensure that safe emergency obstetric services are available, accessible and acceptable to all groups of women and to adolescent girls.

Through TBAs, health care providers and midwives, conduct an IEC campaign on recognizing signs of complications and on the need to refer.

Approach 4:

Integrate effective detection and management of STI cases, including HIV, in maternal and perinatal care

Provide confidential STI case management through all health facilities. Ensure that services are accessible and acceptable to all groups. Standardized STI treatment protocols will be used.

Train staff in syndromic case management (i.e. syndromic diagnosis, treatment, confidentiality, education and counseling, condom notification and follow-up) and in referral of complicated cases.

Ensure an adequate and consistent supply of medical supplies, drugs and barrier protection.

Screen pregnant women for STIs/HIV as determined in national protocols.

Follow national protocols for preventing HIV transmission through blood transfusion.

When blood donation for an expectant mother is required, provide confidential pre-test and post-test counseling for all donors.

Provide staff training on the appropriate use of blood for transition, recruitment and care of donors, pre-test and post-test counseling, confidentiality, and safe disposal of waste products.

Develop guidelines and train all health workers in national infections prevention.

Provide equipment and supplies for staff and patient protection, for sterilization, disinfection, cleaning and safe disposal of sharps and waste.

Refer to National STI/HIV Policy for details.

Component 4. General reproductive health

Preamble

Definition of Reproductive Health Care:

"The constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems" (ICPD-PoA, para 7.2)

The Reproductive Health Strategy emphasize the benefits of child spacing to improve the health status of mothers and infants with the objective of reducing the number of

maternal and infant deaths. Apart from childbearing, other important reproductive health issues include safe sexual behavior and prevention of reproductive health conditions. Reproductive health is not relevant only for women in the childbearing years of their lives. Women who have completed their child-bearing, or have elected not to have children also have reproductive health needs not necessarily linked to fertility regulation, such as screening for cancer of the reproductive system and care of the elderly. And men and young people have different reproductive health needs that must be addressed.

This is reflected in the ICPD's recognition of the importance of meeting the reproductive health needs of women and men in all stages of life as a critical requirement for human and social development. As a consequence of the acceptance of the definition of reproductive health, health care services have to be reorganized to provide one service targeted at all aspects of reproductive health, throughout the life cycle.

The approach to reproductive health is a holistic one. It takes into consideration not only the bio-medical aspects of reproductive health complications experienced by women, related to pregnancy and childbirth, but also the social and cultural dimensions of their health conditions; focuses on a diverse range of target groups, addresses gender concerns/issues in the population development programs to promote gender equality and equity; considers the health consequences from violence against individuals, male participation in reproductive health and their support in fostering women's health status through equality of women and men.

Policy statement

The Government will substantially increase the level of people's awareness about positive sexual and reproductive health behaviour or activity, provide them with a broad range of appropriate knowledge and information to contribute to changes in their attitudes and health seeking behavour.

To ensure the broad-based life cycle approach to reproductive health interventions at this stage the Government will highlight access of men to information and services on male reproductive health problems; counseling on issues associated with active ageing and reproductive health cancers.

The Government will explore the opportunities for health, participation and security in order to embrace quality of life as people age through promoting healthy lifestyles, reducing health risks and increasing quality of life. The Government will ensure that all women and men are informed about emotional, physical and hormonal changes during the ageing process; services take sexual health needs of the ageing population seriously and provide counseling as appropriate; measures will be taken in future to ensure access to treatment, preventing the complications of hormonal changes. The Government will also explore the most effective ways of establishing screening programs for early recognition and treatment of reproductive cancers.

The Government will ensure that social issues such as the prevention and management of gender-based violence are also part of integrated reproductive health care. Preventive measures will be established, and appropriate medical, psychological and legal responses will be organized.

Strategic approach

Approach 1:

Substantially increase the level of knowledge in the general population on issues related to reproductive health:

To build the evidence base for high-quality, non-discriminatory, acceptable and sustainable sexual and reproductive health education and services.

To facilitate transfer of reproductive health knowledge using appropriate strategies and media.

Social awareness on reproductive rights, changing reproductive health need over life cycle and availability of reproductive medical services for all groups of population through accurate, culturally acceptable, gender-sensitive informational package. Most emphasis will be placed on behavioral and socio-psychological outcomes.

Taking into account community beliefs and practices regarding nutrition, food taboos etc, develop IEC materials and conduct community education on the nutrition needs of groups with special needs.

Through key informants and focus group discussions, identify target audience and develop culturally appropriate IEC materials on STI and HIV/AIDS. Develop community IEC materials on gender-based and sexual violence in collaboration with both men and women.

Increase awareness within community of reproductive cancers (cervical, breasts). Increase women's knowledge on reproductive cancers prevention and early diagnosis.

Women and men will be informed about emotional, physical and hormonal changes during aging, and about the possibilities to prevent complications related to this process

Approach 2:

Increase male commitment to sexual and reproductive health

Improve men's knowledge, access to and use of effective reproductive health care services, especially in the areas of family planning, maternal health, prevention of sexually transmitted infections (STIs), including human immunodeficiency virus/AIDS, and the prevention of violence against women.

Promote healthy male lifestyles as part of a new concept of a supportive role by men for their partners and their own sexual and reproductive health.

Raise awareness of men about sexual activity risk, benefits of protection and the consequences of delayed and inadequate treatment of STI.

Promote male methods of family planning.

Ensure that male adolescents are made aware of the need for lifelong protection for themselves and their partners. The intervention will target youths attending schools, those not attending schools, men in the workplace, the partners of women presenting for antenatal care and at social events attended by men potentially at risk.

Ensure availability, accessibility and sustained reproductive health services for men.

Approach 3

Increase availability of high-quality, culture and gender sensitive and non-stigmatizing services for the prevention, care and management of STIs and HIV/AIDS and to provide care for people with HIV/AIDS.

Through key informants and focus group discussions, identify target audiences and develop culturally appropriate IEC materials on STIs and HIV/ADS, safer sexual behavior, treatment of STIs, and attitudes to and care of people with AIDS

Through community education classes and women's groups, provide opportunities for women, men and adolescents to explore attitudes to sexuality and decision-making within relationships and to explore ways that women, men and adolescents can protect themselves from STD and HIV/AIDS.

Integration of STIs and HIV/AIDS related services such as STI management, voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) in wider sexual and reproductive health services.

Provide confidential STI case management through all health facilities. Ensure that services are accessible and acceptable to all groups.

Develop clear guidelines on HIV testing. Train staff in pre-test and post-test counseling, emphasizing voluntary testing and confidentiality of results.

Provide ongoing support for people who have tested HIV positive.

Provide comprehensive care for people with HIV/AIDS through clinics and inpatient services and through support for community-based home care for HIV/AIDS patients and their families

Train health workers in clinical recognition and case management of AIDS, use of essential drugs for care of HIV-related illness, nursing care, counseling, and patient and family education.

Refer to National STIs/HIV Policy.

Approach 4:

Provide a confidential, sensitive and culturally appropriate response to victims of gender-related and sexual violence.

Develop IEC materials and appropriate interventions on gender-related and sexual violence in collaboration with female and male key informants.

Include gender-related and sexual violence in the training of all health workers.

Develop protocols for a confidential and sensitive medical response to gender-related and sexual violence. Ensure that services are acceptable and accessible to all groups in the community.

Establish a system for referral to other services (protection, legal, social services, and counseling) that respects the victim's confidentiality and right to decide what action should be taken.

Through women's groups and informal networks, inform women in the community about the medical services that are available for victims of gender-related and sexual violence.

With key informants from community, identify the most effective and culturally appropriate ways to respond to the psychological need of survivors of sexual violence. Develop culturally appropriate professional counseling services alongside the community-based response.

Identify and support community resources that can assist in psychological responses.

4. Institutional approach

The Ministry of Health has now established the organic law, which outlines departments and levels of service delivery. National Reproductive Health Strategy (RHS) along with other priority strategies form an integral part of this structure. The institutional framework that supports the RHS is:

> *"Under the Division of Health Services Delivery and consist of a Department of Maternal and Child Health and a unit for health promotion and its term of reference will be to play a strategic role. Districts will be directly responsible for RH activities. Districts will coordinated their activities with higher level for planning, implementing, specialized advice and quality control of the program". (MoH, Health policy Framework, 2001)*

4.1. The institutional framework

Community Level

The primary delivery of the NRHS will be at the community level. This is a core component of the MoH Basic Package of Services of primary health care.

