Strategic Plan for the Implementation of Reproductive, Maternal, Newborn, Child and Adolescent Health and Healthy Ageing Programmes in Eritrea

2022–2026

HEALTH FOR ALL

MINISTRY OF HEALTH. ERITREA

Contents

Foreword

The Government of the State of Eritrea is committed to improving reproductive, maternal, newborn, child, adolescent and elderly people's health and wellbeing, and to attaining the health-related Sustainable Development Goals (SDGs) 3 ("Ensure healthy lives and promote well-being for all at all ages") and 5 ("Achieve gender equality and empower all women and girls"), to which it is a signatory. To this end, the country has made significant efforts in the implementation of various high-impact evidence-based interventions across the continuum of care, as guided by national policies, guidelines and protocols. Despite this, several health system challenges still need to be addressed to facilitate effective and efficient implementation of reproductive, maternal, newborn, child and adolescent health and healthy ageing (RMNCAH & HA) services.

This RMNCAH & HA Strategic Plan 2022–2026 is designed to provide the overall strategic and health sector RMNCAH & HA priorities for the five-year period 2022–2026. It takes cognizance of the vision of the 2020 National Health Policy (NHP 2020), namely "Improved health status, wellbeing, productivity and quality of life of the Eritrean people". By guiding the country in strengthening its health systems towards the attainment of Universal Health Coverage (UHC) and Primary Health Care (PHC), it aligns with the third Health Sector Strategic and Development Plan (HSSDP III) and contributes to the attainment of critical impact indicators in the HSSDP III.

The focus of this new strategic plan is on the implementation of high-impact evidence-based RMNCAH & HA interventions across the life course. It recognizes that implementation must be accelerated, scaled up, with quality and ensuring availability and accessibility by vulnerable and underserved population groups including older adults, both in stable and emergency situations. The document has been designed to enable quick identification of the situation and priority actions for each specific RMNCAH & HA area. Key RMNCAH & HA indicators in the NHP 2020, HSSDP III 2022–2026, the Global Strategy for Women, Children and Adolescent Health 2016–2030 and the SDG 3 targets have been included in the monitoring and evaluation framework to ensure efficient and timely reporting.

Moving forward, this RMNCAH & HA Strategic Plan will be the guiding document for everyone involved in planning, implementing and supporting RMNCAH & HA initiatives in the State of Eritrea. To this end, I would like to call upon all MoH directors, programme managers at national and Zoba levels, medical training institutions, UN agencies and all stakeholders to ensure that the technical and financial investments, as well as their annual operational plans and programme reporting are all in line with this strategic plan. With teamwork, focus and determination we will achieve the goals of the NHP 2020 and accelerate attainment of the health-related SDG goals by 2030 towards a great and prosperous State of Eritrea.

Hon. Amina Nurhussien
Minister for Health
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Acknowledgements

The development of the Reproductive, Maternal, Newborn, Child and Adolescent Health and Healthy Ageing (RMNCAH & HA) Strategic Plan 2022–2026 was the result of the concerted efforts of several individuals and organizations. It was developed through a highly consultative process involving a wide range of stakeholders, including those from Government, both at the national and Zoba levels, and development partners. The process involved analysis of the status of implementation of the 2017–2021 RMNCAH & HA Strategic Plan to identify key achievements, best practices, challenges and possible mitigation measures, which formed the basis of this RMNCAH & HA Strategic Plan.

The Ministry of Health would like to thank the steering committee in the Division of Family and Community Health under the Department of Public Health for providing leadership and coordinating the whole process of the Strategic Plan development. Special thanks go to the Director of the CDC/MoH, Dr. Araia Berhane, the Head of the Division of Family and Community Health, Dr. Berhana Haile, and programme focal persons: SRH/MNH (Mr. Ephrem Zebai), Child Health (Mr. Tesfagabir Gebray), Adolescents and Young People (Mr. Michael Berhe), Nutrition (Mrs. Amleset Hagos and Mr. Yohannes Fesshaye) and Healthy Ageing (Mr. Solomon Kelifa). We are grateful to other departments in the MoH who actively supported the process, including the Department of Planning (Mr. Tzeggai Berhane), HMIS (Mr. Amanuel Kifle), M&E (Mr. Yemane Haile and Mr. Andeberhan Tewelde) and the Orotta National Referral Hospital (Mr. Tewolde Yohannes).

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Abbreviations

AYPFHS	Adolescent-and-Young-People-Friendly Health Services
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARR	Annual Rate of Reduction
ART	Antiretroviral Therapy
ASR	Age-Standardized Rate
BCC	Behaviour Change Communication
BEmOC	Basic Emergency Obstetric Care
BF	Breastfeeding
CBD	Community-Based Distribution
CBE	Clinical Breast Examination
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHA	Community Health Agent
CHW	Community Health Worker
c-IMNCI	Community-based Integrated Management of Newborn and Childhood Illnesses
CME	Continuing Medical Education
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
DHIS-2	District Health Information Software – 2
DHS	Demographic and Health Survey
EBF	Exclusive Breast Feeding
ECD	Early Childhood Development
EDHS	Eritrean Demographic and Health Survey
EHCP	Essential Health Care Package
EmONC	Emergency Obstetric and Newborn Care
eMTCT	Elimination of Mother-to-Child Transmission
EPHS	Eritrea Population and Health Survey
EPI	Expanded Programme on Immunization
EPMM	Ending Preventable Maternal Mortality
FP	Family Planning
GBV	Gender-Based Violence
GMP	Growth Monitoring and Promotion
Hep-B	Hepatitis B
HF	Health Facility
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HRH	Human Resources for Health
HSSDP	Health Sector Strategic Development Plan
iCCM	Integrated Community Case Management
ICOPE	Integrated Care for Older People
ICPOGA	Integrated Care for People of Grace Age
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
ENC	Essential Newborn Care
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
IUCD	Intrauterine Contraceptive Device
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LMICS	Low Middle-Income Countries
LMIS	Logistic Management Information System
LQAS	Lot Quality Assurance Sampling
MAM	Moderate Acute Malnutrition
MCCoD	Medical Certification of Cause of Death
M & E	Monitoring and Evaluation

MDGs	Millennium Development Goals
MHH	Menstrual Health and Hygiene
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MoCT	Ministry of Communication and Transport
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoLSW	Ministry of Labour and Social Welfare
MoJ	Ministry of Justice
MPDCSR	Maternal, Perinatal and Child Death Surveillance and Response
MVA	Manual Vacuum Aspiration
NCD	Non-Communicable Diseases
ORT	Oral Rehydration Therapy
PHARMECOR	Pharmaceutical Corporation of Eritrea
PSBI	Possible Serious Bacterial Infection
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNC	Postnatal Care
PPH	Postpartum Haemorrhage
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCAH & HA	Reproductive, Maternal, Newborn, Child and Adolescent Health and Healthy Ageing
RMNCAH, N & HA	Reproductive, Maternal, Newborn, Child and Adolescent Health, Nutrition and Healthy Ageing
SAM	Severe Acute Malnutrition
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendance
SBE	Self Breast Examination
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
Td	Tetanus Diphtheria
TFR	Total Fertility Rate
TWG	Technical Working Group
U5	Under 5
U5MR	Under-5 Mortality Rate
UHC	Universal health coverage
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing (HIV)
VIA	Visual Inspection with Acetic Acid
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

Eritrea formally ratified the Sustainable Development Goals (SDGs) that were launched by the UN General Assembly in September 2015. With less than 10 years to the SDG reporting date of 2030, the country has developed the RMNCAH & HA Strategic Plan 2022–2026 with the goal of accelerating progress towards ending all preventable deaths of women, newborns and children, and realize the health and wellbeing of adolescents and elders in Eritrea. It will guide the implementation of high-impact evidence-based interventions to improve maternal, newborn, child, adolescent and older people outcomes towards attainment of the health-related SDGs 3 and 5.

The RMNCAH & HA strategic plan 2022–2026 was developed using an all-inclusive process led by the Eritrean MoH's National Division of Family and Community Health, the Zoba level, other key departments in the MoH including Planning, Communicable Disease Control (CDC), M&E, and with UN agencies (WHO, UNICEF, UNFPA and UNAIDS) from the country and regional levels. The strategic priorities are based on the findings of a Short Programme Review (SPR) of the implementation of the previous RMNCAH, Nutrition & HA 2017–2021.

The SPR noted that significant progress was made in the implementation period of the RMNCAH, N & HA strategic plan 2017–2021. The institutional maternal mortality ratio declined from 118 per 100,000 live births to 108.6 per 100,000 live births. The 1st antenatal care (ANC) visit increased from a baseline of 92 per cent in 2017 to reach 98 per cent in 2019, surpassing the set target of 96 per cent, while the 4th ANC visit increased marginally from 61 per cent in 2017 to 64 per cent in 2019. The number of community hospitals and regional hospitals providing comprehensive emergency obstetric and newborn care (CEmONC) increased from 12 to 14. The proportion of deliveries attended by a skilled health worker (SHW) increased from 62 per cent in 2017 to 71 per cent by 2019, against the set target of 80 per cent, while the number of mother-baby pairs who received postnatal care (PNC) within 48 hours of the postpartum period from a skilled health care provider increased from 88.1 per cent in 2017 to 100 per cent in 2020, surpassing the set target of 96 per cent. That notwithstanding, neonatal mortality and stillbirth rates remained static at 18 per 1,000 live births and 25 per 1,000 total births respectively.

Regarding sexual and reproductive health (SRH), adolescent-and-young-people-friendly centres (AYPFCs) doubled from a baseline of 6 to 12. The contraceptive prevalence rate (CPR) increased from 7.8 per cent in 2014 to reach 13.5 per cent in 2019/20. Other SRH services being offered included cervical cancer screening, post-abortion care (PAC), gender-based violence (GBV) management, infertility management, obstetric fistula management and prevention and control of female genital mutilation/cutting (FGM).

In the area of child health, for the period 2017–2021, the infant mortality rate (IMR) declined from a baseline of 32 per 1,000 live births to 30 per 1,000 live births, while the under-5 mortality rate (U5MR) declined from the baseline of 43 per 1,000 live births to 40 per 1,000 live births. Nonetheless, the national targets of 25 per 1,000 and 40 per 1,000 respectively were not attained. Malnutrition continued to be a major public health issue in Eritrea and one of the top-10 causes of morbidity both in outpatient and inpatient services.

Healthy ageing, being a relatively new programme, had significant information gaps on the number of older persons, their health status, living conditions, housing and environmental conditions, among other parameters. However, conducive policies are in place with all health service areas open to older people, including a policy of no user fees for older adults seeking health services in place.

The RMNCAH & HA Strategic Plan 2022 –2026 has been developed with a Vision of improved health status, wellbeing, productivity, and quality of life for every woman, newborn, child, adolescent, young person and older person in Eritrea. The Mission is to ensure universal access to comprehensive, high-impact, quality, cost-effective and culturally-sensitive reproductive, maternal, newborn, child and adolescent health and healthy ageing services to all Eritreans along the continuum of care in an equitable and efficient manner. The goal is to accelerate progress towards ending all preventable deaths of women, newborns, children and realization of the health and wellbeing of adolescents and elders in Eritrea.

The plan is organized around four (4) Strategic Objectives as follows:

SO1: Resilient health systems to support delivery of quality RMNCAH & HA services; **SO2A**: Universal coverage of comprehensive maternal and newborn health services along the continuum of care; **SO2B**: Universal coverage of comprehensive sexual, reproductive and adolescent health services along the continuum of care; **SO3**: Universal coverage of effective child health interventions; **SO4**: Institutionalized multisectoral response for healthy ageing.

To ensure user friendliness, enable easy identification of the different programme areas and thus facilitate planning, monitoring and reporting, the RMNCAH & HA Strategic Plan 2022–2026 has been organized into 6 chapters as follows: Chapter 1: Background, organizational framework and process of development; Chapter 2: Summary of situation analysis of the different RMNCAH & HA programmes; Chapter 3: Strategic orientation of the RMNCAH & HA Strategic Plan 2022–2026 (vision, mission, goal, strategic objectives, goal targets); Chapter 4: Key strategies and priority actions by strategic objective; Chapter 5: Monitoring and evaluation of the RMNCAH & HA Strategic Plan 2022–2026; Chapter 6: Leadership and governance, coordination and roles of different stakeholders. The following are in the Annexes: the Implementation Framework, the Results Monitoring Framework, the Logical Framework, and the list of evidence-based RMNCAH & HA interventions.

The Division of Family and Community Health shall provide oversight of the implementation of the RMNCAH & HA strategic plan 2022–2026. It is important to highlight that this is the guiding document that should be used by all MoH Departments at the national and Zoba levels and all development partners, including United Nations Agencies for planning, implementation, monitoring and reporting for all RMNCAH & HA programmes. The MoH believes that if the strategic priorities enunciated in this document are implemented consistently, to scale and with quality, the country will accelerate the reduction of maternal, neonatal and child mortality and improve the health and wellbeing of adolescents, young people and older adults in the State of Eritrea and hence attain the 2030 health-related SDG targets.

Chapter 1

Introduction and Background

1.1 Background

Eritrea is located in the Horn of Africa and borders the Red Sea to the east, the Republic of Djibouti to the south-east, Ethiopia to the south and the Republic of Sudan to the north and west. The country is administratively divided into six Zobas, namely, Gash Barka (GB), Anseba, Debub, Debubawi Keih Bahri (DKB) – also known as Southern Red Sea – Maekel (MA) and Semenawi Keih Bahri (SKB) – also known as Northern Red Sea. The population of Eritrea was estimated at 3,546,421 in 2020 and is projected to grow to 3,937,197 by 2026. About 44 per cent of the total population is under the age of 15, of which an estimated 13 per cent is under the age of 5 years. The number of women of reproductive age (WRA) is estimated to be 709,284 (20 per cent of the population), while that of adolescents is 851,141 (24 per cent of the population).[1]

The State of Eritrea has made huge strides in improving the lives of women and children since independence. This is primarily due to the strong political commitment to social development, particularly the drive to improve the lives of women, children and adolescents.

1.2 The Context

1.2.1 Global Context

The SDG 3 targets linked to this strategic plan are: the reduction of maternal mortality (Target 3.1); the ending of preventable newborn and child deaths (Target 3.2); fighting communicable diseases such as HIV, TB and hepatitis (Target 3.3); ensuring universal access to sexual and reproductive health care including family planning (Target 3.7); and achieving universal health coverage (Target 3.8). Whilst significant progress has been made, many countries especially in sub-Saharan Africa (SSA) still lag behind, thus impacting progress in the pathway to the attainment of these global targets.

1.2.2 Country Context

The Government of Eritrea is committed to attaining the targets in the Global Strategy for Women's, Children's and Adolescents' Health. Under the leadership of the MoH, much has been done; nevertheless, there is a need to accelerate the implementation of high-impact cost-effective interventions to accelerate the realization of health-related SDGs within the less than 10 years left to the 2030 SDG reporting date.

The National Health Policy[2] obligates the health sector to work towards the progressive attainment of Universal Health Coverage (UHC) and Sustainable Development Goal 3 (SDG3), through the promotion of Primary Health Care (PHC) and increased coverage of essential services, especially to vulnerable and hard-to-reach populations. RMNCAH is at the core of the UHC agenda, whose primary goal is to leave no one behind.

1 HSSDP III 2022–2026 draft

2 Eritrean National Health Policy 2020

The country has also developed the HSSDP III, which spans the same period as this strategic plan (2022–2026) and aims to achieve progress in the attainment of impact targets, including a reduction in maternal and under-5 and neonatal mortality, and an increase in healthy life expectancy in years.

Additionally, the country has developed the Eritrea Essential Health Care Package,[3] which defines the services that should be available at each level of care, services required for each age cohort and interventions needed across each public health function for a given service (preventive, promotive, curative and palliative). This allows not only for more effective and equitable health service delivery, but also for the establishment of a functional referral system and allocation of appropriate funding for priority high-impact interventions.

1.3 Institutional and Organizational Framework

1.3.1 Organization of the Health System

In Eritrea, healthcare delivery is organized around a three-tier system with the primary level comprising community-based health services, health centres and community hospitals. The secondary level contains second-contact hospitals and Zoba referral hospitals, and the tertiary level consists of national referral hospitals, as shown in figure 1.1 below. There are 333 health facilities distributed throughout the country providing services to the public, with most of them owned by the government.

The National Health Policy promotes provision of essential health services at all levels (primary, secondary and tertiary) of health care, which includes the existing health services as well as geriatric health care, palliative care and rehabilitative care services. The policy aspires to provide at the Zoba level most of the secondary care which is currently provided at the national referral hospitals. Basic secondary care services, such as caesarean sections and neonatal care, shall be made available at Zobal referral hospitals and second-contact hospitals.

1.3.2 Institutional and Organizational Framework of RMNCAH, N & HA Programmes

RMNCAH and Nutrition programmes are under the Division of Family and Community Health leadership, as indicated in the organogram in figure 1.2 below. This arrangement has worked to the advantage of these programmes, which include EPI, health promotion, medical services, nursing services, AIDS/HIV control, malaria control, NCD, bioengineering and others, because some of their activities cut across and opportunities exist for collaboration, joint planning, resource sharing and integration of services to achieve their objectives.

3 Eritrean Essential Health Care Package 2021

Figure 1.1
Three-Tier Health Delivery Organization in Eritrea

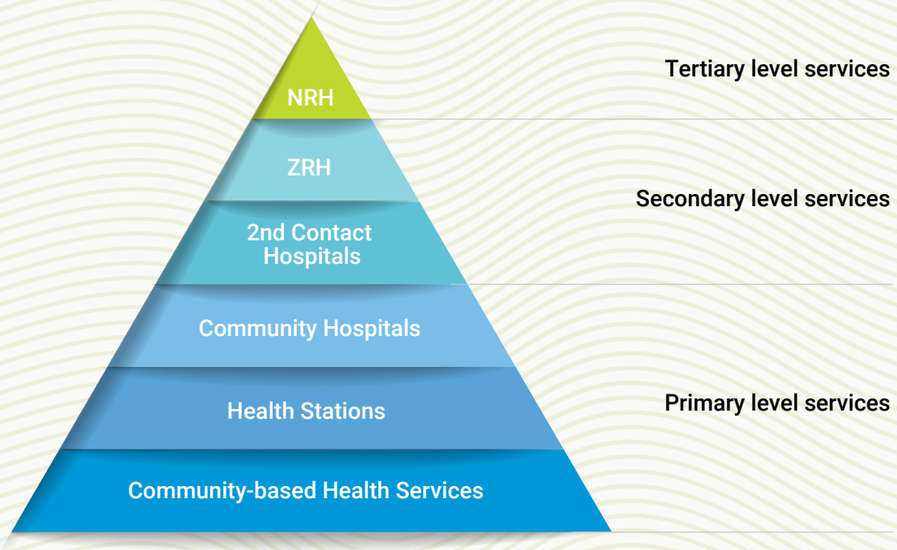
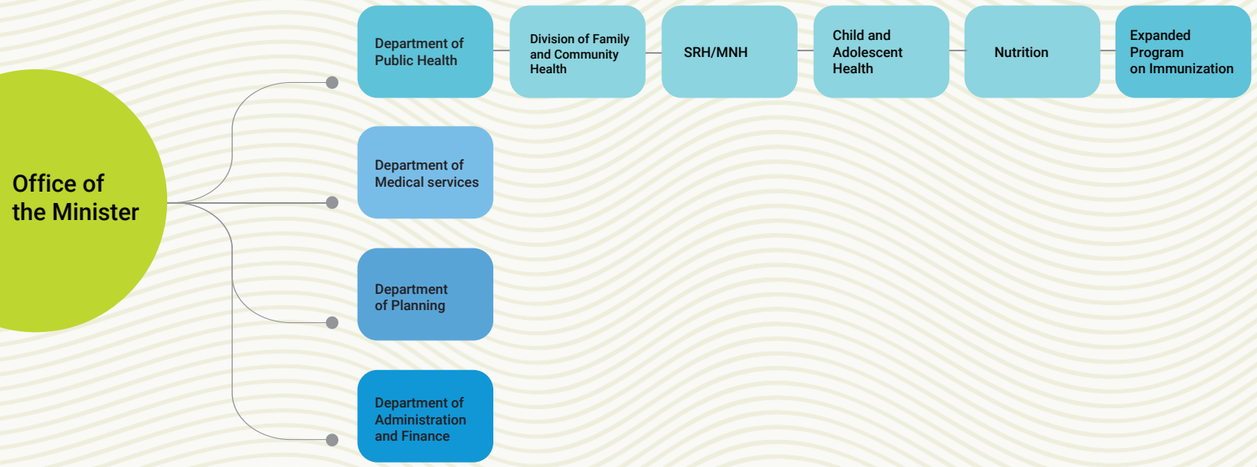


Figure 1.2
Organogram of the Division of Family and Community Health



1.4 The Process of Development Of the RMNCAH, N & HA Strategic Plan 2022–2026

The MoH has undertaken a comprehensive review of the implementation of the 2017–2021 RMNCAH, Nutrition and Healthy Ageing strategic plan. The objectives of the review were to: assess progress; identify key problems and gaps (hindrances); identify facilitating factors and good/best practices; identify priority areas of focus for the future; and develop recommendations for improving programme performance.