The aim of working at the community level is to contribute to the empowerment of women, men, families and communities to improve and increase control over maternal and newborn health, as well as to increase access and utilization of health services, particularly those provided by skilled attendants. The availability of quality services will only produce the desired health outcomes where there is a possibility for women, men, families, and communities to be healthy, to make healthy decisions, and to be able to act on these healthy decisions. The interventions at the community level are to foster supportive environments for survival but also for healthier mothers, healthier newborns, healthier families and healthier communities.

The aims will be achieved through strategies of education, communication action for health, partnerships, institutional strengthening and local advocacy. Interventions for working at the community level are organized into four priority areas:

- developing CAPACITIES to stay healthy, make healthy decisions and respond to reproductive health problem;

- increasing AWARNESS of the rights, needs and potential problems related to reproductive health ;

- strengthening LINKAGES for social support between women, men, families and communities and with the health care delivery system;

- improving QUALITY of care and of health services and of their interactions with women, men, families and community.

For the development of CAPACITIES, interventions in workplaces, schools, adult education and through multi-channel communication will be employed as interacting strategies. Individual and collective AWARENESS and capacities will be maximized through the establishment or strengthening of social networks, which are able to collaborate and interact with health service networks. Partnership between individuals, community organizations and other actors of the district health system and at the community level are the basis of social networks. All actors and resources should be considered, including traditional healers, health development committees, NGOs and local government. Social network organizations and structures can participate in analyzing the situation of reproductive health, finding solutions for transport and health expenses, contributing to improvements in the quality of care, and participating in local level advocacy. Social networking activities strengthen the LINKAGES between pregnant women, mothers and their newborns, the family and the community, while reinforcing the linkage with health services. A strong entry point for community and health services collaboration can be developed through approaches that involve the community in defining and monitoring the QUALITY of care. The reproductive health policy concept of communities embraces a community – centered approach to quality; therefore, community involvement in defining quality and providing feedback to the healthcare system is key.

Education is an essential element of primary health care. Communication approaches such as information, education and communication (IEC), social marketing, and behavior change communication (BCC) represent systematic attempts to provide a positive influence on the health practices of large population.

As with education, community action for health is critical in all the priority areas of interventions outlined below. The community has a particularly strong role to play in strengthening linkage with health services, in increasing awareness of reproductive health needs and in improving the quality of care. In these areas, increased knowledge of the community results in increased action for health and increased action for health and increased participation in problem-solving to meet maternal ad newborn health needs.

As decentralization strengthens, efforts and planning will include strengthening of district and community forums so that community representatives can actively assume ownership of reproductive strategies and pass this ownership on the community in general. For community interventions, skills for community mobilization, community dialogue, communication, research, educational approaches and for interacting with the community, need to be assessed.

Community efforts should work closely with advocacy efforts of reproductive health programs. Several community interventions are advocacy-oriented, increasing the “demand” from communities, raising community awareness about reproductive health issues and participation in the decisions taken at the district level for finding solutions and allocating resources.

District Level

The various levels of the district health services (DHS) are directly responsible for planning, implementing, and managing RH program activities. The structure of the MoH DHS extends from the first point of contact, the Health Post, to more advanced services in the Health Centre with small mobile clinics providing services to significant population groups in the absence of fixed facilities.

Districts will draw on support from the Service Directorate, Maternal Health, for strategic direction, technical and specialized advice and quality control of the reproductive health interventions and activities, drawing on the strategies of the strategy. All RH interventions will be undertaken within the MoH planning framework of the DHP.

Within the District Health Management Team (DHMT) there will be appointed a focal point for RH who should coordinate and integrate the components of Reproductive Health. These district officers will work with other DHMT officers to establish mechanisms for RHS activities within the district framework.

It is the RH focal point responsibility, as a component of the DHMT, to ensure technical guidance, support (flow of supplies, training needs and delivery, access to guidelines and protocols) and monitoring of RH are incorporated into the DHP planning, processes, monitoring and evaluation.

The combined DHMT will have the responsibility to ensure that the principles of service provision are carried out. These include the holistic approach to healthy interventions, the essential requirement of community engagement plus the intersectorial collaboration in planning and intervention action.

A referral systems feeds from the front line health services through to referral hospitals for either anticipated cases of complicated deliveries or for emergency obstetric services and certain types of family planning methods, and eventually to the National Hospital in Dili for highest level of service when required.

The referral system will be based on a radio communication system where first line of service can contact facilities with higher levels of service to provide advice and arrange transfers. An ambulance transfer service will move obstetric emergencies from health posts and health centres to referral hospitals.

National Level

The Maternal and Child Health Unit will be the focal point of the RH Strategy at the national level. The unit will be structured according to the four components of the RH Strategy, and will provide a resource of expertise for partners in RH including technical and strategic support for District focal points. This unit will coordinate and work closely with all central service units including health promotion in issues relating to RH, and across all young people's health areas, including behaviour change initiatives. Together the units will collaborate to:

- Develop and disseminate policies and strategies and keep them up to date.
- Produce and disseminate national standards and protocols for all components of the strategy.

- Provide technical assistance to districts including identifying needs and providing training opportunities as required.
- Monitor and evaluate implementation and impact.
- Provide clear lines of accountability and reporting reuirements.
- Define and use clear indicators for monitoring and evaluating progress
- Build capacity of the MCH unit and district level managers and health workers
- Advocate RH Strategy to all policy makers and development partners to ensure healthy outcomes.

The central unit will also ensure that the multi-sectorial approach to provision of services and in addressing determinants of ill health and wellbeing is fully developed and implemented for reproductive health issues. This includes advocating for law reform, inter-agency, inter-ministry planning and action, education, law enforcement and the like.

4.2. Partnerships

Strong political commitment and strategic partnerships at all levels are crucial for gaining the needed inter-sectoral collaboration. All stakeholders at both national and local levels, including public and private providers, all related programmes and representatives from women's and community groups, should be actively involved from a very early stage in identifying priorities, assessing needs, developing, implementing, monitoring and evaluating maternal and newborn health programmes and plans. The involvement of other ministries, such as those dealing with education, finance, transportation, social welfare and women's affairs etc., is critical. Collaborative efforts with other relevant public health programmes and initiatives should be systematically addressed and established.

Partnerships within the Ministry of Health:

- MCH
- CDC
- Nutrition
- Health Promotion
- NCHET and National Institute of Health Sciences (NIHS) *# when established*
- Other linked sections (eg finance, logistics etc)

Other Ministries:

- Ministry of Finance and Planning
- Ministry of Education, Culture, Youth and Sport
- Minister of Internal Affairs
- Ministry of Transportation, Communication and Public Works
- Other relevant ministries

UN, Donors, NGO's and Research Institutions:

- UN and development partners: on access to technical advice, resources and global initiative.
- NGOs: to assist in the co-coordinated delivery of services to coordinate delivery of services to community and intervention from the community.

- Research institutions: on identifying research needs, translating research results to improve existing policy and practice.

4.3. Mechanisms for coordination

Coordination and cooperation between the multiple partners involved in reproductive health service provision is essential to avoid unnecessary duplication of efforts and waste of resources, and to ensure that all partners are working towards common goals.

The National RH Strategy Coordination Committee, Team or Working Group will provide a forum for partners in the RH Strategy to exchange information, coordinate RH plans and activities, and monitor progress against objectives. The National RH Coordination Committee is a standing committee of the Ministry of Health and will report on activities and recommendations of the committee to the MoH. This Committee will be integrating all four components in Reproductive Health. The terms of reference of this committee will include:

- To advice and guide the Ministry of Health on National RH policy and strategy development.
- To provide advice and support for the Mother and Child Health Unit on implementing strategies within the NRHS.
- To advise and guide the Mother and Child Unit and allied units in RH in the content and organization of the National RH Work Plan
- To act as a forum for exchange of information between development and implementing partner plans and activities
- To receive and analyze NRHS implementation reports from Mother and Child Health Unit and provide recommendations on outstanding issues and concerns when requested.

The Committee will meet at six months intervals. Ad hoc meetings on specific area may be arranged in exceptional circumstances. This committee has a right to invite representatives of inter-ministerial, multi-sectorial departments, special groups or the community to attend as observers or consultants when required.

The composition of this committee will be determined as required.

Multisectoral national working groups to support policy development and legislative actions in respect of reproductive health and development to be established and convened as required. Terms of reference could include:

Utilizing the media, NGOs and international agencies for advocacy in relation to policies and legislation for RH and development.

Strengthen the collaborative efforts between governments and NGOs for implementation of policy decisions and legislation.

Utilize local-level NGOs for advocacy, and for initiating service models, as well as for supporting and sustaining community actions.

Intensify advocacy and IEC efforts for improvement of health and education services for all groups.

Encourage local-level young people organizations to develop peer groups to plan, implement and coordinate young persons programs.

Mobilize family and community resources for young person's health concerns and development programmes, together with the active participation of adolescents themselves.

5. Implementation

5.1. Annual plans of action

Each component of the ten year NRHS will be broken down into milestones, set before the start of each financial year. The District Health Management Team (DHMT) will develop a detailed annual plan to reach these milestones. The plans will identify activities, responsibilities, resources needed and time-scales. The detailed implementation plans will include time-lines and show linkages, indicating precisely when each activity will be implemented and by whom. It will also include district level monitoring and evaluation mechanisms linked to the overall monitoring at national level. Draft plans will be used to negotiate for Governmental resources and donor funds, and final plan will then be fitted to the resources available.

5.2. Advocacy and political support

The MoH will press for adequate and sustainable resource allocation and lobby policy makers to get a political support for NRHS through the appropriate parliamentary channels.

5.3. Information service

Information is vital to the coordinated and strategic response to NRHS, enabling all partners at all levels to make decisions in concert with national policy. The MCH Unit and other relevant units will develop information dissemination tools through distribution of all policy documentation and guidelines to districts, national and international partners. They will ensure that updated information from research, surveys and routinely collected information (HMIS) on RH is adequately analyzed and disseminated to policy developers and planners.

5.4. Building Capacity

The MCH Unit will coordinate and focus on capacity building approaches in collaboration with decentralized support as part of the health sector reform process. Capacity building will be developed around the strategic approaches, systems for assessing RH training needs and building partnerships.

5.5. Resources

Budgeting for RH will be undertaken within the MoH budgetary system and will be tied to annual work plans at all levels

At lower levels, as decentralization proceeds, RH will be incorporated and earmarked in budgets for delivery of the total health package.

At national level, a budget will be attached to the MCH and allied units work plan and other programme and function in MoH. Resources for this plan will come through the recurrent and development budgets and negotiations with development partners.

To ensure adequate resources for NRHS activities, the following will be fundamental:

RH Activities must be integrated every year into comprehensive district health plans as part of the Health Sector Reform Process.

MCH Unit technical assistance will be available to ensure district work plans conforms to RH priorities.

MCH Unit will facilitate relevant international agencies to raise more resources to implement NRHS.

5.6. Human resources

The specific skills to be developed to improve reproductive health care will include senior and mid-level management skills, supervisory skills and clinical skills. Teaching-learning materials and teachers/trainers will be updated in relation to both pre-service and in-service training programmes to reflect the knowledge and skills required for activity implementation. Training or re-training of reproductive health care providers will be done in the context of the development of human resources for the health system as a whole.

The MCH unit will be responsible for liaison with National Institute of Health Sciences (NIHS) in developing training materials and organizing the trainings.

6. Monitoring and evaluation

6.1. Policy

Progress on the implementation of strategies and attainment of objectives needs to be assessed on a regular basis.

The Ministry of Health will ensure processes are in place to monitor and evaluate the impact, process, outcomes and responsiveness of the reproductive health system in order to know whether the strategies adopted are producing the expected outcomes and impact. At each level of the system a set of indicators will be developed with, data collected and analyzed on a periodic basis. This monitoring and evaluation will take place at the service delivery level with simple data sets providing information for health workers to plan response service delivery and interventions. Basic data sets will be included in the HMIS routine data gathering system and captured from activity registers of the health posts, health centres and hospitals. At the district level, data will be gathered to inform district support, including supervision, for service interventions. Further data will be required by central services. These data will be a consolidation of district reporting in conjunction with specific data collection, periodic reviews and ad hoc field research. Central services will use this specific and consolidated data to assess the effectiveness of the overall NRHS and issues that may emerge in the implementation.

6.2 Monitoring indicators

A number of key indicators to inform development and delivery of reproductive health interventions include:

Component NRHS	Indicator	Means of verification
Young people's reproductive health	Fertility rate of women 15-19 (measure of impact)	Vital statistics, population censuses or population based surveys
	Incidence of STIs in young people (measure impact)	Routine heath services data, population-based surveys.
	% of family planning clients who are adolescents (process indicator, measure of utilization)	Routine heath services data, population-based surveys.
Family Planning	Total fertility rate (measure of impact)	Vital statistics, population censuses or population based surveys
	Contraceptive prevalence rate by method (process indicator, measure of utilization)	Population-based surveys; routine reporting.
	# of acceptors new to modern contraception	Service statistics, survey.
	# of contraceptive methods available at primary health care centers (measure of availability)	District records; facility surveys
	% of family planning clients who are (i) adolescents, (ii) men (measure of accessibility)	Survey; community health registers
	% of women up to 6 weeks postpartum offered family planning (measure of quality of care)	Survey; community health registers
Safe Motherhood General	Maternal Mortality Ratio (measure of impact)	Vital registration; service statistics and population based surveys.
	Low birth weight rate (measure of impact)	Survey; community health registers
	Stillbirth rate (measure impact)	Vital registration; service statistics and population based surveys.

	Neonatal mortality rate (measure of impact)	Vital registration; service statistics and population based surveys.
	Perinatal mortality rate (measure of impact)	Vital registration; service statistics and population based surveys.
	Percent of Audients that know 3 primary danger signs of obstetric complications	Population-based survey.
Safe Motherhood Antenatal, intrapartum and postpartum care	Coverage of antenatal care (measure of impact)	Routine heath services data, population-based surveys.
	Tetanus toxoid coverage (measure of impact)	Routine heath services data
	Incidence of spontaneous abortion (measure of impact)	Routine heath services data, population-based surveys.
	% of birth attend by skilled attendant (process indicator measure of utilization)	Survey; community health registers; service data.
	Vaccination coverage in newborns (outcome indicator)	Routine heath services data.
	Coverage of postpartum care (outcome indictor)	Routine heath services data, population-based surveys.
	Number of referrals to a higher center (process indicator, measure of quality)	Routine heath services data.
Safe Motherhood Emergency Obstetric care	Case fatality rates for direct obstetric complications (measure of impact)	Routine heath services data, population-based surveys.
	# health centers per 500 000 population able to provide basic essential obstetric care (output indicator, measure of availability)	District records; facility surveys
	# district hospitals per 500 000 population able to provide comprehensive essential obstetric care (output indicator, measure of availability)	District records; facility surveys
	Proportion of women estimated to have direct obstetric complications that are seen in EOC facilities (process indicator, measure of utilization)	Hospital registers

	Caesarean sections as a proportion of all live births in the population. (process indicator, measure of utilization)	Hospital registers.
General Reproductive Health	Estimated prevalence of STIs (by sex) (measure of impact)	Routine heath services data
	Estimated prevalence of cases of gendeer-based or sexual violence.	Routine heath services data, population-based surveys.

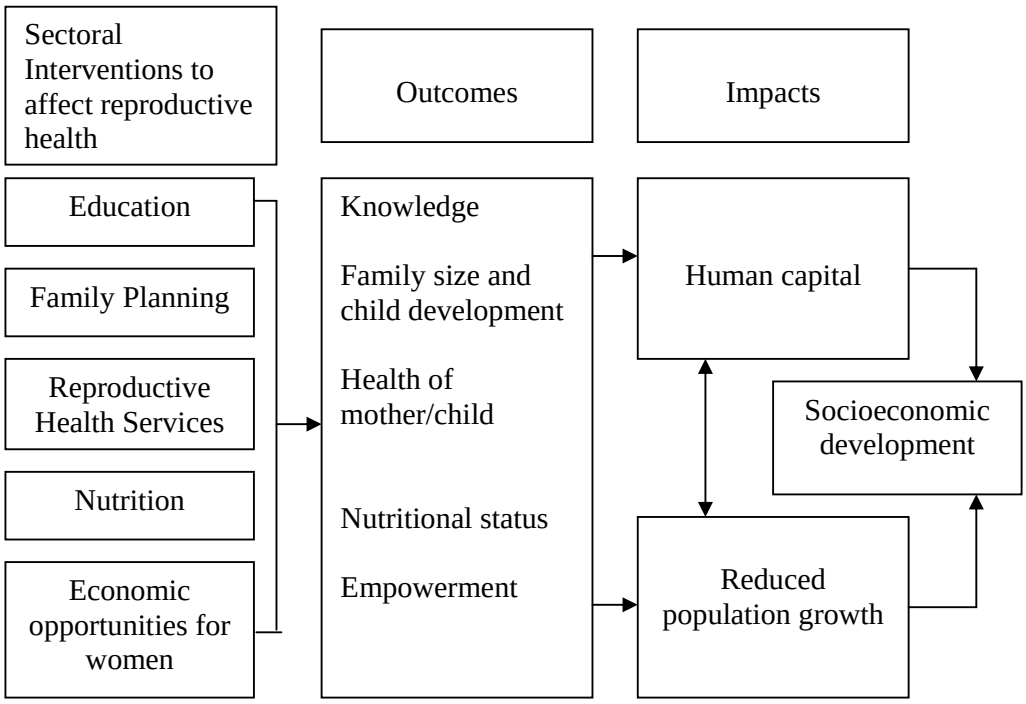
6.3. Strategy Review

In keeping with the overall policy of the MoH, this National Reproductive Health Strategy will be reviewed for continuing relevance in regard to MoH internal systems, planning procedures and further changes in overall service delivery. This review will take place not later than 2 years after the official introduction of this strategy.