The methodology included: a desk review, data extraction and analysis of core RMNCAH & HA indicator data in HMIS, qualitative analysis of RMNCAH programmes' performance using the Short Programme Review tool (WHO's Programme Review for Reproductive, Maternal, Newborn, Child, and Adolescent Health 2017, adapted to include a healthy ageing module). Key informant interviews and focus group discussions (FGDs) were conducted, and the programme review report was consolidated and validated by stakeholders. The results have provided useful information for the development of this RMNCAH, N & HA Strategic Plan 2022–2026. New evidence-based high-impact interventions and new programmes launched globally, regionally and nationally, which had not been expressed in the previous strategic plan, have been incorporated in the new plan.

It is anticipated that this RMNCAH & HA Strategic Plan 2022–2026 will accelerate the realization of the national health sector targets and health-related SDGs as articulated in the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030, the National Health Policy 2020 and the HSSDP III 2022– 2026.

Chapter 2

Situation Analysis of the RMNCAH, Nutrition and Healthy Ageing Programmes

2.0 Introduction

A comprehensive review of the implementation of the Integrated RMNCAH, Nutrition and Healthy Ageing Strategic Plan 2017–2021 has been undertaken to assess progress of implementation and to identify key problems and gaps, facilitating factors and good/best practices. From this review, priority areas of focus for inclusion in the next strategic plan were identified.

This chapter presents a summary of the results of the programme review for the RMNCAH, Nutrition and Healthy Ageing Strategic Plan 2017–2021. The results are presented by programme area as follows:

2.1 Maternal and Newborn Health

The main objective for the MNH programme was to improve the coverage and quality of services provided to pregnant women and neonates from the preconception period, antenatal care, labour and delivery to the post-natal period, to reach 70 per cent of the targeted population by 2021. Progress in the strategic plan period is outlined below.

Maternal Mortality Ratio

During the implementation of this strategic plan, the institutional maternal mortality ratio declined from 118 per 100,000 to 108.6 per 100,000 in 2020 (HMIS 2020 data). Contributors to the reduction in maternal mortality ratio included the introduction of maternity waiting homes, availability of CEmONC facilities, an improved referral system and community awareness of skilled attendance at birth.

The most common causes of maternal morbidity, as shown in figure 2.1 below, were obstructed labour, hypertensive disease, haemorrhage, sepsis and anaemia. All these morbidities are preventable with good preconception care, antenatal care, proper monitoring of labour, referral/caesarean section intervention and quality postpartum care.

Stillbirths and Neonatal Mortality

The neonatal mortality rate and stillbirth rates remained static from the baseline values of 18 per 1,000 live births and 25 per 1,000 total births respectively against the set targets of 15 per 1,000 live births for neonatal mortality and 17 per 1,000 total births for stillbirths. Notably, the stillbirth rate has been quite high over the years, which is a clear reflection of the quality of ANC and intrapartum care. Figure 2.2 shows institutional stillbirth and neonatal mortality rates against the global target.

Evidence-based interventions should be implemented to reduce the incidence of adverse perinatal outcomes. Furthermore, disaggregation into fresh and macerated stillbirths is key to guiding focused preventive measures.

Preconception Care

Preconception care is the provision of biomedical, behavioural and social health interventions to women and couples before conception occurs. It aims at improving their health status and reducing behaviours and individual and environmental factors that contribute to poor maternal and child health outcomes (WHO). While clients with medical conditions (e.g., HIV, diabetes, hypertension, thyroid disorders etc.) are followed up in their respective clinics, preconception care services have not been formalized within the Reproductive and Maternal Health programme. It is envisaged that the country will develop an orientation package and data tools to identify data elements to capture preconception care data in DHIS-2.

Antenatal Care

The proportion of women attending 1st ANC increased from a baseline of 92 per cent in 2017 to reach 98 per cent in 2019, surpassing the set target of 96 per cent (LQAS, 2017 and 2019). The 4th ANC visit increased marginally from 61 per cent in 2017 to 64 per cent in 2020 – falling short of the 70 per cent target. Key challenges identified in ANC attendance included late initiation of ANC and poor adherence to the ANC schedule, making it impossible for these mothers to complete the recommended visits and interventions and hence fully benefit from the services. Community engagement and increased coverage and quality of ANC services, including through outreach, will be critical for effective ANC performance.

Figure 2.1
Trends in the 5 Commonest Maternal Morbidities

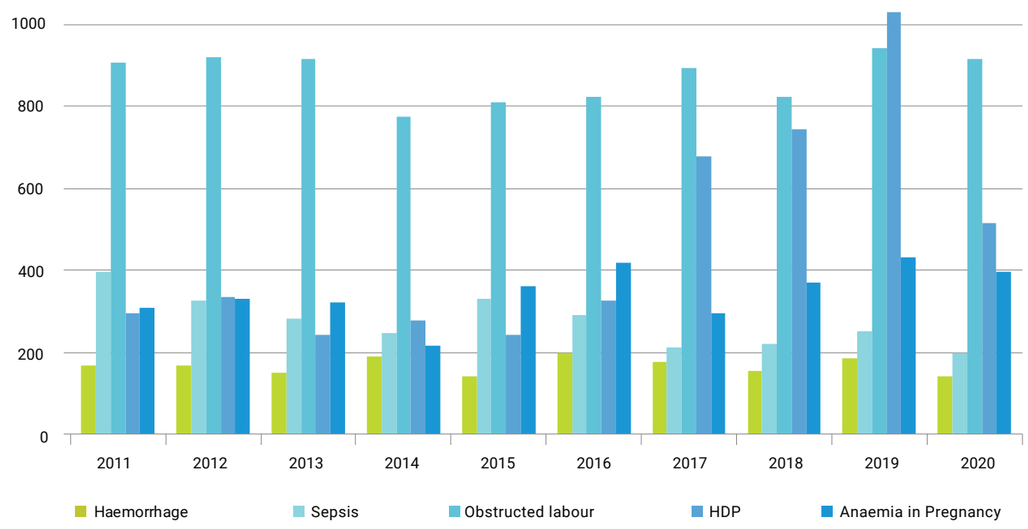
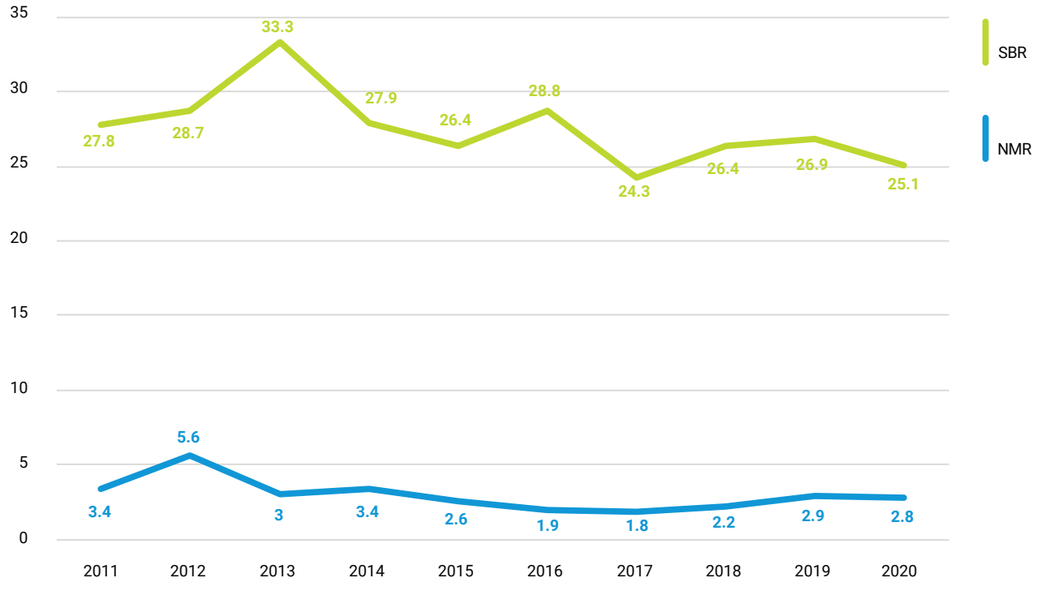


Figure 2.2
Trends in institutional NMR and SBR



Skilled Birth Attendance (SBA)

The proportion of deliveries attended by a skilled health worker has continued to increase from 62 per cent in 2017 to 71 per cent by 2019 (LQAS, 2017 and 2019). This was below the set target of 80 per cent in the RMNCAH, Nutrition and HA Strategic Plan 2017–2021. Establishment of maternity waiting homes in health facilities targeting clients in hard-to-reach areas helped to not just increase skilled attendance, but also improve maternal and perinatal outcomes. Health promoters were also identified and linked to health facilities with a role of community mobilization for services.

Emergency Obstetric and Newborn Care

All the 54 health centres were offering most of the BEmONC signal functions. The challenge lay in the unavailability of vacuum delivery equipment and shortage of MVA equipment for PAC services. The number of health facilities (community hospitals and regional hospitals) providing CEmONC increased from 12 to 14 against the target of 16 facilities. Capacity building has been done for general practitioners in performing caesarean sections and more theatres are available in the hospitals at the Zoba level. At the population level, caesarean section rates higher than 10 per cent are not associated with reductions in maternal and newborn mortality rates (WHOs[4]). This does not, however, apply to healthcare facilities where rates of caesarean births vary widely depending on various factors.

4 WHO Statement on Caesarean Section Rates, WHO/RHR/15.02, WHO 2015

Figure 2.3
Trends in caesarean section rates

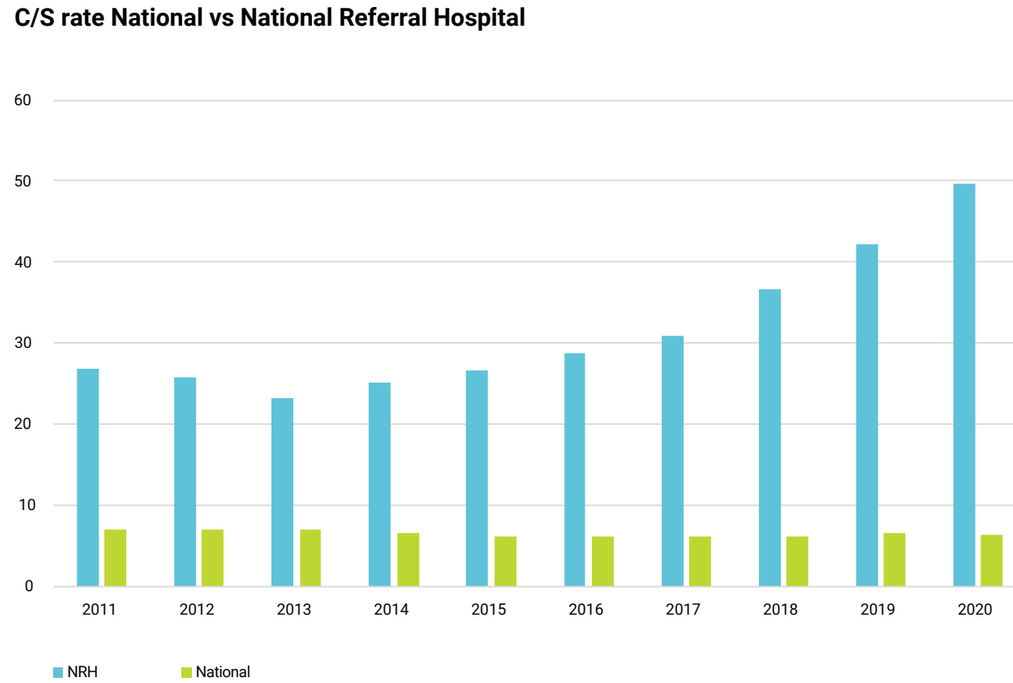


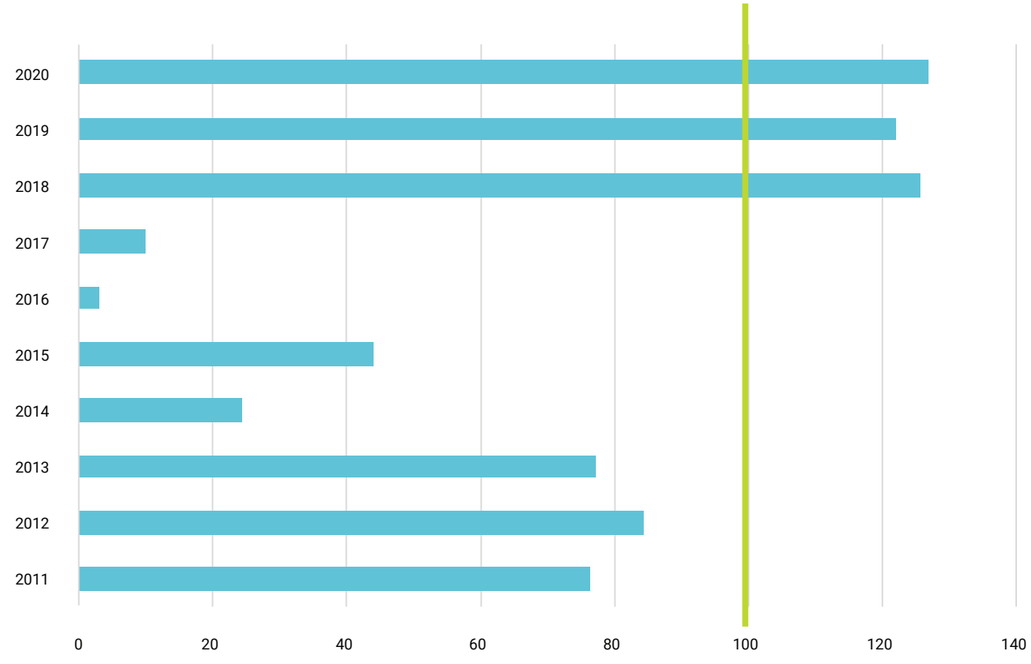
Figure 2.3 above shows the caesarean section (C/S) rate in public health facilities nationally. While the national C/S rate is overall under 10 per cent, the National Referral Hospital (NRH) consistently reported very high C/S rate over the years reaching around 50 per cent in 2020. Challenges in blood for transfusion and oxygen continued to plague the lower-level hospitals, hence the increased number of referrals to the National Referral Hospital. Efforts to strengthen the capacity of the regional hospitals to offer caesarean section services will be augmented in order to reduce the pressure on the National Referral Hospital.

Postnatal Care

The number of mother-baby pairs who received PNC within 48 hours of the postpartum period from a skilled health care provider increased from 88.1 per cent in 2017 to 100 per cent in 2020, surpassing the target of 96 per cent that had been set (LQAS 2019). As depicted in figure 2.4 below, there was a marked improvement in the number of mothers who received PNC within 24 hours of delivery. Per centages above the 100 per cent mark may be attributable to home deliveries who presented to PNC at the health facility within 24 hours of delivery.

The increase in PNC utilization (2018–2020) may be attributed to enhanced community awareness and mobilization, introduction of home-based maternal and newborn care by community health workers and home visits by qualified health personnel for PNC visits after 24 hours. This strategic plan will prioritize strengthening of community-based health information systems to improve documentation of community health service delivery data in HMIS.

Figure 2.4
Trends in per cent of live births who attended PNC within 24 hours



2.2 SEXUAL AND REPRODUCTIVE HEALTH (SRH)

The SRH objectives in the RMNCAH, Nutrition and Healthy Ageing Strategic Plan 2017–2021 were to:

- Increase access to Sexual and Reproductive Health services to reach 30 per cent of the targeted populations by 2021
- Increase cervical pre-cancer screening coverage to 25 per cent of the eligible population (25–49 years old) by 2021
- Reduce prevalence of physical, sexual or psychological violence among women and girls
- Reduce by 50 per cent new HIV infections among women 15–49 years old by 2021

Progress towards attainment of these targets is elucidated below:

Family Planning

According to recalculated HMIS data for Contraceptive Prevalence Rate 2013–2019, using the WPP-2019 estimation for number of women of reproductive age (15–49), the current CPR (2019) stands at 13.5 per cent.[5] The CPR was higher in 2013 but declined through 2014 to reach 7.8 per cent in 2015. The CPR picked up again in 2016 and has been gradually increasing over the years to reach 13.5 per cent in 2019, as shown in figure 2.5 below.

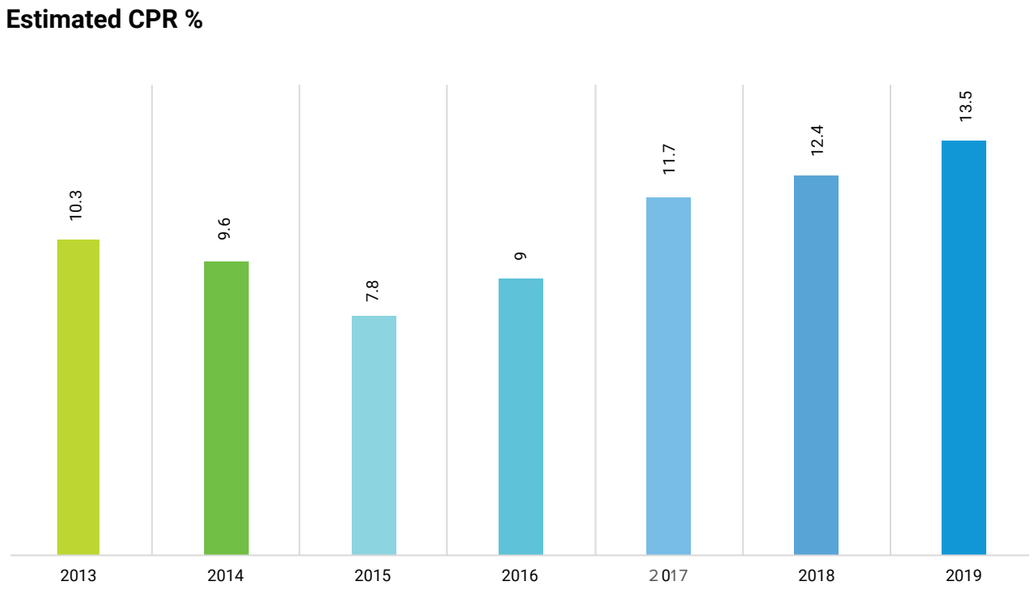
The increasing CPR is mainly attributable to user preference of shorter-acting contraceptive methods with very limited uptake of long-acting reversible methods (figure 2.6 below). Additionally, there seems to be a reversal of trends, with the per centage of

5 HSSDP III 2022–2026 draft

new users consistently much higher than continuing users for all methods of contraception. This points to high contraceptive discontinuation rates, effectively negating the benefits of modern contraceptives to the health and wellbeing of individuals, families and communities. Factors affecting FP uptake were identified as: recurrent stockouts and erratic supply of FP commodities, lack of provider skills in longer-acting FP methods, lack of male engagement and geographical barriers.