Annex 1: Human Capital Framework of Reproductive Health

Figure 1 presents an example of a framework of interventions that contribute to improve reproductive health. In this human capital framework interventions that contribute to improved reproductive health are education, family planning, reproductive health services, nutrition, and expansion of economic opportunities for women. The framework of reproductive health interventions, developed from the definition of reproductive health embodied in the Program of Action, include services with the goals of preventing unwanted pregnancy; reducing reproductive maternal mortality and morbidity; reducing reproductive tract infections, including sexually transmitted diseases; reducing HIV/AIDS; reducing reproductive cancer; preventing female genital mutilation; preventing sexual and gender-based violence; and reducing and helping to manage infertility. Programs associated with the interventions at the far left of the framework have an impact on the specific factors that directly create human capital, the proximate determinants of human capital. Determinants include knowledge, family size and child development, health status, nutritional status and female empowerment. Both individually and collectively, improvements in these outcomes – most of which are identified in the Programme of Action's reproductive health agenda – will increase human capital.

Figure 1. Human capital framework for reproductive health.



Annex 2. Integrated RH care package by level of health care facility

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	Mobile clinic, Health Post Level1	Community Health Center Level 2	Community Health Center Level 3	Community Health Center Level 4	Referral hospital	National hospital
Type of services	Basic package of preventive/promotive interventions and curative services, maternal care (antenatal, normal deliveries, postnatal care)	Same as for MC and HP plus coordination of preventive/promotive sub-district activities, treatment of STI, simple laboratory or collection of samples and send them to nearest laboratory	Same as for CHC L2 plus coordination of preventive/promotive district activities, basic emergency obstetric care, essential laboratory (malaria, TB, basic haemotology, basic stool and urine strips test)	Same as for CHC L3 plus IPD including basic emergency obstetric care. Complete laboratory (essentials plus cell counting, hematocrit, coagulation, urine sediment test)	Same as CHC L4 plus anesthetist, surgery and obstetrics including comprehensive emergency obstetric care. Complete laboratory and other diagnostic means are available (X-Ray)	Same as RH plus elective surgery, basic specialists (P/O/MI/S). Complete laboratory and other diagnostic means are available (X-Ray, USG, ECG)
Main role	Offer minimum services to remote accessible areas and facilitate referral to higher levels	All services except those needing inpatient services	All services for OPD plus observation (not more than 24 hours)	All services for OPD plus IPD services	Referred services for OPD plus IPD services including emergency surgery	All services for OPD specialist plus IPD services including emergency and elective surgery
Catchments	All population living in a radius of two hours walking distance (4-8km)	All population living in a radius of two hours walking distance (4-8km) plus referral for the whole subdistrict	All population living in a radius of two hours walking distance (4-8km) plus referral for the whole district	All population living in a radius of two hours walking distance (4-8km) plus referral for the whole district	All population living in a radius of two hours walking distance (4-8km) plus referral for the nearest districts	Emergencies and all cases referred from other levels of the system

Component 1. Young People's Reproductive Health

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Mobile clinic, Health Post Level1	Community Health Center Level 2	Community Health Center Level 3	Community Health Center Level 4	Referral hospital	National hospital
Information on growth and development, nutrition, sexual maturation, positive behavior including safe sex, gender equity, substance abuse, rights and responsibilities and services for young people.					
Access to confidential family planning services prenatal and postnatal care, safe delivery, syndromic STI management. Referral to higher level for basic reproductive health services if needed.	Access to basic reproductive health services in young people friendly clinic: family planning, prenatal and postnatal care, safe delivery, syndromic STI management, treatment complications of abortions. Referral to higher level for comprehensive reproductive health services if needed.			Access to full range of comprehensive reproductive health services in young people friendly clinics. Management/counseling all referral cases.	Access to full range of comprehensive reproductive health services. Management all referral cases.
Culturally appropriate psychosocial counseling.	Culturally appropriate psychosocial counseling. Services for the protection from sexual abuse, district level mental health services as appropriate			Culturally appropriate psychosocial counseling and mental health services. Services for the protection from sexual abuse,	

Component 2. Family Planning Services

<table>
<tr><td>Level 1</td><td>Leve l 2</td><td>Level 3</td><td>Level 4</td><td>Level 5</td><td>Level 6</td></tr>
<tr><td colspan="6">Promotion family planning within the community. Providing information and councelling on infertility, methods of contraception, sexuality and gender information, education and counseling for adolescents, youths, men and women</td></tr>
<tr><td colspan="2">Distribution condoms, spermicides, oral contraception and injectable methods of contraception. Referral to high level for other methods (IUD, Norplant, sterilization). Counseling/ management/ referral for side-effects and method related problems</td><td>In addition to the services provided at level 1 and 2: Insertion IUD and subdermal implants (by trained midwives only) Referral to high level for other methods (IUD, Norplant, sterilization)</td><td>In addition to the services provided at level 3: Insertion IUD and subdermal implants. Referral to high level for other methods (sterilization)</td><td colspan="2">In addition to the services provided at level 4:

Performing tubal legation and vasectomy Management/counseling for side-effects and method related problems</td></tr>
<tr><td colspan="2">Provide counseling and confidential syndromic STI management, or referral to higher level if needed.</td><td colspan="2">Provide counseling and comprehensive confidential syndromic case STI management</td><td colspan="2">Provide comprehensive confidential syndromic or laboratory diagnosed STI management</td></tr>
<tr><td colspan="2">Provide counseling about diagnosis and treatment of infertility. Referral for management to higher level.</td><td colspan="2">Provide counseling on diagnosis and treatment of infertility. Referral to higher level for treatment and diagnosis.</td><td>Diagnosis and treatment of infertile couple. Referral to national hospital all complicated cases.</td><td>Management referral cases of infertility.</td></tr>
</table>

Component 3. Safe motherhood

<table>
<tr><th>Level 1</th><th>Level 2</th><th>Level 3</th><th>Level 4</th><th>Level 5</th><th>Level 6</th></tr>
<tr><td colspan="6">Health promotion and education on safe pregnancies and clean delivery. Advising and counseling on nutrition, FP, labour signs, danger signs, exclusive breastfeeding, STI prevention, immunization, routine and follow-up visits</td></tr>
<tr><td>At least 4 ANC contact with women either at the health facility or at the outreach village sites. Record clinical data and care provided to women during pregnancy in the home-based maternal record</td><td>Collection of samples for laboratory testing if required</td><td colspan="2">Testing pregnant woman for syphilis, Hb, urine test, referral for volunteery testing for HIV</td><td>Testing pregnant woman for syphilis, Hb, urine test, volunteery testing for HIV</td><td>Same as RH plus other diagnostic services if needed (USG, ECG)</td></tr>
<tr><td>Early detection of complications of pregnancy and referral for treatment.</td><td>Same as L1 plus treatment of uncomplicated cases of anaemia, STIs, malaria, lower UTI according to the national guidelines</td><td>Early detection and treatment of complications of pregnancy. Referral to higher level if needed.</td><td>Early detection, diagnosis, treatment of complications of pregnancy and referral to higher levels if needed.</td><td>Early detection of complications of pregnancy and treatment. Management of all referrals from districts and referral to higher level if needed.</td><td>Early detection of complications of pregnancy, outpatient specialist consultation (only with referral letter). Management of all referrals from other levels the system.</td></tr>
<tr><td colspan="2">Provide confidential syndromic STI management, or referral to higher level if needed. Referral pregnant woman for syphilis, volunteery testing for HIV</td><td colspan="2">Provide comprehensive confidential syndromic case STI management. Testing pregnant woman for syphilis, referral for volunteery testing for HIV</td><td colspan="2">Provide comprehensive confidential syndromic or laboratory diagnosed STI management. Voluntary testing for HIV</td></tr>
<tr><td colspan="6">Prepare a birth (choosing the place for delivery) and emergency plan (where and when to seek care for complications) and review at each visit. Referral women with complications and high risk (younger than 17 or older than 40, grand multipara, significantly short stature, obstetric history of any previous complications) for institutional delivery. Providing iron and foliate supplementation, tetanus toxoid immunization (at least 2 doses during pregnancy), malaria prophylaxis according to national policy.</td></tr>
</table>