This strategic plan period undertakes to address gaps in FP service delivery and to support sustained use of modern contraceptives by clients through: awareness-raising and community engagement on benefits and continuation of FP and contraceptive use, strengthening of LMIS to ensure consistent supply of FP commodities, training of health care workers in FP (especially longer-acting methods), building capacity of community health assistants (CHAs) in counselling and provision of short-acting FP methods, and advocacy with policy makers to increase funding for FP commodities.

Figure 2.5
Trend in CPR for women of reproductive age (15-49)



Cervical Cancer Prevention and Control

Cervical cancer ranks as the second most frequent cancer among women in Eritrea and the second most frequent cancer among women between 15 and 44 years of age.[6] The national guidelines for cervical cancer screening and treatment as well as data tools were developed in 2019 and a national TOT was conducted on cervical cancer screening using VIA and management of screen-positive clients with cryotherapy. At the time of this review, cervical cancer screening services were only offered at the National Referral Hospital (using Pap smears) and screening with VIA and cryotherapy has not been rolled out nationally. Regarding HPV vaccination, training has been conducted and the vaccine will be launched in early 2022. This strategic plan will prioritize scaling up cervical cancer screening and treatment services including tracking key indicators in the DHIS.

6 ICO/IARC Information Centre on HPV and Cancer: Eritrea HPV and related cancers fact sheet 2021

Figure 2.6
Trends in FP method mix

Post-abortion Care (PAC)

Currently, clients presenting with incomplete abortions are managed by doctors using the evacuation and curettage method in theatre. This service is not available in lower-level health facilities due to shortages of MVA equipment. In this strategic plan period, it is envisaged that the PAC guidelines and training package will need to be updated to have MVA equipment procured and distributed nationally, and capacity of midwives and nurses in PAC built to improve access to PAC services.

Infertility

Whereas the prevalence of infertility among outpatient department attendants in the Orotta National Referral Maternity Hospital in Asmara-Eritrea in 2007–2015 was found to be quite low (2.8 per cent),[7] the impact on individuals and families is devastating. Notably, infertility services in Eritrea are only available in the National Referral Hospital. There are no standard protocols for assessment and management of infertility, nor data tools to capture infertility data. During the period of this strategic plan, efforts will be made to develop infertility guidelines and protocols, scale up basic services to peripheral hospitals and derive key indicators for inclusion into DHIS-2.

7 Ghirmay Ghebreigziabher et al.. The prevalence of infertility among outpatient department attendants in Orotta National Referral Maternity Hospital in Asmara-Eritrea, 2007-2015; https://ijamscr.com/ijamscr/article/view/435/1946

Gender-based Violence

Violence against women and girls is one of the most prevalent human rights violations in the world. Gender-based violence undermines the health, dignity, security and autonomy of its victims. The elimination of all forms of violence against women, stereotyping and harmful practices is a priority for the Government of Eritrea. Currently, GBV clients are treated and provided with Post-Exposure Prophylaxis (PEP) and emergency contraceptives. There are specific guidelines for Intimate Partner Violence (IPV) but none for GBV. Nonetheless, there are no specific data tools for GBV, making it challenging to assess its true magnitude and design necessary interventions. This strategic plan will promote the development of guidelines and tools, derive indicators, engage communities and strengthen linkages to support of those affected by GBV.

Obstetric Fistula

Eritrea is among the countries in Africa in the Obstetric Fistula (OF) belt (high prevalence of OF). To date in Eritrea, repair of obstetric fistulae is only done in Medefera hospital (Zoba Debub) with few healthcare providers trained in fistula repair. Community Health Assistants (CHAs) are responsible for finding the clients with fistulae and referring them to the health facility for treatment. There is no active rehabilitation programme. During this strategic plan period, priority will be given to scaling up obstetric fistula treatment centres in all Zobas and strengthening the rehabilitation and reintegration programme at the community level.

FGM

The Eritrea Government has scaled up advocacy and community engagement towards the elimination of the practice of FGM. Community sensitization has been going on about the harmful effects of FGM and ways of preventing its propagation. A law has been enacted to eliminate FGM. The country is also in the process of certifying and declaring FGM-free villages and sub-Zobas. Educational materials have been produced in local languages and distributed within communities. A mobile video unit is in place to help in disseminating messages about FGM prevention. Moving forward, the country will intensify community sensitization in efforts to eliminate FGM.

2.3 Child Health

The main objective for child health was to improve coverage of effective child health interventions to reach 70 per cent of children under five years old by 2021. During the period 2017–2021, the infant mortality rate (IMR) improved from a baseline of 32 per 1,000 live births to 30 per 1,000 live births while the under-5 mortality rates (U5MR) improved from the baseline of 43 per 1,000 live births to 40 per 1,000 live births. Though this was a 6.3 per cent decline in IMR and 7 per cent decline in U5MR, the national targets of 25 per 1,000 and 40 per 1,000 respectively were not attained (UNIGME 2019).

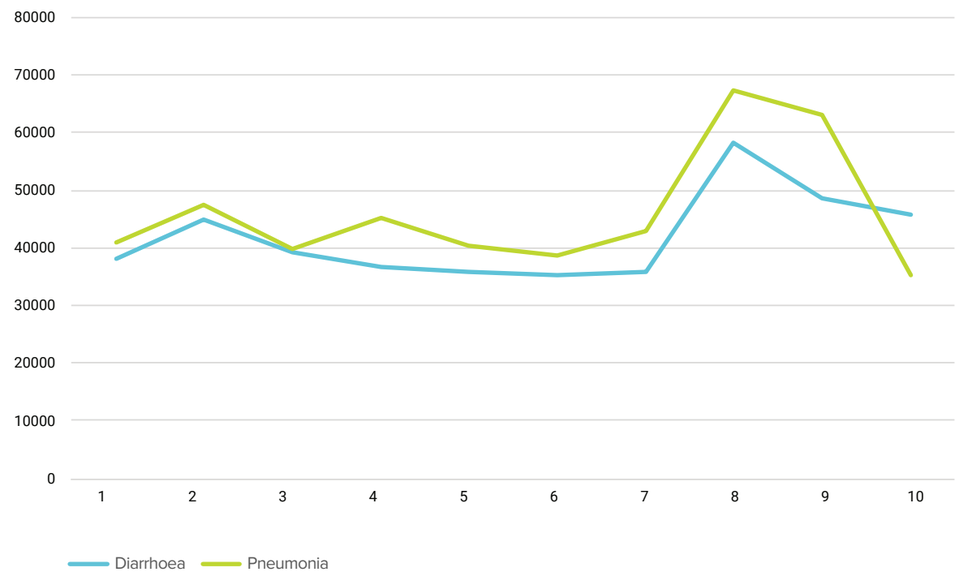
The figure above shows progressive declines in diarrhoea and diarrhoea deaths over the last 10 years. Interventions that have contributed to improving child health indicators include scaling up IMNCI at both facility and community level and capacity building of healthcare providers. Among the challenges identified in implementing child health interventions were stockout of essential commodities, cultural practices affecting health-seeking behaviour, geographical barriers to access, poor staff attitude and inadequate supportive supervision. This strategic plan will focus on improving access to and utilization of child health services, including new approaches such as nurturing care for early childhood development and care of sick and small newborns.

Nutrition

Malnutrition remains a major public health issue in Eritrea, with high level of stunting and high level of acute malnutrition, as shown by a high Global Acute Malnutrition (GAM) rate of 15.3 per cent amongst children under five years old, and with 4.2 per cent being severely malnourished.[8]As per the mid-term review of the HSSDP II conducted by the MoH in December 2019,[9] malnutrition remains one of the top-10 causes of morbidity both in outpatient and inpatient services. Moreover, most of the general population are undernourished, with half of women and men aged 15-49 years having BMIs under 18.5, while most of the population suffer from hidden hunger (micronutrient deficiencies). Iron deficiency anaemia is prevalent and reported in 24 per cent of pregnant women.

8 Eritrea EPHS, 2010.
9 The Ministry of Health's Mid-Term Review of the Eritrea Health Sector Strategic Development Plan-II was conducted in December 2019.

Figure 2.7
Trends in Pneumonia and Diarrhoea Deaths



Additionally, only 32 per cent of children aged 6–23 months have access to iron-rich foods. This strategic plan incorporates specific elements of AHINI, which are managed under the Family Health Department to facilitate efficient implementation and integration.

In the just-concluded strategic plan period (2017–2021), the MoH in conjunction with partners implemented a wide range of nutrition interventions in the country. Consequently, 324,191 children were effectively reached with life-saving treatments for acute malnutrition. Of these, 96,632 were treated for severe acute malnutrition (SAM) – a life-threatening form of malnutrition, 227,560 were treated for moderate acute malnutrition (MAM) and 899,880 children were reached with vitamin A supplementation. Additionally, around 450,461 pregnant women, adolescent girls and primary givers obtained iron folic acid supplementation, and about 465,450 primary caregivers of children aged 0–23 months received counselling on infant and young child feeding (IYCF). Moreover, 723,541 children 6–59 months were screened for acute malnutrition using MUAC in the community as well as health facilities.[10]

2.4 Adolescent and Young People's Health

The objectives for adolescent and young people's health in the RMNCAH, Nutrition and Healthy Ageing Strategic Plan 2017–2021 were to improve prevention and management of teenage pregnancy and to institutionalize adolescent-friendly health services in all health facilities.

Between 2017 and 2021, adolescent-and-young-people-friendly centres increased from a baseline of 6 to 12 out of the potential 347 health facilities.[11] Additionally, the programme collaborated with the Ministry of Education to implement the School Health Programme (comprising awareness of students to health issues as well as screening for ear, nose, throat, eye, teeth and skin problems). These actions, though limited in scope, demonstrate the importance of providing adolescent-and-young-people-friendly sexual and reproductive health (AYPFSRH) services, although some centres were not optimally utilized.

It further calls for re-evaluating the approaches for mainstreaming AYPFSRH services into all service areas where adolescents present for care.

The major bottlenecks in AYPSRH programme implementation that will need to be addressed in this strategic plan include unavailability of data on ASRH because of non-segregation of data by age and sex in the HMIS, shortage of health care providers trained in AYPH service delivery and early marriage. This strategic plan will prioritize scaling up adolescent-and-young-people-responsive health services in health facilities and in schools. Intensified efforts will be made to integrate AYPFSRH service delivery into the existing service areas through innovative approaches such as flexible service provision hours.[12]

2.5 Healthy Ageing

Healthy Ageing is a relatively new programme that was incorporated in the RMNCAH and Nutrition Strategic Plan 2017–2021 with the objectives to:

- Increase the per centage of women and men aged 65 years and above who are up to date on a core set of clinical preventive services to 30 per cent by 2021
- Create an enabling age-friendly environment for the provision of quality and integrated health services for active ageing
- Provide quality and integrated health services for active ageing by 2021

A desk review conducted in December 2018[13] showed significant information gaps on the number of older persons, their health status, living conditions, housing and environmental conditions, among other parameters. Subsequently, the "National Guideline on Integrated Care for People of Grace Age (ICPGA) at Primary Healthcare Level – Interventions to Manage Declines in Intrinsic Capacity" was developed in November 2020[14] based on the WHO ICOPE guidelines. Additionally, the Healthy Ageing TWG has been constituted at the national level and there is a national focal person for the programme in the MoH. All health service areas are open to older people, though distance and lack of transportation are known constraints. A policy of no user fees for older adults seeking health services is in place. Eritrea has no retirement age and older adults can contribute to society throughout their lives and are generally highly respected by society.

Nonetheless, little progress has been made on institutionalizing the healthy ageing programme intra- and intersectorally. There is a need to strengthen HMIS to provide disaggregated data for older adults over 60 years of age. In this strategic plan period, orientation of health care workers on healthy ageing, promotion of age-friendly multisectoral actions, implementation of older-people-responsive health services and community engagement on healthy ageing will be prioritized in order to attain the national goals and realize the targets of the 4 action areas of the UN Decade of Healthy Ageing (2021– 2030).

10 MoH HMIS and DHIS-2
11 Programme report 2017/2019

12 Adolescent Friendly health Services – An Agenda for Change; WHO 2002
13 Healthy Ageing: A Desk Review: MoH/WHO December 2020
14 National Guideline on Integrated Care for People of Grace Age at Primary Health Care Level: Interventions to Manage Declines in Intrinsic Capacity; MoH, November 2020

2.6 Health System Support

Leadership and Governance

Strengthening leadership and governance in the health system involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. The need for greater accountability arises both from increased resource allocation and a growing demand to demonstrate results.

The RMNCAH & HA coordination framework spans national, Zoba, sub-Zoba and health-facility levels. Policies, guidelines and standards for service provision are available and are effectively communicated to the frontline health workers through dissemination workshops, training and supervision. The Zobas hold review meetings annually with the national level and bi-annually with the sub-Zobas. However, several RMNCAH guidelines, protocols and training manuals need to be updated. Whereas costed annual plans exist at national and Zoba levels, the planning is needs-based rather than resource-based, meaning that some planned activities are not implemented due to resource constraints. The success of this strategic plan will be underpinned by a resolute planning process and ensuring a conducive policy environment to facilitate implementation of planned actions.

Infrastructure

The physical work environment is a key element for effective, efficient and safe provision of RMNCAH services while ensuring a positive client experience. Apart from the building infrastructure, amenities such as toilets, water, sanitation and hygiene (WASH) facilities and reliable power sources are critical. In this regard, infrastructure standards are available for each level of health facility in Eritrea. However, maintenance of existing facilities has been limited. Reports of inconsistent supply of electricity and water and shortage of solar batteries have been noted in some of them. There are plans to upgrade some health facilities and renovate others in line with the health facility improvement plan.[15]

Strategic Information Systems

The DHIS-2 system has been in place since 2017 and installation to sub-Zoba level is underway. Quarterly review meetings are held at Zoba level to review programme performance. Despite this, routine data is not disaggregated by age and sex for all age cohorts, making it difficult to obtain information especially around adolescents and older adults. Moreover, data elements for key areas of SRMNCAH such as cervical cancer, GBV and infertility are missing from the HMIS indicator booklet. Apart from the LQAs, the country has not undertaken a DHS since 2010, thus limiting availability of up-to-date population-based data for key elements which would facilitate progress assessment. Weak data management processes have resulted in limited capacity for analysis and usage of data at health facility level. This plan recognizes the critical role of strong routine data systems for effective RMNCAH & HA services and will prioritize investments to ensure availability and use of high-quality routine data.

Human Resources for Health (HRH)

The ability of a country to meet its health goals depends largely on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering health services. In fact, the availability of a skilled attendant is the single most important variable for reducing maternal and perinatal mortality. Of note, the Government of Eritrea has made significant strides in strengthening both human resources development and HR management in the public sector. To this end, the country maintains comprehensive data for HRH where the numbers of the health workforce are known by cadre and by place of deployment.

As of the end of 2020, the workforce under the MoH rose by 18.5 per cent, from 9,338 in 2017 to 11,068 in 2020. Out of the 11,068 workers, 58.7 per cent (4566) are technical staff. That notwithstanding, the country has some way to go to meet the health worker population index (doctors, nurses and midwives) of 4.45 per 1,000 population required to meet the SDG targets.[16] The specialist doctor per 1,000 population ratio is currently 0.02 and general-practice doctors, excluding specialists, per 1,000 population is 0.08. The nursing staff (including midwives and associate nurses) per 1,000 population is 1.2. (The WHO health workforce recommendation for the population (Africa region) of physicians per 1,000 population is 0.3 while the nurses/midwives per 1,000 population is 1.2.[17])

As of the time of review, staff shortages were reported across all levels in terms of numbers, cadres and skills, with some programmes such as cervical cancer screening, healthy ageing and AYP requiring both pre- and in-service intensified skill building. In view of the high volume of new evidence-based recommendations and approaches across RMNCAH, new graduates from medical training institutions will often need to be updated accordingly. Regarding human resource management, enhancing staff motivation and recognition and reducing attrition will need to be prioritized during this strategic plan period.

Health Care Financing

The purpose of health financing is to make funding available and to set the right financial incentives to providers to ensure that all individuals have access to effective public health and personal health care. As part of Universal Health Coverage, women, children, adolescents and older adults should have access to the essential health services that they need, when and where they need them, without financial hardship.

Between 2017 and 2021, the Government of Eritrea made notable progress. Essential health services are free at health centres and health stations, while at hospitals, clients pay a nominal 6 Nakfa for registration. A poverty certificate is used for waiving registration fees for those clients who are not able to afford them. In addition, 24-hour emergency services are free for all. For all major Non-communicable Diseases (NCDs), medication and services are provided free of charge.

This strategic plan will build on ongoing efforts to ensure sustainable financing for essential RMNCAH & HA services and specifically for new programmes such as healthy ageing.

Quality Improvement (QI)

Approximately 8.6m deaths per year in LMICs are due to inadequate access to quality care, of which 5 million are people who sought care but received poor-quality care. Without quality there is no Universal Health Coverage. Quality improvement (QI) is a management approach that health workers can use to reorganize patient care at their level to ensure that patients receive good quality healthcare. It is a problem-solving approach within the local context in health facilities, usually not requiring additional resources.

Review of the 2017–2021 RMNCAH strategic plan revealed that quality improvement systems are in place in all hospitals and quality assurance committees exist. The '5S' system of QI was initiated in 2019, but implementation has been slow. The Zobas and sub-Zobas conduct integrated supportive supervision using the recommended checklists, though some of those checklists are not updated. Supervision is not conducted regularly because of budgetary constraints, and MPDSR systems are not fully functional across the country.

Considering the important contribution of quality improvement in the reduction of maternal, perinatal and child mortality and in the health and wellbeing of adolescents and older adults, this strategic plan prioritizes strengthening QI structures across all Zobas, including training of health care workers in QI and scaling up maternal, perinatal and child mortality surveillance and response.

Medicines, Commodities and Equipment

Drugs and supplies are essential elements of all functioning health systems. Making sure facilities have the right drugs and supplies at the right time and those patients can access affordable products when needed is imperative to delivering high-quality primary health care and achieving the Sustainable Development Goals.[18]

The essential medicines list of Eritrea[19] outlines the minimum drugs or medicines required to provide essential health services in the country. It includes the most efficacious, safe and cost-effective medicines for priority conditions including for RMNCAH & HA. A quality control unit (NMFA) ensures the quality of commodities. While most drugs are available, interrupted supply of some essential RMNCAH & HA drugs or medicines (e.g., Anti-D, Diazepam, IFA

15 National Health Policy 2020

16 WHO: Global strategy on human resources for health: workforce 2030.

17 Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals: Background paper No. 1 to the Global Strategy on Human Resources for Health WHO 2016

18 Primary Health Care Performance Initiative - Improvement Strategies Model: Drugs & Supplies, September 2019

19 Eritrea National List of Medicines, 7th Edition (2019).

Supplementation, Methyldopa, spinal anaesthesia drugs and contraceptives) has been reported. As of the time of review, the country did not have an essential devices list. This strategic plan includes priority actions to address RMNCAH & HA commodity security including essential equipment and devices for RMNCAH & HA services.

Referral System

A referral can be defined as a process in which a health worker at a one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in or take over the management of the client's case.[20] Referral is a critical lifesaving strategy, especially for maternal and child emergencies, and requires an appropriate and functional transportation system, a functional inter-facility communication system, referral guidelines and protocols, among others.

Review of the referral system revealed that referral guidelines and tools (registers, inter-facility and community-to-facility) are available. Generally, referral transportation is available, and clients do not have to pay for ambulance services. Some of the challenges include insufficient ambulances which are often lacking adequate supplies and commodities, fuel shortages and a weak vehicle maintenance programme. This strategic plan emphasizes updating of referral guidelines and tools, procurement of additional ambulances, regular maintenance of existing ones and managing administrative issues around efficient referrals.

20 https://www.who.int › management › Referral notes

Chapter 3

The RMNCAH & HA Strategic Plan for Eritrea 2022–2026 – Strategic Orientation

3.1 Vision

Improved health status, wellbeing, productivity and quality of life for every woman, newborn, child, adolescent, young person and elder in Eritrea.

3.2 Mission

Ensure universal access to comprehensive, high-impact, quality, cost-effective and culturally-sensitive Reproductive, Maternal, Newborn, Child And Adolescent Health And Healthy Ageing Services To All Eritreans Along The Continuum Of Care In An Equitable And Efficient Manner.

3.3 Goal

Accelerated Progress Towards Ending All Preventable Deaths Of Women, Newborns, Children And Realization Of The Health And Wellbeing Of Adolescents And Elders In Eritrea.

3.4 Guiding Principles

The Implementation Of The Rmncah, Nutrition And Healthy Ageing Strategy Will Be Guided Accordingly By Principles And Values In Line With The Eritrea National Health Policy 2020, The Eritrea Health Sector Strategic Development Plan (Hssdp Iii) 2022–2026, The Global Strategy For Women, Children And Adolescent Health 2016–2030, And The Who Afro Regional Framework On Health Ageing.

In This Regard, The Rmncah & Ha Strategic Plan Is Guided By Several Well-Established Principles Of Global Health And Sustainable Development. It Is Country-Owned And Country-Led, Culturally Sensitive And Responsive To Country Context, Equity-Driven (Leaving No One Behind), Gender-Responsive And Human Rights-Driven. Moreover, It Fosters Integrated People-Centred Care, Delivery Of Evidence-Informed High-Impact Interventions, Strategic Partnerships And Multisectoral Engagement, The Continuum Of Care And Life Course Approach, Sustainability And Accountability At All Levels Of Care.

3.5 Strategic Objectives

SO 1: Resilient health systems to support delivery of quality reproductive, maternal, newborn, child and adolescent health and healthy ageing (RMNCAH & HA) services

SO 2A: Universal coverage of comprehensive maternal and newborn health services along the continuum of care

SO 2B: Universal coverage of comprehensive sexual, reproductive and adolescent health services along the continuum of care

SO 3: Universal coverage of effective child health interventions

SO 4: Institutionalized multisectoral response for healthy ageing

3.7 Goal Targets

Impact (Goal) Targets

- Reduce maternal mortality ratio from 184 to 114 per 100,000 live births by 2026
- Reduce neonatal mortality rate from 16 to 14 per 1,000 live births by 2026
- Reduce infant mortality rate from 29 to 24 per 1,000 live births by 2026
- Reduce under-5 mortality rate from 40 to 33 per 1,000 live births by 2026
- Increase Eritrea Healthy Life Expectancy from 53.7 to 63.6 by 2026

Chapter 4

Key Strategies and Priority Actions

This chapter presents the key RMNCAH & HA priority actions for each of the strategies, identified under each strategic objective, that will be implemented in order to achieve the objectives and goals set in this strategic plan. The priority actions under each strategy respond to the gaps identified during the programme review and incorporate new evidence as highlighted in Annex 3 (intervention packages).

Strategic Objective 1:

Resilient health systems to support delivery of quality reproductive, maternal, newborn, child and adolescent health and healthy ageing (RMNCAH & HA) services

This strategic objective will focus on addressing the health system elements required for effective implementation of quality high-impact RMNCAH & HA interventions. Health system strengthening requires a coordinated approach involving strong governance and financing systems, resilient infrastructure, competent and motivated health workforce and access to quality medicines and other health technologies. In addition, the health information system (HMIS) is vital in informing decision-making and monitoring progress. The individuals, families and communities, being the ultimate beneficiaries of RMNCAH & HA services, must be oriented and be actively engaged in implementation to ensure demand creation, acceptability, utilization and sustainability.

The proposed strategies respond to the health system bottlenecks identified during the programme review. Under this strategic objective, the following strategies will be implemented during the period 2022–2026 through the highlighted priority actions:

Strategy 1.1 Strengthen leadership and governance for effective delivery of RMNCAH & HA services at all levels

Priority actions

1.1.1 Build capacity in leadership and governance at all levels

1.1.2 Revitalize RMNCAH & HA coordination and oversight mechanisms at all levels

Strategy 1.2 Strengthen infrastructure development to ensure provision of quality RMNCAH & HA services

Priority actions

1.2.1 Incorporate RMNCAH & HA-specific requirements in the national infrastructure improvement plan

1.2.2 Institute a system of preventive maintenance for equipment

Strategy 1.3 Strengthen strategic information systems for effective RMNCAH & HA programming

Priority actions

1.3.1 Ensure quality documentation and reporting of routine RMNCAH & HA data into DHIS-2

1.3.2 Conduct periodic surveys and assessments to collect population and facility-based data for RMNCAH & HA programming

1.3.3 Expand linkages with IDSR, M&E, CRVS for improved maternal, perinatal and child mortality reporting

1.3.4 Use innovative technologies for collection, analysis, reporting and use of information and data

1.3.5 Implement the RMNCAH & HA score card

1.3.6 Utilize the data for evidence-based planning and programming at different levels

Strategy 1.4: Ensure availability of competent, certified, licensed and regulated RMNCAH & HA health care workers at all levels of health care

Priority actions

1.4.1 Train health workers

1.4.2 Deploy health care providers equitably

1.4.3 Improve human resource (HR) management

Strategy 1.5: Ensure adequate financing for RMNCAH & HA services

Priority actions

1.5.1 Mobilize resources for RMNCAH & HA programmes

1.5.2 Harmonize and align partner resource for better coordination of RMNCAH & HA support

Strategy 1.6: Strengthen quality of care for RMNCAH & HA services

Priority actions

1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)

1.6.2 Implement infection prevention and control standards and patient safety standards

1.6.3 Strengthen maternal and perinatal death surveillance and response (MPDSR) at all levels

Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)

Priority actions

1.7.1 Update the essential list of medicines and devices for RMNCAH & HA in line with up-to-date evidence-based guidelines and protocols

1.7.2 Contribute to the strengthening of the efficiency and effectiveness of the national LMIS

Strategy 1.8: Effective seamless functional referral mechanism for continuity of care

Priority actions

1.8.1 Implement referral guidelines and standard operating procedures (SOPs) at all levels of care

Strategy 1.9: Community engagement in RMNCAH & HA

Priority actions

1.9.1 Utilize multisectoral platforms at community level to create demand for RMNCAH services

1.9.2 Build capacity of community health agents and barefoot doctors (especially in very remote areas) in RMNCAH & HA service provision

1.9.3 Scale up community-based RMNCAH & HA packages

1.9.4 Implement verbal autopsy for maternal, perinatal and child deaths (community-based MPDSR)

Strategy 1.10: Communication for Development (C4D)

Priority actions

1.10.1 Enhance health providers interpersonal communication (IPC)

1.10.2 Promote health-seeking behaviour at community level

Strategic Objective 2A:

Universal coverage of comprehensive Maternal and Newborn health services along the continuum of care

Pregnancy, childbirth and the first 6 weeks after childbirth are crucial times for maternal and newborn survival. Good quality preconception, antenatal, intrapartum and postnatal care are vital in reducing adverse outcomes of pregnancy, labour and delivery and optimizing the wellbeing of mothers and their infants. HMIS data 2020 shows 1st ANC attendance of 70 per cent, 4th ANC attendance of 40 per cent and skilled birth attendance of 58 per cent against the global target of 90 per cent for each of these indicators. Obstructed labour is still the leading cause of maternal morbidity, followed by hypertensive disease. HMIS 2020 data also shows a stillbirth rate of 25 per 1,000 total births and neonatal mortality rate of 18 per 1,000 live births against a global target of 12 per 1,000 live births. Institutional maternal mortality ratio, according to HMIS 2020 data, is at 108 per 100,000 live births. The strategic plan 2022–2026 will strive to accelerate reduction in maternal and perinatal mortality by implementing evidence-based high-impact interventions through the following strategies and priority actions:

Strategy 2A.1 Institutionalize preconception care services

Priority actions

2A.1.1 Develop guidelines and tools and determine entry points for preconception care

2A.1.2 Build capacity on preconception care

2A.1.3 Create demand for preconception care

Strategy 2A. 2 Strengthen utilization of quality antenatal care (ANC) services

Priority actions

2A.2.1 Update the ANC protocol for implementation of quality ANC services

2A.2.2 Raise public awareness of ANC

Strategy 2A.3 Strengthen quality of care during labour and delivery

Priority actions

2A.3.1 Update essential intrapartum care protocols in line with the WHO intrapartum care recommendations for a positive childbirth experience for implementation of labour and delivery services

2A.3.2 Raise public awareness of facility delivery, danger signs and companionship in labour

2A.3.3 Expand maternity waiting homes to remote areas

Strategy 2A.4 Strengthen emergency obstetric and newborn care

Priority actions

2A.4.1 Conduct EmONC assessment

2A.4.2 Ensure implementation of EmONC in accordance with up-to-date protocols and guidelines

Strategy 2A.5 Strengthen postnatal care at facility and community

Priority actions

2A.5.1 Define the core package of essential postnatal care for Eritrea

2A.5.2 Implement integrated postnatal care interventions at community and facility levels according to up-to-date protocols

Strategy 2A.6 Strengthen essential newborn care (ENC)

Priority actions

2A.6.1 Finalize and disseminate the Essential Newborn Care (ENC) clinical care pocket guide

Strategy 2A.7 Strengthen performance of maternal and perinatal death surveillance and response (MPDSR) systems

Priority actions

2A.7.1 Scale up MPDSR across all levels of care

Strategy 2A.8 Strengthen maternal and newborn health (MNH) monitoring and evaluation

Priority actions

2A.8.1 Monitor implementation of MNH services (routine data, surveillance, monitoring and evaluation)

Strategic objective 2B:

Universal coverage of comprehensive sexual, reproductive and adolescent health services along the continuum of care

Target 3.7 of the Sustainable Development Goal 3 (SDG 3) focuses on ensuring universal access to sexual and reproductive healthcare services, including to family planning, information and education, and calls for the integration of reproductive health into national strategies by 2030. The Eritrean government has ensured that SRH is explicitly included in national strategies including the RMNCAH, N & HA Strategic Plan 2017–2021 and the HSSDP III. Moreover, a full strategic objective is dedicated to this target in the current strategic plan.

Nonetheless, the contraceptive prevalence rate stands at 13.5 per cent (HMIS 2019) with the uptake of short-acting contraceptives being higher than for long-acting methods. Stockouts of FP commodities, lack of provider skills in long-acting FP methods and low demand for FP services by the community continue to be a challenge. The other SRH services (reproductive organ cancer screening, post abortion care, obstetric fistula prevention and management, infertility management, GBV and FGM prevention) are provided in few health facilities. In line with the gaps identified, the 2022–2026 strategic plan will strive to increase demand for and utilization of FP services as well as scale up provision of the other SRH services through the following strategies and priority actions:

Strategy 2B.1 Increase access to and utilization of quality FP services

Priority actions

2B.1.1 Conduct high-level advocacy for an enabling environment and resource allocation

2B.1.2 Build capacity of health workers in counselling and provision of quality FP services at facility and community level

2B.1.3 Generate demand for FP services

2B.1.4 Scale up sustained utilization of FP services through innovative approaches such as self-care (referrals linkages, addressing high dropout rate)

2B.1.5 Integrate FP with other SRH/HIV/MNH/nutrition/outreach services

2B.1.6 Support sustained supply of FP commodities and increase method choice

Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management

Priority actions

2B.2.1 Expand the cervical cancer screening and management programme

2B.2.2 Integrate breast cancer screening (CBE and SBE) into other SRH and MNH services

2B.2.3 Strengthen prostate cancer screening

2B.2.4 Strengthen documentation of cancers including RH organ cancers

Strategy 2B.3 Strengthen the provision of quality post-abortion care (PAC) services to the full extent of the law

Priority actions

2B.3.1 Expand coverage of PAC services to facilitate access

Strategy 2B.4 Strengthen infertility management services

Priority actions

2B.4.1 Obtain strategic information to guide infertility service delivery

2B.4.2 Expand preventive management approaches for infertility

2B.4.3 Strengthen the country's capacity to offer comprehensive infertility services

Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems

Priority actions

2B.5.1 Expand GBV service provision

Strategy 2B.6 Strengthen prevention and management of obstetric fistula services

Priority actions

2B.6.1 Prevent obstetric fistulae

2B.6.2 Scale up provision of obstetric fistula services

2B.6.3 Engage the community in increasing utilization of obstetric fistula services and support for survivors

Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/cutting (FGM)

Priority actions

2B.7.1 Scale up FGM prevention interventions with key stakeholders

2B.7.2 Conduct community mapping to transform social and gender norms that lead to collective and public decisions

2B.7.3 Scale up service provision for FGM prevention, protection and care

Strategy 2B.8: Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)

Priority actions

2B.8.1 Scale up the coverage of AYP-responsive health services

Strategy 2B.9: Strengthen multisectoral collaboration to promote adolescent and young people health and well being

Priority actions

2B.9.1 Implement the School Health Programme for junior, secondary, and higher education institutions

2B.9.2 Advocate for resource mobilization and allocation for AYP health interventions

2B.9.3 Provide evidence-based planning and resource allocation for AYP health services

Strategic objective 3:

Universal coverage of effective child health interventions

Protecting and improving the health of children is of fundamental importance to child survival and development. Between 2017 and 2021, the government scaled up IMNCI at facility and community levels. This resulted in the decline of infant mortality rate from a baseline of 32 per 1,000 live births to 30 per 1,000 births while the under-5 mortality improved from the baseline of 43 per 1,000 live births to 40 per 1,000 live births – an improvement of 6.3 per cent and 7 per cent respectively. Notably, the IMR and U5MR fell short of the national targets of 25 per 1,000 and 40 per 1,000 live births respectively (UNIGME 2019).

The RMNCAH Strategic Plan 2022–2026 will implement strategies aimed at prevention, early detection and treatment of childhood illnesses, nurturing care for early childhood development and health promotion including school health. The strategies and corresponding priority actions are highlighted below.

Strategy 3.1: Strengthen IMNCI services at facility and community levels and integrated community case management (iCCM) at community level

Priority actions

3.1.1 Scale up provision of quality IMNCI services at facility and community levels, especially to hard-to-reach areas and nomadic populations

3.1.2. Scale up provision of quality iCCM, especially to hard-to-reach areas.

3.1.3 Support documentation and reporting for community IMNCI into HMIS

Strategy 3.2: Strengthen service delivery for sick and small newborns at facility level

Priority actions

3.2.1 Adopt and implement standards for improving the quality of care for sick and small newborns in health facilities

3.2.2 Scale up kangaroo mother care (KMC) services (guidelines and tools)

Strategy 3.3: Reach every child/district (REC/D)

Priority actions

3.3.1 Increase coverage of integrated outreach services, especially to hard-to-reach and nomadic populations

3.3.2 Promote integrated mass health campaigns for children

3.3.3 Increase access to child health interventions for out-of-school children and children with disabilities

Strategy 3.4: Promote health, development and wellbeing of children

Priority actions

3.4.1 Integrate early childhood development (ECD) interventions along the continuum of care services

3.4.2 Engage with families, caregivers, communities and key stakeholders for adoption and implementation of nurturing care for ECD interventions

Strategy 3.5: Enhance health awareness disease prevention and health promotion among school children

Priority actions

3.5.1 Revitalize the School Health Programme in collaboration with the Ministry of Education (MoE)

Strategy 3.6: Foster intra- and intersectoral collaboration to ensure uptake of child health interventions

Priority actions

3.6.1 Improve linkages with nutrition, PMTCT, immunization, malaria, clinical services and environmental health programs

3.6.2 Improve linkage with other relevant sectors as appropriate (MOLSW, MOE, associations like those involved with disability, blindness etc.)

Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive Nutrition Strategy)

Priority actions

3.7.1 Scale up growth monitoring for under-5 children at all levels of healthcare

3.7.2 Conduct SAM and MAM interventions

3.7.3 Support infant and young child nutrition

Strategy 3.8: Institutionalize facility-based child death audit and reviews (CDAR)

Priority actions

3.8.1 Implement child death audits and reviews (CDAR) at all levels

Strategy 3.9: Advocate for safe environment and against harmful traditional practices around breastfeeding

Priority Actions:

3.9.1 Promote safe environments and cessation of harmful traditional practices that negatively impact breastfeeding

Strategic objective 4:

Institutionalized multisectoral response for healthy ageing

As the proportion of older persons increases worldwide and in the country, it is important to develop a national healthy ageing programme that will ensure the maintenance of functional ability in older adults in line with the actions of the UN Decade of Healthy Ageing (2021–2030) and the AFRO framework for improving the health and wellbeing of older adults.

A Healthy Ageing Desk Review conducted in 2018 revealed a marked shortage of information on the population above 65 years and no formal healthy ageing programme. Since then, the government has put in place policies and guidelines to inform the programme and instituted a multisectoral TWG to ensure availability of age-friendly environments and services. The 2022–2026 strategic plan will prioritize the implementation of the 4 action areas of the UN Decade of Healthy Ageing as a path to improving the health and wellbeing of the elderly by implementing the following strategies and corresponding priority actions:

Strategy 4.1 Combat ageism (attitudes and stereotypes to ageing

Priority actions

4.1.1 Create awareness and sensitization on healthy ageing

Strategy 4.2: Foster Age-friendly environments

Priority actions

4.2.1 Collaborate with other stakeholders to establish older-people-friendly social services (transportation, medical services etc.)

Strategy 4.3: Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)

Priority actions

4.3.1 Establish Age-friendly infrastructure standards to support provision of services for older people

4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH

Strategy 4.4 Strengthen community-based Integrated Care of Older People – ICOPE

Priority actions

4.4.1 Establish community-based health services for older people

Strategy 4.5 Improve strategic information, monitoring and evaluation, research, and innovation for healthy ageing

Priority actions

4.5.1 Monitor and evaluate healthy ageing initiatives

Strategy 4.6 Strengthen governance and leadership for the healthy ageing programme

Priority actions

4.6.1 Establish healthy ageing programme at Zoba and sub-Zoba level

Chapter 5

Monitoring and Evaluation

Monitoring and evaluation processes are essential functions to ensure that priority health actions outlined in the RMNCAH & HA Strategic Plan 2022–2026 are implemented as planned against stated objectives and desired results. The goal of monitoring and evaluation of RMNCAH & HA activities will be to provide reliable information on progress towards ending all preventable deaths of women, newborns, children and realization of the health and wellbeing of adolescents and elders.

5.1 Monitoring

Monitoring is the continuous process of tracking progress of programme interventions during the implementation period to ensure they are proceeding according to plan.

Data Sources

A situation analysis of new programmes will be conducted to provide baseline information to guide implementation and monitoring. Progress on improvements in quality, productivity and efficiency in service delivery shall be tracked through routine data (DHIS-2/HMIS), supervision visits, health-facility surveys (Health Facility Assessment – HFA, Service Availability and Readiness Assessment – SARA, EmONC assessment) and implementation research. Impact and outcome-level indicators in reducing maternal mortality ratio and perinatal, infant and under-5 mortality rates shall be tracked through population-based surveys (such as the EDHS, MICS, EPHS, LQAS), civil registration and vital statistics (CRVS).

Data Quality

The MoH will be conducting regular data quality assessments (DQAs) during this strategic plan period to identify gaps and improve RMNCAH & HA data quality and utilization.