<table>
<tr><td>Conducting safe and clean delivery at home using delivery kits.
Giving support and care throughout labour and delivery.</td><td>Active management of labour, including use of the partograph to monitor labour and delivery, active management of third stage of labour. Provide HIV positive women with ARV drugs during pregnancy and labour.
Parenteral administration of antibiotics (IM)
Parenteral administration of oxytocics (IM)
Parenteral administration of anti-convulsiveness (IM)
Suturing perineal tears</td><td>Active management of labour, including use of the partograph to monitor labour and delivery, active management of third stage of labour plus management of multiple birth, breech delivery. Provide HIV positive women with ARV drugs during pregnancy and labour.
Parenteral administration of antibiotics (IM/IV)
Parenteral administration of oxytocics (IM/IV)
Parenteral administration of anti-convulsiveness (IM/IV)
Manual removal of Placenta
Removal (by aspiration) of retained products in uterus
Assisted vaginal delivery (by vacuum extractor)</td><td colspan="2">Active management of labour, management of multiple birth, breech delivery. Provide HIV positive women with ARV drugs during pregnancy and labour.
Parenteral administration of antibiotics (IM/IV)
Parenteral administration of oxytocics (IM/IV)
Parenteral administration of anti-convulsiveness (IM/IV)
Manual removal of Placenta
Removal (by aspiration) of retained products in uterus
Assisted vaginal delivery (by vacuum extractor)
Cesarean Section
Safe Blood Transfusion</td></tr>
<tr><td colspan="2">Provide emergency obstetric care which involves early identification of complications in mother or baby, immediate first aid and referral to facility.</td><td colspan="2">Management complications such an uncomlicated cases of incomplete abortion (in first trimester), postpartum haemorrage without blood transfusion and surgical procedures, prolong labour if required vacuum extraction, preeclampsia and eclampsia, identification of other complications, initiate first aid and referral to hospital</td><td>Management complications such an incomplete abortion (in 2nd trimester), septic abortion, postabortion complications, sever preeclampsia and eclampsia, the cases of antepartum bleeding, post partum hemorrhage requiring blood transfusion and surgical procedures, prolong labour with admission of oxytocin or surgical procedures (CS), puerperal pelvic abscess, thrombophlebitis, uterine rupture, repair of cervical and severe vaginal tears.</td><td>Same as level5 plus management of all cases sever complications</td></tr>
<tr><td colspan="4">Provide newborn care, including clearing the airways, keeping baby warm (thermal control), cord care, eye care, and helping mother begin breastfeeding. If needed newborn resuscitation (ventilation by mouth-to-mouth breathing or bag and mask). Recognition, referral and follow-up of complications and problems in the newborn.</td><td>Management the birth asphyxia by ventilation with oxygen, intubation if necessary; the neonatal hyperthermia rearming using appropriate methods</td><td>Management of all cases for mother as well as newborn.</td></tr>
<tr><td colspan="5">Provision of postnatal (< 24 hours, first 7 days, 6 weeks) care. Advice on postpartum care, danger sings, when to seek routine/emergency care, and family planning. Provide vit A, iron and foliate to women. Provide BCG and first polio immunization, vit K to newborn. Register birth and death.</td></tr>
</table>

Component 4: General reproductive health

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
To substantially increase the level of knowledge in the general population on issues related to reproductive rights, changing reproductive health need over life cycle and availability of reproductive medical services for all groups of population. Provide information on cervical cancer prevention and early diagnosis. Inform women and men about emotional, physical and hormonal changes during aging, and about the possibilities to prevent complications related to this process					
Improve men's knowledge, access to and use of effective reproductive health care services, specially in the areas of family planning (condom distribution), maternal health, prevention of sexually transmitted infections/HIV, and the prevention of violence against women.		Improve men's knowledge, access to and use of effective reproductive health care services, specially in the areas of family planning (condom distribution), maternal health, prevention of sexually transmitted infections/HIV, and the prevention of violence against women.		Improve men's knowledge, access to and use of effective reproductive health care services, specially in the areas of family planning (condom distribution, vasectomy), maternal health, prevention of sexually transmitted infections/HIV, and the prevention of violence against women.	
Education of individuals at risk on modes of disease transmission and means of reducing the risk of transmission Increase the level of knowledge in the general population on issues related to STIs/HIV Counseling to help individuals make informed decisions on HIV testing. Provide confidential syndromic STI management, or referral to higher level if needed Home-based care to people with advance HIV infection/AIDS related illnesses		Education of individuals at risk on modes of disease transmission and means of reducing the risk of transmission. Increase the level of knowledge in the general population on issues related to STIs/HIV Counseling to help individuals make informed decisions on HIV testing. Provide comprehensive confidential syndromic case STI management.		Education of individuals at risk on modes of disease transmission and means of reducing the risk of transmission Increase the level of knowledge in the general population on issues related to STIs/HIV Counseling to help individuals make informed decisions on HIV testing. Provide comprehensive confidential syndromic or laboratory diagnosed STI management.	
Inform women about the medical services that are available for victims of gender-based and sexual violence. Referral for confidential and sensitive medical response and counseling to gender-based and sexual violence. Give emergency contraception. Referral to other services (protection, legal, social services, counseling, medical services) if needed.		Inform women about the medical services that are available for victims of gender-based and sexual violence. Provide/referral confidential and sensitive medical response. Give emergency contraception. Referral to other services (protection, legal, social services, counseling, medical services) if needed.		Educate women about the medical services that are available for victims of gender-based and sexual violence. Provide confidential and sensitive medical response to gender-based and sexual violence. Give emergency contraception. Referral to other services (protection, legal, social services, counseling) if needed. Provide culturally appropriate professional counseling services.	

Annex 3. Objectives, Activities, and Targets for Reproductive Health Strategies

Component 1: Reproductive health of young people

Strategies	Main Activities	Process and outcome objectives by 2009	Process and outcome objectives by 2015	Impact objectives by 2015
To strengthen the provision of information and skills to young people, families, communities in order to achieve an optimal level of health and development in young people.	Formulate and use specifically targeted, clear, consistent messages to promote health and development of young people. Develop an information package on growth and development, nutrition, sexual maturation, positive behavior including safe sex, gender equity, substance abuse, rights and responsibilities and services for young people to be targeted at young people, parents, teachers and the community at large. Develop module and provide life-skills training that is age-appropriate and culturally acceptable, enabling young people to cope with their health and development including reproductive health. Education on sexuality and reproduction for young people has been included in all secondary school curricula. Out of school activities to promote young people's sexual and reproductive	Informational package on young people's health and development will have been developed to be targeted at young people, parents, teachers and the community at large. Life skills training integrated in school curriculum 50% of secondary school provide life skills training 30% of young people out school get life skills training	80% of secondary school provide life skills training 50% of young people out school get life skills training	Reduce the percentage of all births that occur to adolescents by 30% Reduce the incidence of STI/HIV among young people by 30%

	health.			
To increase easy access to a broad range of young-friendly services.	National standards, protocols and practice guides for YPH care will be adapted and translated to national conditions and needs. Develop training programs for service providers on YPRH issues, especially related to counseling and service provision. Provide skills training to service providers to deal with adolescent health and development problems. Reorient the existing primary health care services to be young person-friendly. Establish counseling services, which would encompass young people health and development, concerns.	Young people health service protocols will have been developed for different levels. 50% of health providers will have received training on young people health services, especially related to counseling and service provision. At least 40% of primary health care system and districts hospital will have been reoriented in young people's friendly facilities and services will include basic reproductive health services at the level of HP, CHC and comprehensive reproductive health services at the level referral hospital as well as services for the protection from sexual abuse, culturally appropriate psychosocial counseling and mental health services, substance abuse/smoking and alcohol use, negotiating skills, nutrition and control of endemic disease at all levels of services. At least 20% of sexually active young people will use a method of contraception	Young people health service will have been implemented for different levels. 80% of health providers will have received training on young people health services, especially related to counseling and service provision. At least 80% of primary health care system at community level and districts hospital will have been reoriented in young people's friendly facilities. At least 30% of sexually active young people will use a method of contraception	