Indicators

To support the monitoring and evaluation of this strategic plan, a monitoring framework outlining the indicators, baseline values, milestones and targets for the five-year period, sources of data and frequency of data collection has been developed and is presented in Annex 2.

Input indicators will help ensure that resources are properly mobilized, equitably distributed and efficiently utilized for ensuring quality and addressing inequalities.

Output indicators will be used to measure utilization and coverage and assess whether the services are provided to the intended target groups.

Outcome and impact indicators reflect the result of interventions within and outside the health sector.

Performance review

Monthly, quarterly and annual reports will be produced and disseminated using various channels (review meetings, factsheets, publications).

Performance review meetings shall be held at all levels (national, Zoba and sub-Zoba) quarterly and annually. During these meetings, achievements, best practices, challenges and mitigation measures will be reviewed.

The RMNCAH & HA Scorecard will be used to visually highlight high-performing areas as well as low-performing areas to enable identification of bottlenecks to be addressed through locally adapted solutions. The national scorecard will be updated annually while the Zoba and sub-Zoba dashboards will be updated quarterly.

5.2 Evaluation

Evaluation is assessment done at a point in time to see whether the objectives have been achieved and the interventions have produced the desired impact. A mid-term evaluation of the strategy will be conducted at the end of the second year of the strategic plan implementation. The purpose will be to document achievements and challenges during implementation. The findings will be used to guide revisions or updates of the set targets and implementation strategies as appropriate.

An independent end-of-term evaluation of the strategy implementation will be done at end of the fifth year to assess the impact of the strategy against the set targets as well as to guide planning for the next strategic period.

Chapter 6

Coordination

6.1 Leadership and Governance

The national RMNCAH & HA Strategic Plan 2022–2026 is a core component of the national Health Sector Strategic Development Plan 2022–2026 (HSSPD III) goal of healthy lives and well-being for all Eritreans at all ages. The implementation of the RMNCAH, Nutrition and Healthy Ageing strategy will therefore follow the national institutional and structural procedures that govern health development and provision of services in Eritrea provided in the HSSPD III.

The Division of Family and Community Health shall provide oversight in the implementation of the RMNCAH & HA Strategic Plan 2022–2026. Operational plans will be developed and implemented at all levels – national, Zoba and sub-Zoba. Support to the Zoba and sub-Zoba levels to accomplish their respective responsibilities in the implementation of the priority actions outlined in the implementation plan will be provided by the respective programmes under the Division of Family and Community Health.

6.2 Role of Stakeholders

The implementation of the RMNCAH, Nutrition and Healthy Ageing Strategy calls for a multisectoral approach and the involvement of all the different stakeholders, including other sectors, to address issues that impact access to and utilization of RMNCAH & HA health services, such as sanitation, safe drinking water, malnutrition, gender equality and the empowerment of women. The Ministry of Health will engage with these stakeholders through the various technical working groups and the Inter-Agency Coordinating Committee.

Ministry of Education

The influence of education in health-seeking behaviour in RMNCAH has long been documented, with access to education directly linked to uptake and adherence to services. The RMNCAH & HA Strategic Plan has outlined strategies to be incorporated into the School Health Programme, including screening for diseases, micronutrient supplementation, menstrual hygiene education, life skills training and relevant vaccinations. Collaboration with the Ministry of Education to addresses sexual and reproductive health behaviour in adolescents and young people will enable integration of life skills education into the curriculum for secondary schools.

Ministry of Labour and Social Welfare

Collaboration with the MoLSW, mainly around support for the older members of society, is reflected in the strategies around healthy ageing. These include permission for civil servants to work in the public sectors for “as long as they are physically fit and capable to carry out their daily responsibilities”, giving priority to older people in accessing social services and financial support through a form of pension scheme. The MoLSW is also critical in early childhood development, addressing dangerous practices like early gender-based violence, child marriage, mistreatment of people with disabilities, as well as giving access to services to those needing poverty certificates, among others.

Ministry of Communication and Transport

This Ministry is important in mitigating the second delay through facilitating access to transportation and especially emergency transportation when needed. To address intrinsic declines in mobility in older individuals and the needs of people with disabilities, the Ministry will be responsible for ensuring age-friendly transportation services. To actualize this, it will need close liaisons with the Ministry of Roads and the Ministry of Local Government.

Ministry of Public Works

The MoPW is critical in ensuring that infrastructure development and maintenance for health facilities is up to standards and provides a conducive environment for service delivery. Taking cognizance of the United Nation’s Decade of Healthy Ageing, this Ministry will be instrumental in ensuring age-friendly infrastructure to facilitate access and utilization of health facilities by all people including children, those with disabilities and older adults.

Development partners, including United Nations agencies

Development partners have a key role to play in this strategic plan, including mobilizing necessary technical and financial resources to support implementation, capacity building, monitoring and evaluation, and progress reporting. These partners are coordinated through the various TWGs and the Inter-Agency Coordinating Committee. To maximize resource utilization, the partners should align their priorities and plans with those in the strategic plan.

Medical training institutions and regulatory bodies

Competent health professionals are key to ensuring quality RMNCAH services. Medical training institutions and regulatory bodies are critical due to their important role in the training of health professionals, certification, licensing and regulation of practice. To facilitate acquisition and transfer of competencies necessary for implementation of this strategic plan, these bodies should incorporate evidence-based RMNCAH & HA interventions into both pre-service and in-service training curricula.

Ministry of Local Government

The Ministry of Local Government has a key role to play by ensuring that communities and local partners are engaged and made aware of the priority actions of this plan and especially those that need their participation at individual, family and community levels. This may involve the following: social mobilization for increased health service utilization, combating harmful traditional practices and construction or renovation of health facilities and maternity waiting homes, always ensuring availability of functional ambulance services and coordinating establishment of a post-referral payment mechanism at the village/community level.

Ministry of Agriculture (MoA)

The MoA is very critical in ensuring food security, specifically in promoting the production and utilization of micronutrient-rich foods, especially for vulnerable households. The MoA will also be instrumental in promoting homestead production of vegetables and fruits and small-animal rearing through the provision of agricultural inputs to vulnerable households

Chapter 7

Financial Requirements

7.1 Introduction

The World Health Organization (WHO) defines health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system." It states that the "purpose of health financing is to make funding available, as well as to set the right financial incentive to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000). Costing is the process of determining, in monetary terms, the value of inputs that are required to generate a particular output. It involves estimating the quantity of inputs required by an activity or programme. Costing may also be described as a quantitative process, which involves estimating both operational (recurrent) costs and capital costs of a programme. The process ensures that the value of resources required to deliver services is cost-effective and affordable.

7.2 Costing models

7.2.1 One Health Model

The One Health Model is a tool for medium- to long-term (3-10 years) strategic planning in the health sector at the national level. The model computes the cost implications of achieving the targets set under disease programmes and for the health system. The One Health Model is therefore a unified tool in two ways: in enabling joint planning, costing, budgeting, impact and financial space analysis, and in combining disease programmes and health systems.

The model provides health sector planners with a single framework. The tool facilitates an assessment of costs related to a wide range of areas, including sexual and reproductive health (maternal, newborn and FP); child health; immunization; malaria; TB; HIV/AIDS; nutrition; water, sanitation and hygiene (WASH, including environmental health); non-communicable diseases; among others. This is important in informing progress towards the Sustainable Development Goals, including assessment of achievable health impact. In addition, it contains modules for the areas of human resources, infrastructure, logistics, financial space, programme and channel analysis, intervention coverage and costing, bottleneck analysis, programme costing, summary outputs and budgeting. The OneHealth Tool is used for supporting national strategic health planning in low- and middle-income countries. The tool facilitates an assessment of resource needs associated with key strategic activities and their associated costs, with a focus on integrated planning and strengthening health systems.

The results of the OneHealth analysis represent a robust resource base for answering questions related to epidemiology, programmatic reach, implementation strategy and cost in the health sector. While many investments will be front-loaded to the initial years of the strategy, a growing population and ambitious service delivery scale-up targets mean the annual cost will grow over the years of implementation. This increase in resource need does not factor in anticipated epidemiological shifts, such as the rising burden of noncommunicable diseases, potential for new disease outbreaks or other unexpected disruptions to the health system. Further, rising costs will be accompanied by various financial, managerial and logistical demands for which the Ministry of Health will need to prepare.

Cost analysis of programme management

Programme management costs incurred by a health programme may include training, supervision, monitoring and evaluation, transportation, advocacy and communication, and media and outreach. These costs derived from health programme managers' inputs and were incorporated into the annual costs at the programme level.

The costing of the RMNCAH, Nutrition & Healthy Ageing plan is evidence-based. The evidence is collected majorly from secondary sources based on the following aspects: efficacy, efficiency, equity and effectiveness of the interventions. Key informant discussions provide input on how RMNCAH programming at the country level has taken shape over the years and the challenges they face during resource mobilization as well as implementation.

7.2.2 Activity-based costing

Activity-based costing (ABC) is a method of allocating costs to products and services based on each intervention and activity with the aim of achieving set goals or results. It focusses on the bottom-up approach. ABC is generally used as a tool for planning and control. All costs of activities are traced to the product or service for which the activities are performed. Direct labour and materials are relatively easy to trace directly to products, but it is more difficult to directly allocate indirect costs to products. Where products use common resources differently, some sort of weighting is needed in the cost allocation process.

In ABC, each of the activities requires inputs, such as labour, conference halls etc. These inputs are required in certain quantities and with certain frequencies. The sum of the product of the unit cost, the quantity and the frequency of the input will give the total input cost. Unit cost refers to the value of resources to provide a service to one unit/person (client or a patient). In

Figure 7.2.a
Intervention costs (direct)

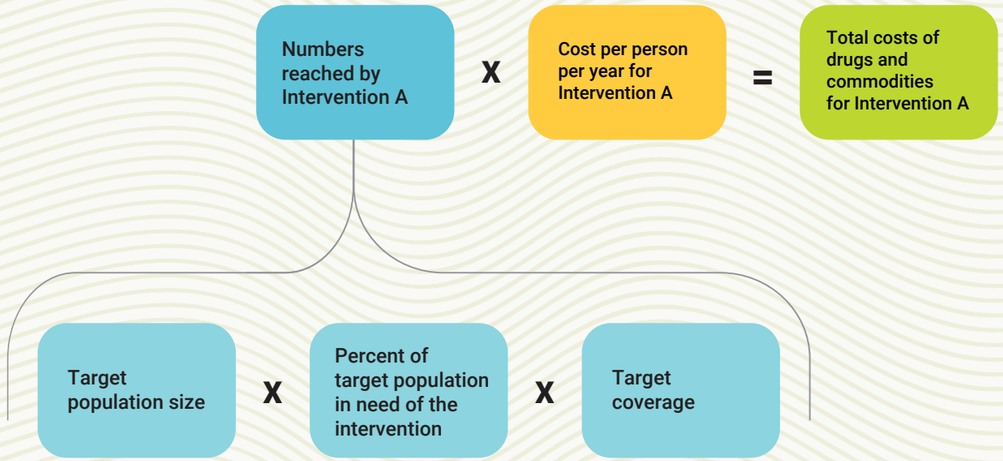
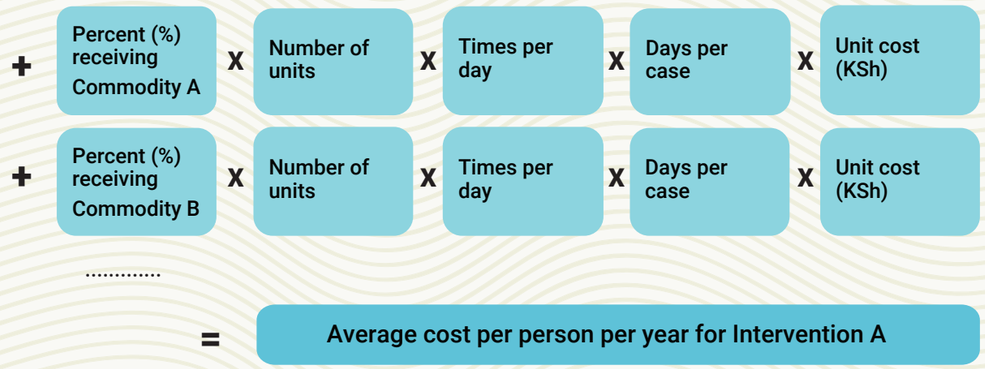


Figure 7.2 b
Intervention cost: Unit



activity-based costing, all the ingredients to provide a service to one person are clearly defined. The quantity of each input (ingredient) in the provision of the service is required. The cost price of a unit of the input is also required for calculation of the unit cost.

ABC is relevant to performance budgeting in two ways:

i. As a tool for better expenditure prioritization, as it permits much improved programme costing, hence providing a systematic way of determining how to apply limited resources to the right activities to produce the right results (improve quality of expenditure)

ii. As a means of developing a tighter link between planned outputs and funding by determining the cost of the activities that are required to produce the planned outputs

7.3 Scenario analysis

The analysis projected three main scenarios: Baseline (modest projections), Moderate and Aggressive. The development of the scenarios was mostly based on the main cost drivers:

Baseline Scenario – Assumed the status quo and largely relied on existing health systems.

Moderate Scenario – Took into consideration infrastructure requirements for maternal health (procuring necessary equipment and supplies, including food items, for maternity waiting homes).

Aggressive Scenario – Took into consideration infrastructure requirements for maternal health (additional obstetric fistula management centres identified and functional as well as EmONC facilities having all critical equipment and supplies needed to provide all signal functions). Further, coverages were extrapolated exponentially to capture resource requirements if the country was to meet the SDG targets for the year 2026.

7.4 Cost requirement for the implementation of the RMNCAH & HA Strategic Plan

The implementation of the RMNCAH & HA Strategic Plan requires that all interventions or activities are costed. This section describes in detail the level of resource requirements for the strategic plan period, the available resources and the gap between what is anticipated and what is required. The estimates will help not only guide and inform the annual planning, but also prepare the country to ensure the necessary resource mobilization.

Overall Cost Requirement

Figure 7.4.1 provides summary cost estimates by category. From the costing, ERN 1.6 billion is required to finance the strategy over the baseline scenario. Resource needs vary across years and across scenarios.

Resource requirements for the strategy in each of the three scenarios are shown in Table 7.4.1. More details on the cost per activity is included in the Annex.

Figure 7.4.1
Overall Cost Requirement for RMNCAH & HA (ERN Millions)

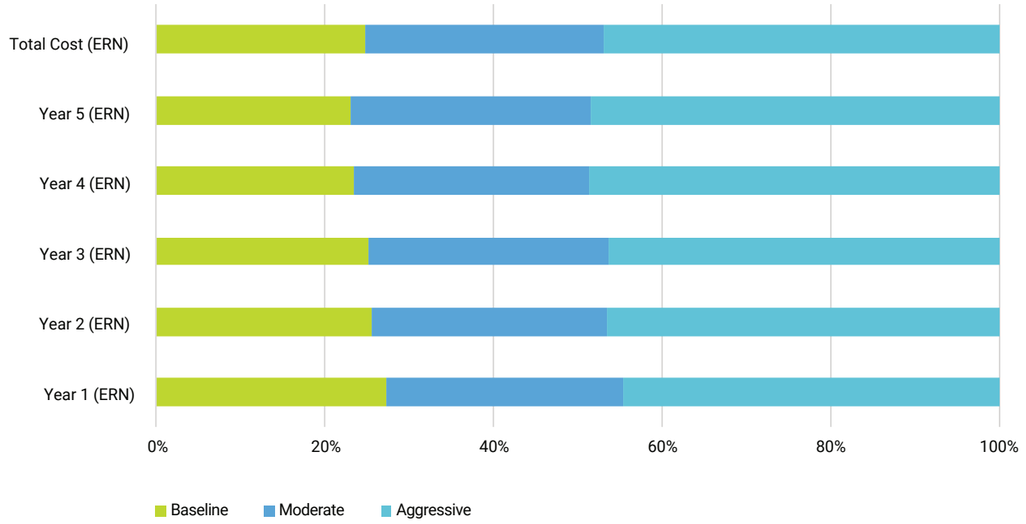


Table 7.4.1: Overall Cost Requirement for RMNCAH & HA (ERN)

Scenarios	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
Baseline	331,948,962	305,195,885	339,073,865	316,609,742	351,576,059	**1,644,404,513**
Moderate	344,137,463	333,466,657	384,234,817	377,911,954	432,642,871	**1,872,393,762**
Aggressive	545,192,068	555,884,595	624,528,568	657,255,646	737,284,847	**3,120,145,724**

Further, resource requirements for the strategy are disaggregated by intervention costs (prevention and treatment) as well as programme management costs in Tables 7.4.2 a, b and c. More details on the cost per activity are included in the Annex.

Table 7.4.2a: Baseline Scenario (ERN)

Scenarios	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
Intervention costs	194,239,630	199,298,490	205,061,096	211,463,543	218,517,297	1,028,580,056	**62.6**
Programme costs	137,709,332	105,897,395	134,012,769	105,146,199	133,058,762	615,824,457	**37.4**
RMNCAH & HA	331,948,962	305,195,885	339,073,865	316,609,742	351,576,059	1,644,404,513	**100.0**

Table 7.4.2b: Moderate Scenario (ERN)

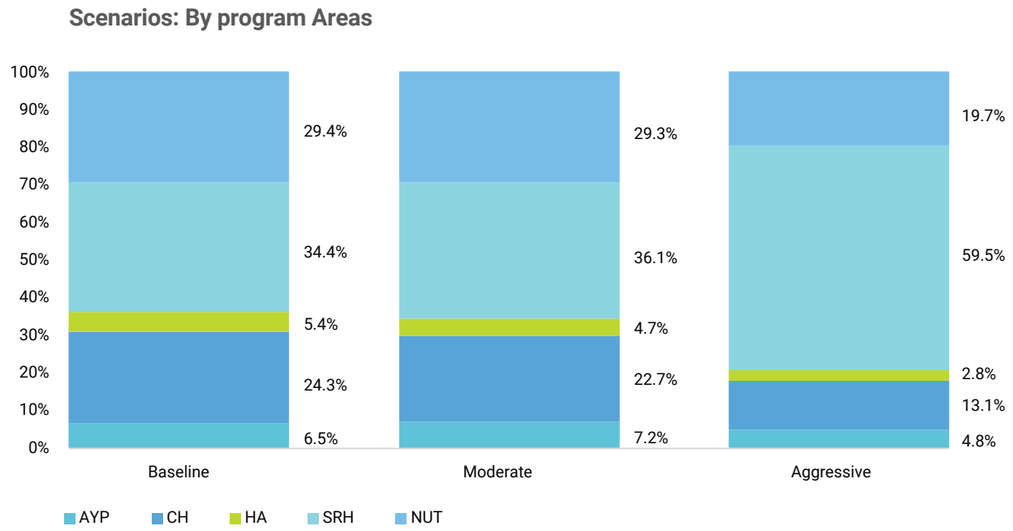
Scenarios	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
Intervention costs	194,263,197	214,726,892	236,838,194	260,985,765	287,256,783	1,194,070,831	**63.8**
Programme costs	149,874,267	118,739,765	147,396,622	116,926,189	145,386,088	678,322,931	**36.2**
RMNCAH & HA	344,137,463	333,466,657	384,234,817	377,911,954	432,642,871	1,872,393,762	**100.0**

Table 7.4.2c: Aggressive Scenario (ERN)

Scenarios	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
Intervention costs	194,305,909	228,382,865	260,551,911	310,342,695	352,224,401	1,345,807,781	**43.1**
Programme costs	350,886,159	327,501,729	363,976,657	346,912,950	385,060,446	1,774,337,943	**56.9**
RMNCAH & HA	545,192,068	555,884,595	624,528,568	657,255,646	737,284,847	3,120,145,724	**100.0**

The strategic plan comprises reproductive, maternal, neonatal, child and adolescent health, nutrition and healthy ageing programmes. Figure 7.4.2 shows a breakdown of cost requirements by programme for the three scenarios. Overall, sexual and reproductive health accounts for the largest share of resources followed by nutrition and child health respectively in all the scenarios.