Component 2. Reproductive choice (Family planning)

Strategies	Main Activities	Process and outcome objectives by 2009	Process and outcome objectives by 2015	Impact objectives by 2015
To increase the knowledge of population on their right to make free and informed choices on the number and timing of children.	Develop IEC materials focusing on birth spacing as the key to improvement in the health of mother and child.	At least 40% of sexually active population will demonstrate appropriate knowledge about family planning.	At least 80% of sexually active population will demonstrate appropriate knowledge about family planning.	Increase the contraceptive prevalence rate of married and unmarried couples to

				40%.
To improve the accessibility and widen the range of contraceptive options offered of contraceptive services for all who want to use them.	National guidelines and essential care standards for fertility regulation adapted to national conditions. Protocols on family planning counseling and practical services will be formulated for each level and adopted into practice. Training of health care providers on the technical aspects of contraception and on counseling skills. Contraceptive services are provided as part of primary health care and acceptable to all groups. Establish a referral system for methods not available on-site.	Service protocols on family planning will have been developed for different levels. At least 80% of health providers will have received training on family planning counseling and practical skills. At least 80% of contraceptive service points are able to explain, offers a choice and maintain supply of at least three different modern methods of contraception, or (in case of surgical contraception) knows where to refer clients to.	Family planning services at different levels will have been implement. All health workers who provide family planning services will be trained (retrained) to provide appropriate family planning services. All contraceptive services delivery points are able to explain, offers a choice and maintain supply of at least three different modern methods of contraception, or (in case of surgical contraception) knows where to refer clients to.	
To provide a basic service for individuals and families for the prevention and treatment infertility which are integrated part of high-quality family planning services.	To provide confidential counseling services for women and men on conception techniques and practices. Evidence-based tools and guidelines for infertility diagnosis, management and treatment adapted and used.	National protocols and guidelines for prevention, diagnosis and treatment of infertility adapted and used. At least 40% of primary health care system will have been provided counseling on infertility issues and will have developed referral system for diagnosis and treatment. At least 40% of district hospitals will have been provided diagnosis and treatment of infertility according to National protocols.	At least 80% of primary health care system will have been provided counseling on infertility issues and will have developed referral system for diagnosis and treatment. At least 80% of district hospitals will have been provided diagnosis and treatment of infertility according to National protocols.	

To increase the active participation and responsibility of men in informed decision-making on RH issues and to promote use of male contraceptive methods.	BCC developed on matters of sexual violence, coerced sex, equitable decision making and gender issues within families on sexual matters. RH services for men are made available.	At least 30% of sexually active men will demonstrate appropriate knowledge about family planning and use male contraceptive methods.	At least 50% of sexually active men will demonstrate appropriate knowledge about family planning and use male contraceptive methods.	
Integrate effective management of STI cases in Family Planning Services and prevent/reduce sexual transmission of STI and HIV/AIDS	Develop culturally appropriate IEC messages on STIs and HIV/AIDS, safer sexual behavior, correct use of condoms, attitudes to and care of people with AIDS. Ensure that dual protection is understood and practiced by all those who could expose themselves to risk. Distribute condoms and actively promote correct condom use, identifying the most appropriate channels and outlets for all those at risk. Provide confidential STI case management through all health facilities. Ensure that services are accessible and acceptable to all groups. Standardized nationally accepted STI treatment protocols will be used. Train staff in syndromic case management (i.e. syndromic diagnosis, treatment, confidentiality, education and	40% of person in target population will recognize a condom, know its preventive effects, and will be able to describe how to use it correctly. Condoms will be available for distribution in 100% of potential outlets All designated health workers will be trained (retrained) to manage STD cases appropriately All health workers will carry out universal precautions	80% of person in target population will recognize a condom, know its preventive effects, and will be able to describe how to use it correctly.	Reduce the incidence of STDs by 40%

	counseling, condom notification and follow-up) and in referral of complicated cases. Ensure a confidential, voluntary, noncoercive system for partner notification. Ensure a consistent supply of drugs and condoms.			

Component 3: Safe Motherhood

Strategies	Main Activities	Process and outcome objectives by 2009	Process and outcome objectives by 2014	Impact objectives by 2014
To substantially increase the level of knowledge in the general population on issues related to pregnancy and childbirth.	The special needs of pregnant and lactating women in terms of nutrition, rest, antenatal, delivery and postpartum care, signs and symptoms of complications and the need to plan for emergency transport to the health center or hospital will be disseminated to all women, families and communities through IEC, popular journalists, the media, TBAs health care providers and midwives during maternal service provision.	At least 50% of population of reproductive age can name at least two danger signs of obstetric complications and aware of the need to refer complicated cases to a higher level of care. At least 50% of population aware of the requirements for a clean delivery and importance of planning for delivery.	At least 80% of population of reproductive age can name at least two danger signs of obstetric complications. At least 80% of population aware of the requirements for a clean delivery and importance of planning for delivery.	Reduce the maternal mortality rate by 40% Reduce the neonatal mortality rate by 40% Reduce the rate of live born infants weighting < 2500 gms by 40%
Improved quality and coverage of maternal and prenatal health care	National standards and guidelines for maternal and neonatal practice, including national ethical codes of professional practice will be established and framework of practical services will be	Service protocols on basic and comprehensive essential maternal and newborn care will have been developed for different levels.	Basic and comprehensive essential obstetric practice at different levels will have been implement. All health workers at all levels of the health care system will have been	Reduce the number of infants born dead by 40% The incidence of spontaneous

	formulated for each level and adopted into practice. Strengthen existing links between the community and the health care system. Ensure human resources are recruited, deployed and managed to enable delivery of quality maternal and newborn care. Identify training needs and ensure provision of training and supportive supervision for all maternal health care providers. Establish sound monitoring and evaluation strategies including appropriate case notes and other records, and feedback on progress for all health care providers.	All health workers at all levels of the health care system will have been trained on management of normal pregnancies and deliveries and detection, management and refer complications. Maternity waiting homes will have been established and equipped in pilot districts. Skill attendants will attend to 80% of pregnant women at least 4 times. At least 80 % of women delivering are adequately vaccinated with TT. At least 90% of pregnant women will get adequate iron supplementation. A skill attendant will attend at least 50% of deliveries. At least 50% of women will receive at least one postpartum visit within 7 days. At least 80% of newborns will receive BCG and Polio vaccination within first month of life.	trained on management of normal pregnancies and deliveries and detection, management and refer complications. Trained personnel will attend to all pregnant women at least 4 times for antenatal care, assisting in labour, and postpartum visits. All pregnant women will bw adequately vaccinated with TT and get adequate iron supplementation. All newborns woll receive BCG and Polio vaccination within firs month of life.	abortions should be least than 15%
Improve emergency obstetric care. To ensure recognition, early detection and management or referral of complications of pregnancy and	Ensure a policy framework is in place to permit the delivery of clinical interventions at the appropriate levels, from the community level up as is consistent with practice recognized in national protocols.	All health workers will have been trained in early recognition, stabilizing before referral, referral and/or management of birthing complications (mother and newborn). At least 80% of primary health care	All primary health care system will have been equipped with basic obstetric equipment and will provide the full range of services required to detect and manage birthing complications or stabilize before referral and will have developed	Reduce the incidence of obstetric complications by 40%

delivery.	Develop competencies and technical support systems for first line maternal health workers to recognize and stabilize cases of birthing complications before referral. Review and strengthen emergency referral systems for management of complications. Ensure that national essential drugs lists include key commodities needed by skilled attendants and others to implement the core interventions. Ensure that safe emergency obstetric services are available, accessible and acceptable to all groups of women and to adolescent girls.	system will have been equipped with basic obstetric equipment and will provide the full range of services required to detect and manage birthing complications or stabilize before referral and will have developed referral system. At least 80% of district hospitals will have been equitably distributed, equipped with essential obstetric equipment for providing comprehensive reproductive health services, especially essential emergency obstetric care and will have had adequate supplies and drugs to manage all referral cases on a daily 24-hours basis. % of total deliveries that are performed by Caesarian section will be at acceptable standards. 90% of women with complications due to spontaneous abortions will be treated in a timely and appropriate manner. Effective management to 80% of women with eclampsia, hemorrhage, obstructed labour, puerperal sepsis and newborn birth asphyxia, neonatal hypothermia for all institutional deliveries and home deliveries attended by skilled person.	referral system. All district hospitals will have been equitably distrusted, equipped with essential obstetric equipment for providing comprehensive reproductive health services, especially essential emergency obstetric care and will have had adequate supplies and drugs to manage all referral cases on a daily 24-hours basis. 100% of reported maternal deaths are investigated according to established guidelines, and the results are disseminated to health staff. 100% of women and newborn with obstetric emergencies will be treated in a timely and appropriate manner.	
Integrate effective detection and management of STI	Provide confidential STI screening and management to pregnant women. Test pregnant women for STIs/HIV as	100% of blood drawn for transfusion will be screened for HIV	100% of pregnant women will be screened for syphilis before delivery.	Reduce the percentage of pregnant women