Figure 7.4.2: Cost Requirement for RMNCAH & HA by Programme Areas



Tables 7.4.3 a, b and c provide a breakdown of resource requirements by programme areas for the three scenarios.

Table 7.4.3a: Baseline Scenario (ERN)

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
AYP	23,469,361	19,118,551	22,121,914	20,296,601	22,674,005	107,680,431	**6.5**
CH	77,440,356	73,776,063	81,764,504	78,396,762	87,880,724	399,258,409	**24.3**
HA	17,331,123	16,949,204	17,669,976	17,663,445	18,459,794	88,073,542	**5.4**
SRH	113,236,861	108,054,371	121,733,231	102,378,481	120,361,385	565,764,331	**34.4**
NUT	100,471,261	87,297,696	95,784,241	97,874,452	102,200,151	483,627,801	**29.4**
RMNCAH & HA	331,948,962	305,195,885	339,073,865	316,609,742	351,576,059	1,644,404,513	**100.0**

Table 7.4.3b: Moderate Scenario (ERN)

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
AYP	23,402,515	21,440,781	27,129,036	28,365,977	34,123,190	134,461,499	**7.2**
CH	77,259,311	76,322,450	87,065,846	86,384,205	98,410,465	425,442,277	**22.7**
HA	17,331,123	16,949,204	17,669,976	17,663,445	18,459,794	88,073,542	**4.7**
SRH	126,103,701	125,460,646	143,856,240	127,891,179	151,934,843	675,246,609	**36.1**
NUT	100,040,814	93,293,575	108,513,719	117,607,148	129,714,579	549,169,835	**29.3**
RMNCAH & HA	344,137,463	333,466,657	384,234,817	377,911,954	432,642,871	1,872,393,762	**100.0**

Table 7.4.3c: Aggressive Scenario (ERN)

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost	Per cent
AYP	22,999,642	24,597,208	29,697,046	35,628,106	37,664,435	150,586,437	**4.8**
CH	76,153,934	74,920,088	85,021,633	82,548,770	89,857,734	408,502,159	**13.1**
HA	17,331,123	16,949,204	17,669,976	17,663,445	18,459,794	88,073,542	**2.8**
SRH	331,293,952	340,814,071	370,397,462	378,087,093	437,139,352	1,857,731,930	**59.5**
NUT	97,413,418	98,604,023	121,742,451	143,328,232	154,163,532	615,251,656	**19.7**
RMNCAH & HA	545,192,068	555,884,595	624,528,568	657,255,646	737,284,847	3,120,145,724	**100.0**

7.5. Available Resources

A good health system raises adequate revenue for service provision, enhances the efficiencies of resource management and provides financial protection to the poor against catastrophic and impoverishing situations. Understanding how the health systems and services are financed, programmed and resourced is important in strategic mobilization of resources, advocating for financing of priority actions and supporting populations to access available health services. Estimation of resources is a critical component towards sustainable financing and mobilization of funding is needed to implement the interventions outlined in the strategy.

The available funding was provided by partners, i.e., UNICEF, UNFPA and WHO, which predominantly support RMNCAH & HA in Eritrea. Government funding was not provided.

Table 5: Available Resources for RMNCAH & HA Strategic Plan

Funding Source	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Government	-	-	-	-	-	**-**
Partners	24,145,098	24,145,098	24,145,098	24,145,098	24,145,098	**120,725,492**
Total available	24,145,098	24,145,098	24,145,098	24,145,098	24,145,098	**120,725,492**

7.5.1. Financial gap analysis

The difference between the resource requirements and the available resource-based budgets provides a measure of the gap in funding that exists and can impede the full implementation of the RMNCAH & HA strategic plan. The identification of the funding gap provides an opportunity for potential stakeholders to see where additional resources will be most useful. This costed strategy will be used as a resource mobilization tool to advocate for funding toward achievement of the aspirations of this strategic framework.

Table 7. 5.1 Financial Gap Analysis (ERN, Millions)

Table 7.5.1a: Baseline Scenario (ERN)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total cost
Total requirements	331.9	305.2	339.1	316.6	351.6	**1,644.4**
Total available	24.1	24.1	24.1	24.1	24.1	**120.7**
Funding gap	307.8	281.1	314.9	292.5	327.4	**1,523.7**

Table 7.5.1b: Moderate Scenario (ERN)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total cost
Total requirements	344.1	333.5	384.2	377.9	432.6	**1,872.4**
Total available	24.1	24.1	24.1	24.1	24.1	**120.7**
Funding gap	320.0	309.3	360.1	353.8	408.5	**1,751.7**

Table 7.5.1c: Aggressive Scenario

	Year 1	Year 2	Year 3	Year 4	Year 5	Total cost
Total requirements	545.2	555.9	624.5	657.3	737.3	**3,120.1**
Total available	24.1	24.1	24.1	24.1	24.1	**120.7**
Funding gap	521.0	531.7	600.4	633.1	713.1	**2,999.4**

Strategies to ensure available resources are sustained

Bridging the funding gap is critical to ensure that implementation of the strategic interventions in this strategic plan is not hampered by lack of resources. There is need for innovative strategies to mobilize and sustain funding, including from non-traditional sources.

A two-pronged approach will be adopted. First, it is necessary to ensure that resources projected as available are made available and prudently utilized. Advocacy and lobbying will be undertaken for increased budget allocations. Additionally, partners and stakeholders will be identified, mapped and continuously engaged for support towards implementation of this strategy.

Second, appreciating that a critical ingredient to the continuity of support is transparency and accountability, the implementation of this strategic plan will be closely monitored to ensure that resources are optimally utilized and that funders receive accountability reports that are accurate and timely. An annual report documenting the progress of achievements made in the implementation of this strategic plan should be prepared and shared with stakeholders to sustain commitment.

Annexes

Annex 1
Implementation Plan

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
Strategic objective 1: Resilient health systems to support delivery of quality reproductive, maternal, newborn, child and adolescent health and healthy ageing (RMNCAH & AH) services	Strategy 1.1: Strengthen leadership and governance for effective delivery of RMNCAH & HA services at all levels	1.1.1 Build capacity in leadership and governance at all levels	1.1.1.1 Conduct a training needs assessment for RMNCAH & HA leadership and governance	Training needs assessment conducted	MoH	X				
	Strategy 1.1: Strengthen leadership and governance for effective delivery of RMNCAH & HA services at all levels	1.1.1 Build capacity in leadership and governance at all levels	1.1.1.2 Conduct two management trainings for RMNCAH managers at national and Zoba levels	2 Management trainings held (WHO's Managing programmes on RMNCAH training)	MoH	X	X			
	Strategy 1.1: Strengthen leadership and governance for effective delivery of RMNCAH & HA services at all levels	1.1.2 Revitalize RMNCAH & HA coordination and oversight mechanisms at all levels	1.1.2.1 Constitute national and sub-national level Technical Working Groups (TWGs) with Terms of Reference (TORs) and convene quarterly meetings	National and Zoba RMNCAH & HA TWGs and their TORs constituted, and meetings held quarterly	MoH	X	X	X	X	X
	Strategy 1.1: Strengthen leadership and governance for effective delivery of RMNCAH & HA services at all levels		1.1.2.2 Constitute the RMNCAH & HA Inter-agency Coordinating Committee (RMNCAH & HA ICC) and hold meetings bi-annually	RMNCAH & HA ICC constituted and holding meetings bi-annually	MoH	X	X	X	X	X
	Strategy 1.2: Strengthen infrastructure development to ensure provision of quality RMNCAH & HA services (including water, sanitation and hand-washing facilities)	1.2.1 Incorporate RMNCAH & HA-specific requirements in the national infrastructure improvement plan	1.2.1.1 Define specific additional infrastructure requirements including renovations of existing infrastructure for the different RMNCAH programme areas in collaboration with the infrastructure improvement planning team and in line with health infrastructure standards	RMNCAH & HA specifications are incorporated during infrastructure construction or renovations	MoH	X			X	

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.2: Strengthen infrastructure development to ensure provision of quality RMNCAH & HA services (including water, sanitation and hand-washing facilities)	1.2.2 Build national capacity to ensure uninterrupted functionality of RMNCAH & HA-specific infrastructure and equipment	1.2.2.1 Conduct Cascade trainings for biomedical engineers in line with the donation and procurement guidelines	Cascade trainings held at Zoba and sub-Zoba levels in line with procurement guidelines	MoH	X			X	
	Strategy 1.2: Strengthen infrastructure development to ensure provision of quality RMNCAH & HA services (including water, sanitation and hand-washing facilities)	1.2.2 Build national capacity to ensure uninterrupted functionality of RMNCAH & HA-specific infrastructure and equipment	1.2.2.2 Operationalize a system of regular maintenance of RMNCAH equipment	Schedule for preventive maintenance available for RMNCAH & HA essential equipment at all levels	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.1 Enhance documentation and reporting of routine RMNCAH & HA data into DHIS-2	1.3.1.1 Define a core set of RMNCAH & HA indicators, including for community	Core set of RMNCAH & HA indicators identified	MoH	X				
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.1 Enhance documentation and reporting of routine RMNCAH & HA data into DHIS-2	1.3.1.2 Avail data tools for documentation and reporting of routine RMNCAH & HA services and indicators	Complete set of RMNCAH & HA data tools available and in use	MoH	X	X			
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.1 Enhance documentation and reporting of routine RMNCAH & HA data into DHIS-2	1.3.1.3 Expand Community health information system (CHIS) to capture more indicators and incorporate reports into HMIS (data flow)	Community health service provision data available and incorporated into HMIS / DHIS-2	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.1 Enhance documentation and reporting of routine RMNCAH & HA data into DHIS-2	1.3.1.4 Train and mentor service providers at all levels in documentation and reporting of RMNCAH & HA	Service providers at all levels trained and mentored in documentation and reporting of routine RMNCAH & HA data	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.1 Enhance documentation and reporting of routine RMNCAH & HA data into DHIS-2	1.3.1.5 Conduct bi-annual data quality audits (DQAs)	DQAs conducted bi-annually	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.2 Ensure availability of population- and facility-based data for RMNCAH & HA programming	1.3.2.1 Participate in EDHS, LQAS, HFA	Periodic surveys include RMNCAH & HA elements as appropriate	MoH	X				X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.2 Ensure availability of population- and facility-based data for RMNCAH & HA programming	1.3.2.2 Conduct RMNCAH & HA assessments and Knowledge, Attitude and Practice (KAP) surveys	(See under specific programme areas) Survey reports	MoH	X				X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.3 Expand linkages with IDSR, M&E, CRVS for improved maternal, perinatal and child mortality reporting	1.3.3.1 Collaborate with IDSR to improve surveillance and notification of maternal, perinatal and child deaths	Improved identification and reporting of maternal, perinatal and child deaths	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.3 Expand linkages with IDSR, M&E, CRVS for improved maternal, perinatal and child mortality reporting	1.3.3.2 Collaborate with CRVS for timely and accurate certification of maternal, perinatal and child deaths	Accurate completion of MCCoD for maternal, perinatal and child deaths	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.4 Employ innovative technologies for collection, analysis, reporting and use of RMNCAH & HA information and data	1.3.4.1 Institute innovative technologies for collection, analysis, reporting and use of RMNCAH & HA information and data (including electronic medical records, digital adaptation kits, m-health/e-health)	Innovative technologies in use for data collection, analysis and reporting	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.5 Implement the RMNCAH & HA scorecard	1.3.5.1 Update national RMNCAH & HA scorecard and Zoba and sub-Zoba dashboards regularly	National RMNCAH & HA scorecard updated annually; Zoba and sub-Zoba dashboards updated quarterly	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.6 Utilize the data for evidence-based planning and programming at different levels	1.3.6.1 Orient RMNCAH & HA staff in data analysis and use, reporting and feedback mechanisms according to level of care	RMNCAH & HA staff at all levels trained in appropriate data analysis, reporting and feedback mechanisms	MoH	X	X	X	X	X
	Strategy 1.3: Strengthen strategic information systems for effective RMNCAH & HA programming	1.3.6 Utilize the data for evidence-based planning and programming at different levels	1.3.6.2 RMNCAH & HA data from all levels used for annual planning and quality improvement at all levels	RMNCAH & HA data utilized for planning and quality improvement at all levels	MoH	X	X	X	X	X
	Strategy 1.4: Improve availability of competent, certified, licensed, and regulated RMNCAH & HA healthcare workers at all levels of health care	1.4.1 Train health workers	1.4.1.1 Conduct pre- and in-service training, CMEs, mentorship in RMNCAH & HA service provision	Health care providers trained or updated on high-impact, essential RMNCAH & HA interventions	MoH	X	X	X	X	X
	Strategy 1.4: Improve availability of competent, certified, licensed and regulated RMNCAH & HA healthcare workers at all levels of health care	1.4.1 Train health workers	1.4.1.2 Review or update pre-service curriculum to incorporate new evidence-based, high-impact RMNCAH & HA interventions	Updated RMNCAH & HA pre-service curriculum and syllabus for all cadres	MoH		X			

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.4: Improve availability of competent, certified, licensed and regulated RMNCAH & HA healthcare workers at all levels of health care	1.4.2 Deploy healthcare providers equitably	1.4.2.1 Advocate for equitable deployment of healthcare workers competent in RMNCAH& HA in line with staffing norms, especially for hard-to-reach locations	Adequate numbers of HCWs with RMNCAH & HA competencies available at all levels of care	MoH	X	X	X	X	X
	Strategy 1.4: Improve availability of competent, certified, licensed, and regulated RMNCAH & HA healthcare workers at all levels of health care	1.4.3 Improve human resource (HR) management	1.4.3.1 Implement staff retention policies to mitigate attrition and enhance staff performance and patient safety	Staff motivation and recognition systems in place and functional	MoH	X	X	X	X	X
	Strategy 1.5: Ensure adequate and sustained financing for RMNCAH & HA services	1.5.1 Mobilize resources for RMNCAH & HA programmes	1.5.1.1 High-level advocacy for increased allocation of funds for RMNCAH & HA programming	“White Paper” or “Investment Case” developed for use in high-level advocacy for RMNCAH & HA resources	MoH	X	X	X	X	X
	Strategy 1.5: Ensure adequate and sustained financing for RMNCAH & HA services	1.5.2 Harmonize and align partner resource for better coordination of RMNCAH & HA support	1.5.2.1 Conduct RMNCAH & HA resource mapping to inform joint planning and joint monitoring of resources	RMNCAH & HA resource mapping and monitoring undertaken	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.1 Adaptation and implementation of RMNCAH & HA standards	RMNCAH & HA standards adapted for each programme area	MoH	X	X			
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.2 Training of health care providers in quality improvement (QI)	Health care providers trained in QI approaches and principles	MoH	X	X			
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.3 Establish functional QI committees or teams at all levels	QI committees or teams available at all levels	MoH	X	X			
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.4. Develop or adapt quality-of-care (QoC) assessment tool for RMNCAH & HA services	QoC assessment tool for RMNCAH & HA services developed	MoH	X				
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.5 Conduct quality-of-care (QoC) assessments including clinical audits	QoC assessments conducted, and clinical audits regularly undertaken	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.6 Implement quality improvement (QI) approaches at facility levels	QI approaches implemented to improve provision and experience of RMNCAH & HA services	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.7 Implement accountability mechanisms to ensure patient safety and positive experience of care	Quarterly client exit interviews undertaken to assess client experience during care and address gaps identified	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.1 Institutionalize quality-of-care systems at all levels of care (provision and experience of care)	1.6.1.8 Conduct quarterly support supervision and mentorship	Supportive supervision and mentorship conducted regularly by national and Zoba teams	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.2 Implement infection prevention and control standards and patient safety standards	1.6.2.1 Provide functional WASH facilities and services (running water, sinks, toilets, bathrooms, soap, sanitizer, waste disposal etc.)	WASH facilities available and functional in all health facilities	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.2 Implement infection prevention and control standards and patient safety standards	1.6.2.2 Implement COVID -19 infection and prevention protocols during RMNCAH & HA service provision	COVID-19 regulations are maintained during RMNCAH & HA service provision	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.3 Strengthen maternal and perinatal death surveillance and response (MPDSR) at all levels	1.6.3.1 Constitute MPDSR committees at national, Zoba, sub-Zoba, health facility and community levels	MPDSR committees are constituted and meeting regularly	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.3 Strengthen maternal and perinatal death surveillance and response (MPDSR) at all levels	1.6.3.2 identify and capture all maternal, perinatal and child deaths in the national HMIS	All maternal, perinatal and child deaths identified, notified and captured in HMIS	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.3 Strengthen maternal and perinatal and child death surveillance and response (MPDSR) at all levels	1.6.3.3 Update MPDSR committees on the latest MPDSR implementation guidance and tools from WHO	MPDSR committees updated on latest WHO implementation guidance and tools	MoH	X	X	X	X	X
	Strategy 1.6: Strengthen quality of care for RMNCAH & HA services	1.6.3 Strengthen maternal and perinatal and child death surveillance and response (MPDSR) at all levels	1.6.3.4 Respond to MPDSR recommendations as appropriate	Responses to death reviews acted upon as indicated in the review report	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.7: Ensure all-time availability of medicines, commodities, and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.1 Update the essential list of medicines and devices (essential medicines list, essential diagnostics list and essential equipment and devices list) for RMNCAH & HA in line with up-to-date evidence-based guidelines and protocols	1.7.1.1 Review and standardize RMNCAH & HA treatment protocols and clinical guidelines at all levels	Standardized treatment protocols and clinical guidelines for RMNCAH & HA available at all levels	MoH	X		X		
	Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.1 Update the essential list of medicines and devices (essential medicines list, essential diagnostics list and essential equipment and devices list) for RMNCAH & HA in line with up-to-date evidence-based guidelines and protocols	1.7.1.2 Review the national list of essential equipment and devices to ensure key RMNCAH & HA equipment and devices (MVA sets, vacuum extractors, ultrasound, LEEP, CPAP, cryotherapy, assistive devices etc.) are available for services provision	Key RMNCAH & HA equipment and devices are available for services provision	MoH	X				
	Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.1 Update the essential list of medicines and devices (essential medicines list, essential diagnostics list and essential equipment and devices list) for RMNCAH & HA in line with up-to-date evidence-based guidelines and protocols	1.7.1.3 Review the essential diagnostics list to ensure key RMNCAH & HA diagnostic tests (haemoglobin test, syphilis, blood grouping etc.) are available for services provision	Availability of key RMNCAH & HA diagnostic tests (haemoglobin test, syphilis, blood grouping etc.) at service delivery point	MoH	X				
	Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.1 Update the essential list of medicines and devices (essential medicines list, essential diagnostics list and essential equipment and devices list) for RMNCAH & HA in line with up-to-date evidence-based guidelines and protocols	1.7.1.4 Review the essential medicines list to ensure key RMNCAH & HA essential medicines (antibiotics, uterotonics, magnesium sulphate, HBV birth dose, Td etc.) are available for services provision	Availability of key RMNCAH & HA essential medicines (antibiotics, uterotonics, magnesium sulphate, HBV birth dose, Td etc.) at service delivery point	MoH	X				
	Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.2 Contribute to the strengthening of the efficiency and effectiveness of the national LMIS	1.7.2.1 Train health care providers in commodity and supply chain management	Health care workers trained in commodity and supply chain management	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.7: Ensure all-time availability of medicines, commodities and equipment for RMNCAH & HA interventions to the last mile (point of use)	1.7.2 Contribute to the strengthening of the efficiency and effectiveness of the national LMIS	1.7.2.2 Apply recommended storage norms, standards and standard operating procedures (SOPs) to maintain the quality and utility of essential RMNCAH commodities and supplies	Proper storage standards for essential RMNCAH commodities and supplies	MoH	X	X	X	X	X
	Strategy 1.8. Effective seamless functional referral mechanism for continuity of care	1.8.1 Implement referral guidelines and standard operating procedures (SOPs) at all levels of care	1.8.1.1 Disseminate referral guidelines, protocols and tools	Referral guidelines, protocols and tools disseminated and in use	MoH	X	X	X	X	X
	Strategy 1.8. Effective seamless functional referral mechanism for continuity of care	1.8.1 Implement referral guidelines and SOPs at all levels of care	1.8.1.2 Sustain a functional transportation system for referrals	Functional emergency transportation system in place	MoH	X	X	X	X	X
	Strategy 1.8. Effective seamless functional referral mechanism for continuity of care	1.8.1 Implement referral guidelines and SOPs at all levels of care	1.8.1.3 Establish communication and feedback systems	Communication and feedback systems in place	MoH	X	X	X	X	X
	Strategy 1.8. Effective seamless functional referral mechanism for continuity of care	1.8.1 Implement referral guidelines and SOPs at all levels of care	1.8.1.4 Implement innovative referral systems targeting hard-to-reach areas (e.g., pool system for ambulance)	Referral systems available and functional in hard-to-reach areas	MoH	X	X	X	X	X
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.1 Utilize multisectoral platforms at community level to create demand for RMNCAH services	1.9.1.1 Scale up demand creation for RMNCAH & HA services	Community champions (opinion leaders, religious leaders, women groups and leaders, community health workers etc.) identified and capacitated to create demand for RMNCAH & HA services	MoH	X	X	X	X	X
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.2 Build capacity of community health workers (CHWs), barefoot doctors (especially in very remote areas) in community RMNCAH & HA service provision	1.9.2.1 Train community health workers, barefoot doctors etc. in community RMNCAH & HA service provision	Community health workers, barefoot doctors trained in RMNCAH & HA service provision at community level	MoH	X	X	X	X	X
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.3 Scale up community-based RMNCAH & HA packages	1.9.3.1 Utilize community health workers and barefoot doctors to offer RMNCAH & HA services at community level (Community IMNCI, CBD, Community MNH, home-based care and Community, ICOPE etc.)	Community health workers and barefoot doctors provide community-level RMNCAH & HA services	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.3 Scale up community-based RMNCAH & HA packages	1.9.3.2 Conduct integrated RMNCAH & HA outreach services (especially in hard-to-reach areas)	Regular integrated RMNCAH & HA outreach services offered, especially in hard-to-reach areas	MoH	X	X	X	X	X
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.4 Implement verbal autopsy for maternal, perinatal and child deaths (community-based MPCDSR	1.9.4.1 Sensitize communities to community-based MPCDSR (VA)	Awareness of community-based MPCDSR built	MoH	X	X			
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.4 Implement verbal autopsy for maternal, perinatal and child deaths (community-based MPCDSR)	1.9.4.2 Create community MPCDSR committees	Community MPCDSR committees formed	MoH	X	X			
	Strategy 1.9: Community engagement in RMNCAH & HA	1.9.4 Implement verbal autopsy for maternal, perinatal and child deaths (community-based MPCDSR)	1.9.4.3 Conduct verbal autopsies for maternal perinatal and child deaths	Verbal autopsies conducted for maternal perinatal and child deaths in the community	MoH	X	X	X	X	X
	Strategy 1.10 Communication for Development (C4D)	1.10.1 Enhance health providers' interpersonal communication (IPC)	1.10.1.1 Train healthcare providers in interpersonal communication (IPC)	Healthcare workers trained in interpersonal communication (IPC)	MoH	X		X		X
	Strategy 1.10 Communication for Development (C4D)	1.10.2 Promote positive health-seeking behaviour at community level	1.10.2.1 Utilize various community platforms to sensitize communities to the elimination of harmful traditional practices and improved health-seeking behaviour	Community sensitized to the elimination of harmful traditional practices and improved health-seeking behaviour	MoH	X	X	X	X	X
	Strategy 1.10 Communication for Development (C4D)	1.10.2 Promote positive health-seeking behaviour at community level	1.10.2.2 Develop or update and disseminate culturally sensitive and appropriate information, education and communication (IEC) materials	Culturally sensitive and appropriate IEC materials developed and disseminated	MoH	X		X		X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
Strategic objective 2A: Universal coverage of comprehensive maternal and newborn health services along the continuum of care	Strategy 2A.1 Institutionalize preconception care services	2A.1.1 Provide national guidance for preconception care and determine entry points	2A.1.1.1Develop and disseminate preconception care guidelines, training package and data tools	Preconception care guidelines, training package and data tools developed and disseminated	MoH		X			
	Strategy 2A.1 Institutionalize preconception care services	2A.1.1 Provide national guidance for preconception care and determine entry points	2A.1.1.2 Integrate preconception care in other health services (FP, AYPFH, HIV services, non-communicable disease clinics etc.)	Preconception care services integrated in other health services (FP, AYPFH, HIV services, non-communicable disease clinics etc.)	MoH		X			
	Strategy 2A.1 Institutionalize preconception care services	2A.1.2 Build capacity for preconception care service provision	2A.1.2.1 Train health care providers on preconception care	Health care providers trained on preconception care	MoH		X			
	Strategy 2A.1 Institutionalize preconception care services	2A.1.2 Build capacity for preconception care	2A.1.2.2 Train Community health agents (CHAs) on preconception care at community level	Community health agents trained on preconception care	MoH		X	X	X	
	Strategy 2A.1 Institutionalize preconception care services	2A.1.3 Increase awareness of and demand for preconception care	2A.1.3.1 Conduct community sensitization meetings on preconception care services	Community sensitization meetings held to generate demand for preconception care services	MoH		X	X	X	X
	Strategy 2A.2 Strengthen utilization of quality antenatal care (ANC) services	2A.2.1 Update the Eritrea ANC protocols in line with WHO ANC recommendation for a positive pregnancy experience	2A.2.1.1 Adapt WHO essential core package for ANC interventions to Eritrean context	Essential core package of ANC interventions for Eritrean context in place and mapped to level and cadre	MoH	X				
	Strategy 2A.2 Strengthen utilization of quality antenatal care (ANC) services	2A.2.1 Update the Eritrea ANC protocols in line with WHO ANC recommendations for a positive pregnancy experience	2A.2.1.2 Revise ANC data tools to incorporate new ANC interventions	ANC tools developed in line with new guidelines	MoH	X				
	Strategy 2A.2 Strengthen utilization of quality antenatal care (ANC) services	2A.2.1 Update the Eritrea ANC protocols in line with WHO ANC recommendations for a positive pregnancy experience	2A.2.1.3 Train healthcare providers on new ANC model, guidelines and tools	Healthcare providers trained on new ANC model	MoH		X	X	X	
	Strategy 2A.2 Strengthen utilization of quality antenatal care (ANC) services	2A.2.2 Raise public awareness to ANC	2A.2.2.1 Conduct community sensitization meetings for early initiation of ANC, completion of ANC contacts, adherence to ANC interventions and male involvement	Community sensitization meetings conducted to enhance utilization of ANC services	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.1 Update essential intrapartum care protocols in line with the WHO intrapartum care recommendations for a positive childbirth experience to guide implementation of labour and delivery services	2A.3.1.1 Define the essential core package of intrapartum interventions for Eritrea	Essential core package of intrapartum care for Eritrea defined and mapped to level of care and cadre	MoH	X				
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.1 Update essential intrapartum care protocols in line with the WHO intrapartum care recommendations for a positive childbirth experience to guide implementation of labour and delivery services	2A.3.1.2 Adapt the WHO labour care guide (next-generation partograph) to the Eritrean context and align other intrapartum care tools to the new guidelines	WHO labour care guide adapted to the Eritrean context	MoH		X			
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.1 Update essential intrapartum care protocols in line with the WHO intrapartum care recommendations for a positive childbirth experience to guide implementation of labour and delivery services	2A.3.1.3 Train healthcare providers on essential interventions for labour and delivery service provision for all women	Healthcare providers trained on essential labour and delivery interventions	MoH	X	X	X		
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.2 Raise public awareness of facility delivery, danger signs, companionship in labour	2A.3.2.1 Conduct community sensitization meetings to promote facility delivery and skilled birth attendance (SBA)	Community sensitization meeting conducted for facility delivery and SBA	MoH	X	X	X	X	X
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.3 Expand maternity waiting home to remote areas	2A.3.3.1 Assess existing maternity waiting homes to identify existing gaps	Assessment of existing maternity waiting homes conducted	MoH	X				
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.3 Expand maternity waiting home to remote areas	2.A.3.3.2 Develop and disseminate maternity waiting home guidelines	Maternity waiting home guidelines developed and disseminated	MoH	X				
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.3 Expand maternity waiting home to remote areas	2A.3.3.3 Renovate and expand maternity waiting homes as needed	Maternity waiting homes renovated and expanded	MoH		X		X	
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.3 Expand maternity waiting home to remote areas	2A.3.3.4 Procure necessary equipment and supplies (including food items) for maternity waiting homes	Maternity waiting homes have essential equipment and supplies	MoH	X		X		X
	Strategy 2A.3 Strengthen quality of care during labour and delivery	2A.3.3 Expand maternity waiting home to remote areas	2A.3.3.4 Conduct community sensitization on utilization and collaboration on maternity waiting homes	Community sensitization conducted on utilization and contribution to maternity waiting homes	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2A.4 Strengthen emergency obstetric and newborn care	2A.4.1 Conduct EmONC assessment	2A.4.1.1 Conduct EmONC assessment to document availability of signal functions, healthcare provider competencies, availability of equipment, commodities, and supplies etc.	EmONC assessment conducted	MoH	X		X		X
	Strategy 2A.4 Strengthen emergency obstetric and newborn care	2A.4.2 Ensure implementation of EmONC in accordance with up-to-date protocols and guidelines	2A.4.2.1 Update EmONC guidelines and protocols using latest evidence-based WHO recommendations	EmONC guidelines and protocols updated	MoH		X			
	Strategy 2A.4 Strengthen emergency obstetric and newborn care	2A.4.2 Ensure implementation of EmONC in accordance with up-to-date protocols and guidelines	2A.4.2.2 Provide full complement of critical EmONC equipment and supplies to health facilities	EmONC facilities have all critical equipment and supplies needed to provide all signal functions	MoH	X	X	X	X	X
	Strategy 2A.4 Strengthen emergency obstetric and newborn care	2A.4.2 Ensure implementation of EmONC in accordance with up-to-date protocols and guidelines	2A.4.2.3 Train healthcare providers on EmONC	Pre- and in-service trainings on EmONC conducted	MoH	X	X	X	X	X
	Strategy 2A.5 Strengthen postnatal care at facility and community	2A.5.1 Define core package of essential postnatal care (PNC) for Eritrea	2A.5.1.1 Update national postnatal care (PNC) protocols in line with WHO PNC recommendations and map by level and cadre	National postnatal care (PNC) protocols aligned to WHO PNC recommendations	MoH			X		
	Strategy 2A.5 Strengthen postnatal care at facility and community	2A.5.1 Define core package of essential postnatal care (PNC) for Eritrea	2A.5.1.2 Orient healthcare providers on the new PNC protocols and tools	Healthcare providers oriented on the new PNC protocols and tools	MoH		X		X	
	Strategy 2A.5 Strengthen postnatal care at facility and community	2A.5.2 Implement integrated essential postnatal care (PNC) interventions at community and facility levels according to protocols (including use of safe drinking water and personal hygiene with emphasis on hand washing with soap)	2A.5.2.1 Train community health workers on community-based PNC	Community health workers trained on community-based PNC	MoH		X	X		
	Strategy 2A.6 Strengthen essential newborn care (ENC)	2A.6.1 Finalize and disseminate the ENC clinical care pocket guide	2A.6.1.1 Finalize, publish and disseminate ENC pocket guide that integrates infection prevention	ENC pocket guide finalized and disseminated	MoH	X				
	Strategy 2A.6 Strengthen essential newborn care (ENC)	2A.6.1 Finalize and disseminate the ENC clinical care pocket guide	2A.6.1.2 Train healthcare providers on ENC	Pre- and in-service training on ENC	MoH		X		X	

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2A.7 Strengthen performance of MPDSR systems	2A.7.1 Scale up MPDSR across all levels of care including community	2A.7.1.1 Disseminate MPDSR guidelines and print reporting tools	MPDSR guidelines disseminated	MoH	X		X		
	Strategy 2A.7 Strengthen performance of MPDSR systems	2A.7.1 Scale up MPDSR across all levels of care including community	2A.7.1.2 Re-orient healthcare providers and community health workers on MPDSR	Healthcare providers and community health workers re-oriented on MPDSR	MoH	X				
	Strategy 2A.7 Strengthen performance of MPDSR systems	2A.7.1 Scale up MPDSR across all levels of care including community	2A.7.1.3 MPDSR committees hold meetings to audit and respond to maternal and perinatal deaths as appropriate	MP death review committee meetings held regularly as per guidelines	MoH	X	X	X	X	X
	Strategy 2A.8 Strengthen maternal and newborn health (MNH) Monitoring and Evaluation	2A.8.1 Monitor implementation of MNH services (routine data, surveillance, monitoring and evaluation)	2A.8.1.1 Conduct quarterly review meeting in collaboration with Zobas, MNH, M & E, HMIS and Environmental Health (EH) programmes	Quarterly MNH review meetings conducted and report available	MoH	X	X	X	X	X
Strategic objective 2B: Universal coverage of comprehensive sexual, reproductive and adolescent health services along the continuum of care	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.1 Promote an enabling environment and dedicated resources for Family Planning	2B.1.1.1 Develop Family Planning advocacy toolkit for high-level audiences, including politicians and other policy makers	High-level Advocacy toolkit for FP developed	MoH	X				
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.1 Conduct high-level advocacy for an enabling environment and dedicated resources for FP	2B.1.1.2 Engage policy makers to support FP programme and allocate dedicated resources for contraceptives and other RH commodities	Advocacy meetings held with policy makers to support FP programme and ensure dedicated budget for FP	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.2 Build capacity of health workers in counselling and provision of quality FP services at facility and community level	2B.1.2.1 conduct competency-based training of doctors, midwives and nurses on counselling and provision of contraceptives, especially MHH and long-acting FP methods	Doctors, midwives, and nurses counsel and provide long-acting FP methods	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.2 Build capacity of health workers in counselling and provision of quality FP services at facility and community level	2B.1.2.2 Train associate nurses on FP counselling and distribution of condoms, pills, injectable contraceptives	Associate nurses distribute condoms, pills, injectable contraceptives	MoH	X	X	X		

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.2 Build capacity of health workers in counselling and provision of quality FP services at facility and community level	2B.1.2.3 Train community health workers/RH promoters on demand creation, counselling and distribution of condoms and pills	Community health workers/RH promoters create demand, counsel, and distribute condoms and pills	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.3 Improve demand for FP services	2B.1.3.1 Conduct sensitization meetings for religious leaders, influencers and opinion leaders to promote FP utilization	Pool of champions comprising religious leaders, influencers and opinion leaders capacitated to promote FP utilization	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.4 Scale up and sustain utilization of FP services through innovative approaches (such as self-care, referrals linkages, addressing high dropout rate)	2B.1.4.1 Support community-based distribution of condoms and pills	Community based distribution of condoms and pills going on	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.4 Scale up and sustain utilization of FP services through innovative approaches (such as self-care, referrals linkages, addressing high dropout rate)	2B.1.4.2 Conduct FP campaigns for long-acting and permanent FP methods	FP campaigns conducted for long-acting and permanent FP methods	MoH	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.5 Integrate FP with other SRH/HIV/MNH/nutrition/ outreach services	Increase provider-initiated Family planning information and services in other service areas including HIV comprehensive care clinics, STI clinics, nutrition clinics and during outreach	FP services offered in other related service areas including HIV, STI, and nutrition clinics; and as part of outreach services	MOH and partners	X	X	X	X	X
	Strategy 2B.1 Increase access to and utilization of quality FP services	2B.1.6 Support sustained supply of FP commodities and increase method choice	Collaborate with procurement and supply chain units to ensure no stock outs of contraceptive supplies and commodities at point of care	Full complement of Contraceptive commodities as appropriate for service delivery level are always available at point of care	X	X	X	X	X	X
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.1 Develop and disseminate training package, protocols and tools for cervical cancer screening and management	Cervical cancer screening training package, protocols and tools developed and disseminated	MoH		X			
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.2 Train, midwives, nurses, general practitioners and specialists, on cervical cancer screening and management	Specialists, GP, midwives, and nurses trained on cervical cancer screening and management	MoH		X			

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.3 Procure and distribute essential supplies and equipment for cervical cancer screening and treatment (HPV testing kits, acetic acid, carbon dioxide cylinders, cryotherapy machines)	Essential Supplies and equipment for cervical cancer screening and treatment available at point of care	MoH	X	X	X	X	X
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.4 Conduct community sensitization and mobilization on cervical cancer screening and management services	Community sensitization and mobilization done for screening and management services	MoH	X	X	X	X	X
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.5 Conduct cervical cancer screening campaigns (e.g., annually during cancer awareness month)	Cervical cancer screening campaigns held	MoH		X	X	X	X
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.1 Expand the cervical cancer screening and management programme	2B.2.1.6 Integrate cervical cancer screening with other services e.g. FP, PNC, HIV counselling	Cervical cancer screening integrated in FP, PNC, HIV and other relevant services	MoH		X			
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.2 Integrate breast cancer screening (CBE and SBE) into other SRH and MNH services	2B.2.2.1 Scale up provision of clinical breast examination (CBE) in other SRH and MoH services and self-breast examination (SBE) in men and women	SRMNH clients offered clinical breast examination in routine care (CBE) and clients taught on self-breast examination (SBE)	MoH		X			
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.2 Integrate breast cancer screening (CBE and SBE) into other SRH and MNH services	2B.2.2.2 Integrate breast cancer screening with FP, PNC, HIV, ANC,	Breast cancer screening integrated with FP, PNC, HIV,	MoH		X			
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.3 Strengthen prostate cancer screening	2B.2.3.1 Orient health care workers on prostate cancer screening	Health workers oriented on prostate cancer screening	MoH			X		
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.3 Strengthen prostate cancer screening	2B.2.3.2 Establish men's health clinics and integrate breast and prostate into regular check-ups	Men's health clinics established, and breast and prostate screening integrated into regular check-ups	MoH			X		
	Strategy 2B.2 Strengthen and expand reproductive organ cancer screening and management	2B.2.4 Strengthen documentation of cancers including reproductive organ cancers	2B.2.4 Establish a cancer registry in collaboration with NCD Department	Cancer registry established	MoH		X			