cases, including HIV, in maternal and perinatal care	determined in national protocols. Train staff in counseling and syndromic case management according to protocols and in referral of complicated cases, on appropriate use of blood for transition and safe disposal of waste products, on universal precautions according to national protocols. Ensure an adequate and consistent supply of medical supplies, drugs and barrier protection. Provide equipment and supplies for staff and patient protection, for sterilization, disinfection, cleaning and safe disposal of sharps and waste.	100% of pregnant women with STDs will be assessed, treated and counseled according to protocol. All designated health workers will be trained to provide information on STDs, including HIV and manage and/ or refer STD cases appropriately. 100% of health workers will care out universal precautions.		who test positively for syphilis by 80%

Component 4: General Reproductive Health

Strategies	Main Activities	Process and outcome objectives by 2009	Process and outcome objectives by 2014	Impact objectives by 2014
To substantially increase the level of knowledge in the general population on issues related to reproductive health	Social awareness on reproductive rights, changing reproductive health need over life cycle and availability of reproductive medical services for all groups of population through accurate, culturally acceptable, gender-sensitive informational package. Most emphasis will be placed on behavioral and socio-psyhological outcomes. Taking into account community beliefs and practices develop IEC materials and conduct community education on the nutrition needs of groups with special needs, on STI and HIV/AIDS, on gender-based and sexual violence, about reproductive cancer (cervical,	Informational package on reproductive rights, changing reproductive health need over life cycle and availability of reproductive medical services for all groups of population will has been developed. At least 30% of women of reproductive age aware about causes and prevention of reproductive cancer. At least of 30% of people of reproductive age aware about	Counseling services on issues related to reproductive health need over life cycle and availability of reproductive medical services for all groups of population will have been implemented. At least 50% of women of reproductive age aware about causes and prevention of reproductive cancer.	Substantially increase the level of knowledge in the general population on issues related to sexuality and reproductive health. Reduce the level of STI by 40% from 2004 levels.

	breasts), emotional, physical and hormonal changes during aging, and about the possibilities to prevent complications related to this process. Increase women's knowledge on breast cancer and cervical cancer prevention and early diagnosis.	changes during aging and about possibilities to prevent complications related to this process.	At lest of 50% of people of reproductive age aware about changes during aging and about possibilities to prevent complications related to this process.	
To increase male commitment to sexual and reproductive health	Improve men's knowledge, access to and use of effective reproductive health care services, specially in the areas of family planning, maternal health, prevention of sexually transmitted infections (STIs), including human immunodeficiency virus/AIDS, and the prevention of violence against women. Promote healthy male lifestyles as part of a new concept of a supportive role by men for their partners and their own sexual and reproductive health. Raise awareness of men about risk, benefits of protection and the consequences of delayed and inadequate treatment of STI. Promote male methods of family planning. Ensure that male adolescents are made aware of the need for lifelong protection for themselves and their partners. The intervention will target youths attending schools, those not attending schools, men at the workplace, the partners of women presenting for antenatal care and at social events attended by men potentially at risk. Ensure availability, accessibility and sustained	Informational package on access to and use effective reproductive health care services will have been developed to target men. At least 40% of men population get effective reproductive health services.	Reproductive health services for men are implement. At least 80% of men populating get effective reproductive health services.	

	reproductive health services for men. Involve male in monitoring of gender relationships and health outcomes.			
To increase availability of high-quality, culture- and gender-sensitive and non-stigmatizing services for the prevention, care and management of STIs and HIV/AIDS and to provide care for people with HIV/AIDS.	Through culturally appropriate IEC materials, community education classes and women's groups, provide opportunities for women, men and adolescents to explore attitudes to sexuality and decision-making within relationships and to explore ways that women, men and adolescents can protect themselves from STD and HIV/AIDS. Integration of STIs and HIV/AIDS related services such as STI management, voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) in wider sexual and reproductive health services. Ensure that services are accessible and acceptable to all groups. Provide ongoing support and comprehensive care for people with HIV/AIDS through clinics and inpatient services and through support for community-based home care for HIV/AIDS patients and their families.	Community based self-help care and support groups will have been established. National guidelines on STI/HIV prevention, care and management will have been developed. Staff will have been trained in pre-test and post-test counseling, emphasizing voluntary testing and confidentiality of results, clinical recognition and case management of AIDS, use of essential drugs for care of HIV-related illness, nursing care, counseling, and patient and family education. Confidential STI case management will have been established through all health facilitates.	HIV related care will have been integrated into basic health services.	
To provide a confidential, sensitive ad culturally appropriate response to victims of gender-based and sexual violence.	Develop a community IEC campaign on gender-based and sexual violence in collaboration with female ad male key informants. Include gender-based and sexual violence in the training of all health workers. Develop protocols for a confidential and sensitive medical response to gender-based and sexual violence. Ensure that services are	Provide basic psychosocial and medical services to 100% of reported SV survivors. All designated health workers are trained to respond to SV survivors.	Psychological and medical services to respond to gender-based and sexual violence will have been established.	

	acceptable and accessible to all groups in the community. Provide emergency contraception through health centers. Establish a system for referral to other services (protection, legal, social services, counseling) that respects the victim's confidentiality and right to decide what action should be taken. Through women's groups and informal networks, inform women in the community about the medical services that are available for victims of gender-based and sexual violence. With key informants from community, identify the most effective and culturally appropriate ways to respond to the psychological need of survivors of sexual violence. Develop culturally appropriate professional counseling services alongside the community-based response. Identify and support community resources that can assist in the psychological response.			

Annex 4: Definitions used in statistics on reproductive health

A:

Anemia prevalence in pregnancy:

Anemia in pregnancy is defined as a hemoglobin concentration of less than 110 g/l. Degree of anemia – classified as mild (109-100 g/l), moderate (99-70 g/l) and severe (< 70 g/l)

$$= \frac{\text{Number of pregnant who are anemic x 100}}{\text{Number of pregnant women attending antenatal clinic}}$$

Antenatal care coverage:

Percentage of women attended, at least 4 times during pregnancy, by skilled birth attendant (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.

ANC=

$$\frac{\text{Number of women who had attended antenatal services at least 4 times x 100}}{\text{Number of live births}}$$

Availability of basic emergency obstetric care:

Number of facilities with functioning basic emergency obstetric care (BEmOC) per 500 000 population. BEmOC = population in area x 4/ 500.000 (minimum # of SOUB recommended for area). Acceptable number is minimum 4 BEmOC per 500 000 poplation

Availability of comprehensive emergency obstetric care:

Number of facilities with functioning comprehensive emergency obstetric care (CEmOC) per 500 000 population. CEmOC = population in area x 1/500.000 (minimum # of SOUC recommended for area). Acceptable number is minimum of 1 CEmOC per 500.000 population.

B:

Basic emergency obstetric care (BEmOC)

An effective BEmOC facility is a health facility that has provided, in the past 3 months, all of the following six basic EmOC functions:

Parenteral administration of Antibiotics (IM/IV)
Parenteral administration of oxytocics (IM/IV)
Parenteral administration of anti-convulsiveness (IM/IV)
Manual removal of Pacenta
Removal (by aspiration) of retained products in uterus
Assisted vaginal delivery (by vacuum extractor)

Birth weight:

The weight of a neonate determined immediately after delivery or as soon as thereafter as feasible; it should be expressed to the nearest gram. Low birth weight (LBW): Less than 2500 g (up to and including 2499g).

Births attended by skilled health personnel

Percentage of births attended by skilled birth attendant (excluding trained or untrained traditional birth attendants).

Exclusive breast-feeding rate:

Proportion of infants less than 6 months of age who are exclusively breast-fed. This indicator includes breast-feeding from a wet nurse and feeding on expressed breast milk.

EBFR =

Infants less than 6 months who were exclusively breast-fed in the last 24 hours x 100
Infants less than 6 months of age

C:

Caesarean Sections proportion over Expected Births

This indicator allows for a comparison of the proportion of women giving birth by Cesarean Section in a population to a range considered appropriate on a population level – between 5 et 15 %. While showing whether the EmOC services are being used by women experiencing obstetric complications, this indicator also shows whether health facilities are actually providing critical EmOC services. Minimum acceptable level 5% and maximum 15%

CS as proportion of all birth (%) = Total number of CS in all EmOC in area

Expected births in area

Case Fatality Rate (Obstetric):

This process indicator gives a rough indication of the quality of care that is provided at EmOC facilities. Case Fatality Rate is best calculated and interpreted at the facility level and therefore is not aggregated at the provincial, regional or national levels. The Case Fatality Rate is not always an accurate measure of the quality of care because if some women with obstetric complications arrived at the hospital in a poor state, the CFR could be high even when the hospital was functioning well.

Obstetric Case Fatality Rate in EmOC facility (%) = Total direct obstetric deaths in EmOC facility X 100
Total complicated cases I same EmOC facility

Comprehensive emergency obstetric care (CEmOC)

An effective CEmOC facility is a health facility that has provided, in the past 3 months, al of the following eight (6+2) comprehensive EmOC functions:

Parenteral administration of Antibiotics (IM/IV)
Parenteral administration of oxytocics (IM/IV)
Parenteral administration of anti-convlsivants (IM/IV)
Manual removal of Pacenta
Removal (by aspiration) of retained products in uterus
Assisted vaginal delivery (by vacuum extractor)
PLUS
Cesarean Section
Safe Blood Transfusion

Contraceptive accessibility=

Number of primary health care centers, providing contraceptive services x 100
Number of primary health care centers

Contraceptive availability=

Number of service delivery points, which offers a choice of at least three different modern methods of contraception x 100
Number of service delivery points

Contraceptive prevalence rate (CPR):

Percentage of women of reproductive age* who are using (or whose partner is using) a contraceptive method** at a particular point in time.

* Women of reproductive age refers to all women aged 15–49

** Contraceptive methods include female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea, where cited as a method.

CPR =

Number of women of reproductive age (married or in union) using a contraceptive method x 100
Total number of women of reproductive age (married or in union)

Condom prevalence=

Number of users of condom x 100
Number of users of any methods contraceptive

Crude birth rate:

Annual number of births per 1 000 population

E:

Early neonatal mortality rate: deaths at 0-7 days after live birth x 1000/live births.

ENMR =

Deaths at 0-7 days x 1000
Live births

Essential obstetric care (EOC):

The minimal health care interventions needed to manage normal pregnancies and deliveries prevent complications of pregnancy and delivery. It comprises surgical obstetrics (caesarean delivery, repair of high vaginal and cervical tears, laparotomy, removal of ectopic pregnancy, evacuation of the uterus, craniotomy, symphysiotomy); anesthesia; medical treatment (of sepsis, shock, eclampsia, anaemia); blood replacement; manual procedures (removal of placenta, intravenous oxytocin, labour monitoring and partography, amniotomy, repair or episiotomies and perineal tears, vacuum extraction); management of women at high risk (intensified prenatal care); and a range of contraceptive methods including oral contraceptives, IUD, subdermal implants, female sterilization, vasectomy, etc, and neonatal special care.

Emergency obstetric incidence =

Number of obstetric emergencies x 1000
Number of live birth

Measures the coverage and outcome of antenatal and obstetric care. Cause-specific rates can be calculated for various obstetric emergencies such as ruptured uterus, eclampsia, or haemorrhage.

H:

HIV prevalence in pregnant women

Percentage of blood samples taken from pregnant women and tested for HIV during routine sentinel surveillance at selected antenatal clinics which test positive for HIV.

I:

Infant mortality rate:

annual number of deaths of infants under one year of age per 1,000 live births.

Infant mortality rate =

$$\frac{\text{Deaths under the age of 1 year after live birth x 1 000}}{\text{Live births}}$$

Instrumental delivery *rate:* forceps or vacuum extractor as % of all deliveries

L:

Late neonatal mortality rate: deaths day 7-28 after live birth x 1000/Iive births

Late neonatal mortality rate =

$$\frac{\text{Deaths at 7-28 days after live birth x 1000}}{\text{Live births}}$$

Low birth weight prevalence:

Percent of live births that weigh less than 2 500 gms. Measures the health status of pregnant women and the adequacy of antenatal care. Birth weights also identify infants at higher risk who may need special care.

$$\frac{\text{Number of live born infants weighing < 2500 gms x 100}}{\text{Total number of the live births (with birth weight recorded)}}$$

M:

Maternal mortality rate:

Annual number of deaths of women from pregnancy related causes per 1 00,000 women.

Maternal mortality ratio (MMR):

Ratio of the number of women dying from pregnancy related causes to the number of live births, expressed as annual number of maternal deaths per 100 000 live births.

MMR=

$$\frac{\text{Number of maternal death x 100 000}}{\text{Number of live births}}$$

Met Need in EmOC:

Met Need in EmOC gives an indication of whether the EmOC services are being used by the women who experience obstetric complications. This indicators describes the proportion of women with complications who receive emergency treatment out of the

total that you would expect to have complications (or 15% of pregnant women). Minimum acceptable level > 100%

Proportion of women estimated to have complications who are treated in EmOC facilities (%) = Total complicated cases in all EmOC facilities in area x 100 / Expected Birth in area x 0.15

Method mix

The percent distribution of contraceptive users by method. A broad method mix suggests that the population as access to a range of different contraceptive methods.

N:

Neonatal mortality rate=

Number of live born infants who die during first 28 days of age x 1000
Number of live births

Measures the overall health status of new borns.

Number of acceptors new to modern contraception

The number of person who accept for the first time in their lives any methods of contraception; to be reported for a defined reference period (e.g., one year).

P:

Perinatal mortality rate (PMR):

Number of perinatal deaths per 1 000 total birth. Measures the adequacy of ante- and intrapartm care and the health status of new borns.

PMR =

Number of infants of 22 gestational weeks or greater than 500 g who are born dead + number of live born infants who die < 7 days of age x 1000
Number of total births (live births+ stillbirth)

Positive syphilis serology prevalence in pregnant women

Percentage of pregnant women attending antenatal clinics whose blood has been screened for syphilis, with positive serology for syphilis.

Number of pregnant women screened for syphilis who tested + for syphilis x 100
Number pregnant women who were tested for syphilis

Postpartum care coverage =

Number of women who have received at least one postpartum visit x 100
Number of live birth

Percent of obstetric and gynaecological admissions owing to abortion

Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services which are due to abortion (spontaneous and pre admission induced, but excluding planned termination of pregnancy).

Prevalence of infertility in women

Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.

Proportion of deliveries taking place in effective EmOC facilities:

It is estimated that 15% of pregnant omen develop obstetric complications serious enough to require medical care. Therefore, if the number of women receiving care in an EmOC facility is not at least 15% of all women giving birth in the population, then it is certain that some proportion of obstetric complications are going untreated. Minimum acceptable level > 15%

$$\text{Proportion of deliveries in effective BEmOC and CEmOC (\%)} = \frac{\text{Number of deliveries having taken place in BEmOC and CEmOC facilities in the area x 100}}{\text{Expected births in the same area}}$$

R:

Reported incidence of urethritis in men

Percentage of men (15–49) interviewed in a community survey reporting episodes of urethritis in the last 12 months.

S:

Skilled birth attendant

is a health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period and in the identification, management and referral of complications in women and newborns.

Stillbirth rate =

$$\frac{\text{Stillbirths x 1000}}{\text{Live births + stillbirths}}$$

A general measure of pregnancy outcome. May be elevated during outbreaks of diseases such as malaria or syphilis

Syphilis screening coverage =

$$\frac{\text{Number of women who had been tested for syphilis during pregnancy x 100}}{\text{Number of pregnant women attending antenatal clinic}}$$

T:

Tetanus vaccination coverage =

$$\frac{\text{Number of women who had been adequately vaccinated with tetanus toxoid x 100}}{\text{Number of pregnant women attending antenatal clinic}}$$

U:

Under five mortality rate:

Annual number of deaths of children under five years of age per 1000 live births. More specifically, this is the probability of dying between birth and exactly five years of age

V:

Vaccination coverage=

Number of new-born who receive BCG and Polio by first month birthday x 100
Number of live birth

Measure the extent to which newborns receive first vaccinations early. It is also used as indicator of quality of postpartum care.