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.3 Strengthen the provision of quality post-abortion care services to the full extent of the law	2B.3.1 Expand coverage of post-abortion care (PAC) services to facilitate access	2B.3.1.1 Update and disseminate PAC guidelines, training package and reporting tools	PAC guidelines, training package and reporting tools updated and disseminated	MoH			X		
	Strategy 2B.3 Strengthen the provision of quality post-abortion care services to the full extent of the law	2B.3.1 Expand coverage of post-abortion care (PAC) services to facilitate access	2B.3.1.2 Train healthcare providers on PAC	Healthcare providers trained on PAC	MoH			X		
	Strategy 2B.3 Strengthen the provision of quality post-abortion care services to the full extent of the law	2B.3.1 Expand coverage of post-abortion care (PAC) services to facilitate access	2B.3.1.3 Procure and distribute manual vacuum aspiration (MVA) and Evacuation and Curettage (E&C) sets, PAC commodities and supplies	Essential PAC equipment, commodities and supplies available at point of care	MoH		X			
	Strategy 2B.4 Strengthen infertility management services	2B.4.1 Obtain strategic information to guide infertility service delivery	2B.4.1.1 Conduct baseline and facility readiness assessment for management of infertility	Baseline assessment conducted to inform infertility management programme	MoH	X	X			
	Strategy 2B.4 Strengthen infertility management services	2B.4.1 Obtain strategic information to guide infertility service delivery	2B.4.1.2 Develop infertility guidelines and tools	Infertility guidelines and tools developed	MoH		X			
	Strategy 2B.4 Strengthen infertility management services	2B.4.1 Obtain strategic information to guide infertility service delivery	2B.4.1.3 Update data elements in HMIS to capture infertility service provision data	Updated infertility management data elements in HMIS	MoH		X			
	Strategy 2B.4 Strengthen infertility management services	2B.4.2 Expand preventive management approaches for infertility	2B.4.2.1 Offer STI prevention services at community level through community health workers and barefoot doctors (e.g., counselling against risky sexual behaviour, condom distribution, timely health-seeking behaviour)	Community health workers and barefoot doctors offering STI prevention services	MoH	X	X	X	X	X
	Strategy 2B.4 Strengthen infertility management services	2B.4.2 Expand preventive management approaches for infertility	2B.4.2.2 Scale up prevention, screening, diagnosis and timely treatment of STIs	Healthcare providers re-oriented on STI prevention, screening, diagnosis and timely treatment	MoH	X	X	X	X	X
	Strategy 2B.4 Strengthen infertility management services	2B.4.3 Strengthen the country's capacity to offer comprehensive infertility services	2B.4.3.1 Define essential package of infertility interventions for each level of care	Package of infertility management interventions for each level of care defined	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.4 Strengthen infertility management services	2B.4.3 Strengthen the country's capacity to offer comprehensive infertility services	2B.4.3.2 Orient healthcare providers at the National & Regional Referral Hospital to offer comprehensive and advanced services	Healthcare providers oriented on the infertility package of interventions for each level of care	MoH	X	X	X	X	X
	Strategy 2B.4 Strengthen infertility management services	2B.4.3 Strengthen the country's capacity to offer comprehensive infertility services	2B.4.3.3 Orient healthcare providers at the lower-level hospitals to offer basic services	Healthcare providers oriented on the infertility package of interventions for each level of care	MoH	X	X	X	X	X
	Strategy 2B.4 Strengthen infertility management services	2B.4.3 Strengthen the country's capacity to offer comprehensive infertility services	Orient healthcare providers in health centres and community to offer infertility preventive and promotive services	Healthcare providers oriented on the infertility package of interventions for each level of care	MoH	X	X	X	X	X
	Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems	2B.5.1 Expand GBV service provision	2B.5.1.1 Develop and disseminate GBV guidelines, protocols, training package and reporting tools	GBV guidelines, protocols, training package and reporting tools developed and disseminated	MoH	X	X	X	X	X
	Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems	2B.5.1 Expand GBV service provision	2B.5.1.2 Train healthcare providers to provide GBV counselling service during ANC, FP, PNC, HIV clinics	Healthcare providers trained to provide GBV counselling service during ANC, FP, PNC, HIV clinics	MoH	X	X	X	X	X
	Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems	2B.5.1 Expand GBV service provision	2B.5.1.3 Train emergency doctors and nurses to identify, manage and refer GBV survivors	ER doctors and nurses trained to identify, manage, and refer GBV survivors	MoH	X	X			
	Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems	2B.5.1 Expand GBV service provision	2B.5.1.4 Engage other health departments and non-health sectors including legal, education and protection to prevent and address GBV and support functional referral pathway for survivors to non-health services	Intra- and multisectoral working group to prevent and address GBV and support functional referral pathway for survivors established and functional	MoH	X	X	X	X	X
	Strategy 2B.5 Strengthen gender-based violence (GBV) prevention and management systems	2B.5.1 Expand GBV service provision	2B.5.1.5 Define and institute minimum criteria for health facilities to conduct GBV enquiry	Facilities have in place the minimum requirements necessary to conduct routine GBV enquiry	MoH	X	X			
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.1 Prevent obstetric fistulae	2B.6.1.1 Conduct community sensitization on harmful practices and timely health-seeking behaviour (skilled birth attendance – SBA)	Communities are aware of harmful practices and timely health-seeking behaviour for deliveries (SBA)	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.1 Prevent obstetric fistulae	2B.6.1.2 Increase access to skilled birth attendance (EmONC)	(Refer to MNH)	MoH	X	X	X	X	X
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.1 Prevent obstetric fistulae	2B.6.1.3 Early identification and management of obstructed labour and other obstetric complications (caesarean section, referrals)	(Refer to MNH)	MoH	X	X	X	X	X
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.2 Scale up provision of obstetric fistula services	2B.6.2.1 Conduct situation analysis and readiness assessment for obstetric fistula service provision	Situation analysis and readiness assessment for obstetric fistula service provision conducted	MoH	X	X			
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.2 Scale up provision of obstetric fistula services	2B.6.2.2 Develop and disseminate obstetric fistula management and treatment guidelines	Obstetric fistula management and treatment guidelines developed and disseminated	MoH	X	X			
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.2 Scale up provision of obstetric fistula services	2B.6.2.3 Develop data tools and identify data elements to incorporate in DHIS	OF data tools developed and key data elements to incorporate in DHIS identified	MoH	X				
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.2 Scale up provision of obstetric fistula services	2B.6.2.4 Train doctors, midwives and nurses on identification and management of obstetric fistulae	Doctors, midwives and nurses competent on identification and management of obstetric fistulae	MoH	X	X	X		
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.2 Scale up provision of obstetric fistula services	2B.6.2.5 Identify and equip additional obstetric fistula management centres	Additional obstetric fistula management centres identified and functional	MoH	X	X	X		
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.3 Engage the community to increase utilization of obstetric fistula services and support for survivors	2B.6.3.1 Conduct community sensitization on OF stigma reduction, availability of services and support for survivors	Community sensitized on OF stigma reduction, availability of services and support for survivors conducted	MoH	X	X	X	X	X
	Strategy 2B.6. Strengthen prevention and management of obstetric fistula services	2B.6.3 Engage the community to increase utilization of obstetric fistula services and support for survivors	2B.6.3.2 Engage other sectors to provide training for income-generating activities for survivors of OF	Sectors engaged in provision of training for income-generating activities for OF survivors	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.1 Scale up FGM prevention interventions with key stakeholders	2B.7.1.1 Conduct community sensitization in collaboration with partners on prevention of FGM	Communities sensitized on FGM prevention	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.1 Scale up FGM prevention interventions with key stakeholders	2B.7.1.2 Train healthcare providers on de-infibulation	Health care providers trained in de-infibulation	MoH	X	X	X	X	
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.1 Scale up FGM prevention interventions with key stakeholders	2B.7.1.3 Undertake surveillance and reporting of FGM activities	FGM activities notified; FGM victims identified and supported	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.1 Scale up FGM prevention interventions with key stakeholders	2B.7.1.4. Community mapping for public declaration of FGM-free communities	Communities mapped for public declaration of FGM-free communities	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.2 Conduct community mapping to transform social and gender norms that lead to collective and public decisions	2B.7.2.1 Facilitate community dialogue sessions to complement community mapping	Community dialogues sessions conducted in different sub-Zobas	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.3 Scale up service provision for FGM prevention, protection and care	2B.7.3.1 Life skills education for adolescent girls and boys to resist FGM	Life-skills education to mitigate FGM integrated in school health curriculum	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.3 Scale up service provision for FGM prevention, protection and care	2B.7.3.2 Institute psychosocial health services, including during antenatal and post-natal visits, to FGM victims and at-risk patients	Package of antenatal and post-natal visits includes psychosocial health services to FGM victims and at-risk patients	MoH	X	X	X	X	X
	Strategy 2B.7 Support national efforts in the elimination of female genital mutilation/ cutting (FGM)	2B.7.3 Scale up service provision for FGM prevention, protection and care	2B.7.3.3 Collaborate with legal and law-enforcement bodies for appropriate support to FGM victims and at-risk people	Mechanism for legal services for FGM victims and at-risk people in place and functional	MoH	X	X	X	X	X
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.1 Conduct facility readiness assessment for AYPFHS	Facility readiness assessment for AYPFHS report	MoH	X	X	X	X	X
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.2 Update and disseminate the AYP health guidelines, policies and training package for health workers	AYPH guidelines, policies and training package updated and disseminated	MoH	X				
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.3. Train healthcare providers in AYPFHS to facilitate integrated person-centred care for AYP in all routine service areas	AYPFHS mainstreamed in all routine service areas	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.4 Develop, print and disseminate key ASRH and other AYPH-related messages	Key messages targeting AYPH developed, printed and disseminated	MoH	X		X		X
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.5 Increase awareness of adolescents and young people on available ASRH and AYPH services using various channels (community platforms, media, IEC materials, learning hubs)	Increased uptake of ASRH services by AYP	MoH	X	X	X	X	X
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.6 Conduct bi-annual supportive supervision of health facilities by National and Zoba teams	Supportive supervision of health facilities conducted bi-annually	MoH	X	X	X	X	X
	Strategy 2B.8 Expand the coverage of adolescent-and-young-people-friendly health services (AYPFHS)	2B.8.1 Scale up coverage of AYP-responsive health services	2B.8.1.7 Conduct annual review meeting on performance of AYP programme and services	Annual review of AYP programme and services	MoH	X	X	X	X	X
	Strategy 2B.9 Strengthen multisectoral collaboration to promote adolescent and young people health and well being	2B.9.1 Implement the School Health Programme for junior, secondary and higher education institutions	2B.9.1.1 Develop and disseminate School Health Programme training guide, referral forms and reporting tools	School Health Programme training guide, referral forms and reporting tools developed and disseminated	MoH	X				X
	Strategy 2B.9 Strengthen multisectoral collaboration to promote adolescent and young people health and well being	2B.9.1 Implement the School health Programme for junior, secondary and higher education institutions	2B.9.1.2 Train health workers and school health focal teachers on provision of School Health Services including climate-resilient WASH services	Health workers and school health focal teachers trained on provision of School Health Services	MoH	X	X	X	X	X
	Strategy 2B.9 Strengthen multisectoral collaboration to promote adolescent and young people health and well being	2B.9.2 Advocate for resource mobilization for AYP health interventions	2B.9.2.1 Convene advocacy forums to mobilize domestic and external resources from key partners for national and Zoba AYP interventions	Advocacy meetings held with key partners to mobilize resources for AYP interventions	MoH	X				
	Strategy 2B.9 Strengthen multisectoral collaboration to promote adolescent and young people health and well being	2B.9.3. Provide evidence-based planning and resource allocation for AYP health services	2B.9.3.1 Conduct AYP operational research	Operational research conducted for AYP	MoH	X				X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
Strategic objective 3: Universal coverage of effective child health interventions	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.1 Scale up provision of quality IMNCI services at facility and community, especially to hard-to-reach areas and nomadic populations	3.1.1.1 Train healthcare providers in IMNCI	Healthcare providers trained in IMNCI	MoH	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.1 Scale up provision of quality IMNCI services at facility and community especially, to hard-to-reach areas and nomadic populations	3.1.1.2 Conduct biannual supportive supervision and mentorship for IMNCI in each Zoba	Biannual support supervision conducted in each Zoba	MoH	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.1 Scale up provision of quality IMNCI services at facility and community, especially to hard-to-reach areas and nomadic populations	3.1.1.3. Conduct c-IMNCI training for community health workers	c-IMNCI training conducted for community health workers	MoH	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.1 Scale up provision of quality IMNCI services at facility and community, especially to hard-to-reach areas and nomadic populations	3.1.1.4 Increase access to IMNCI services to all through integrated outreach services and CHWs and barefoot doctors	Access to IMNCI, especially in hard-to-reach and nomadic populations	MoH	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.2. Scale up provision of quality iCCM at community level, especially to hard-to-reach areas	3.1.2.1 Incorporate PSBI global recommendations into iCCM guidelines	PSBI recommendations incorporated into national iCCM guidelines	MoH	X				
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.2. Scale up provision of quality iCCM at community level especially to hard-to-reach areas	3.1.2.2 Update selected CHWs and barefoot doctors on iCCM	Meetings held and selected CHWs and barefoot doctors updated on iCCM	MoH	X	X	X		
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.2. Scale up provision of quality iCCM at community level, especially to hard-to-reach areas	3.1.2.3 Provide essential supplies and medicines to facilitate iCCM services, especially in hard-to-reach and nomadic populations	Supplies and medicines available to facilitate iCCM, especially in hard-to-reach areas	MoH	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions at community level	3.1.3.1Support documentation and reporting for community IMNCI into HMIS	Provide data capturing tools at community level	Data tools for documenting IMNCI at community level are available	MOH and partners	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions	3.1.3.2 Support documentation and reporting for community IMNCI into HMIS	Train CHWs on collection, documentation and reporting of IMNCI interventions at community level	CHWs trained to document and report on IMNCI activities	MOH and partners	X	X	X	X	X
	Strategy 3.1 Strengthen IMNCI services at facility and integrated child health interventions	3.1.3.3 Support documentation and reporting for community IMNCI into HMIS	Reinforce community-based information system to reflect IMNCI and ensure effective linkage with HMIS	Community IMNCI indicators captured in the HMIS	MoH	X	X	X	X	X
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.1 Adopt and implement standards for improving the quality of care for sick and small newborns in health facilities	3.2.1.1 Conduct paediatric quality of care (QoC) assessment (including WASH services)	Paediatric QoC assessment conducted	MoH	X	X	X	X	X
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.1 Adopt and implement standards for improving the quality of care for sick and small newborns in health facilities	3.2.1.2 Adapt and implement standards for sick and small newborns at all levels	Sick and small newborns standards adapted and implemented	MoH	X	X	X	X	X
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.1 Adopt and implement standards for improving the quality of care for sick and small newborns in health facilities	3.2.1.3 Orient health care workers on small and sick newborns standards	Pre- and in-service health workers oriented on standards for sick and small newborns	MoH	X	X	X	X	X
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.1 Adopt and implement standards for improving the quality of care for sick and small newborns in health facilities	3.2.1.4 Establish newborn intensive care units (NICU) in all hospitals	Newborn intensive care units established and functional in all hospitals	MoH	X	X	X		
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.2 Scale up kangaroo mother care (KMC) services	3.2.2.1 Develop and disseminate kangaroo mother and father care (KM/FC) guidelines and protocols	KM/FC guidelines developed and disseminated	MoH	X	X	X	X	X
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.2 Scale up KMC services	3.2.2.2 Train healthcare workers on KMC	Healthcare workers trained on KMC	MoH	X	X	X		
	Strategy 3.2 Strengthen service delivery for sick and small newborns at facility level	3.2.2 Scale up KMC services	3.2.2.3 Include KMC requirements in facility improvement plans (FIPs)	KMC facilities established or renovated in hospitals and health centres as part of FIPs	MoH	X	X	X		
	Strategy 3.3 Reach every child/district (REC/D)	3.3.1 Increase coverage of integrated outreach services especially in hard-to-reach and nomadic populations	3.3.1.1 Conduct integrated outreach for child health services in collaboration with Zoba and sub-Zoba programme coordinators and relevant stakeholders	Integrated outreach for child health services conducted especially in hard-to-reach areas and to nomadic populations	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 3.3 Reach every child/district (REC/D)	3.3.2 Promote integrated mass health campaigns for children	3.3.2.1 Observe National Child Health and Nutrition Week annually	Annual National Child Health and Nutrition Week observed	MoH	X	X	X	X	X
	Strategy 3.3 Reach every child/district (REC/D)	3.3.3 Increase access to child health interventions for out-of-school children and children with disabilities	3.3.3.1 Conduct mobile outreach child health services to increase access for out-of-school children and those with disabilities	Out-of-school and children with disabilities can access child health services	MoH	X	X	X	X	X
	Strategy 3.4: Promote health, development and wellbeing of children	3.4.1 Integrate nurturing care for early childhood development (ECD) interventions along the continuum of care services	3.4.1.1 Develop and disseminate intra- and intersectoral guidelines and tools for nurturing care for ECD	Intra- and Intersectoral guidelines and tools on nurturing care for ECD developed and disseminated	MoH	X	X			
	Strategy 3.4: Promote health, development and wellbeing of children	3.4.1 Integrate nurturing care for early childhood development (ECD) interventions along the continuum of care services	3.4.1.2 Constitute intersectoral working group on nurturing care for ECD	Intersectoral working group on nurturing care for ECD instituted and functional	MoH	X	X	X	X	X
	Strategy 3.4: Promote health, development and wellbeing of children	3.4.1 Integrate nurturing care for early childhood development (ECD) interventions along the continuum of care services	3.4.1.3 Orient healthcare providers on nurturing care for ECD guidelines and tools	Healthcare providers oriented on nurturing care for ECD guidelines and tools	MoH	X	X	X	X	X
	Strategy 3.5: Enhance health awareness, disease prevention and health promotion among school children	3.4.2 Revitalize school health programme in collaboration with Ministry of Education (MoE)	3.4.1.1 Institute school health TWG or task force with MoE and MoLWE	Regular meetings held with MoE on school health programme	MoH	X	X	X	X	X
	Strategy 3.5: Enhance health awareness, disease prevention and health promotion among school children	3.5.1 Revitalize School Health Programme in collaboration with Ministry of Education (MoE)	3.5.1.1 Orient school teachers and directors on school health programme	Teachers and directors in the MoE oriented on school health programme	MoH	X	X			
	Strategy 3.5: Enhance health awareness, disease prevention and health promotion among school children	3.5.1 Revitalize School Health Programme in collaboration with Ministry of Education (MoE)	3.5.1.2 Conduct screening, assessment and supplementation of school children as per guidelines	Screening, assessment and supplementation of school children ongoing	MoH	X	X	X	X	X
	Strategy 3.6: Foster intra- and intersectoral collaboration to ensure uptake of child health interventions	3.6.1 Improve linkages with Nutrition, PMTCT, immunization, malaria, clinical services and environmental health programs	3.6.1.1 Convene regular meetings with programmes within the MoH on areas of collaboration in childhood interventions	Task force involving health programmes within the MoH on areas of collaboration in childhood interventions in place and functional	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 3.6: Foster intra- and intersectoral collaboration to ensure uptake of child health interventions	3.6.2 Improve linkage with other relevant sectors as appropriate (MOLSW, MOE, associations like disability, blindness etc.)	3.6.2.1 Institute multisectoral TWG with other ministries and associations to enhance collaboration in childhood interventions	Multisectoral TWG on areas of collaboration in childhood interventions in place and functional	MoH	X	X	X	X	X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.1 Scale up growth monitoring for under-5 children at all levels of healthcare	3.7.1.1 Orient pre- and in-service health care providers and community health workers on the new WHO growth monitoring standards and tools	Health care providers and community health workers oriented on new growth monitoring tools	MoH	X	X	X	X	X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.1 Scale up growth monitoring for under-5 children at all levels of healthcare	3.7.1.2 Avail essential growth monitoring equipment at all levels of care	Growth monitoring equipment available at all levels of care	MoH	X		X		X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.2 Conduct SAM and MAM interventions	3.7.2.1 Train health workers on management of SAM and MAM	Healthcare providers trained on management of SAM and MAM	MoH	X	X	X	X	X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.3 Support infant and young child nutrition	3.7.3.1 Orient mothers on essential IYCF throughout the continuum of antenatal, intrapartum and postnatal periods	Mothers receive IYCF orientation throughout antenatal and postnatal periods	MoH	X	X	X	X	X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.3 Support infant and young child nutrition	3.7.3.2 Train health workers including CHWs on IYCF	HCWs and CHWs trained on IYCF	MoH	X	X	X	X	X
	Strategy 3.7: Strengthen implementation of childhood nutrition interventions (in line with comprehensive nutrition strategy)	3.7.3 Support infant and young child nutrition	3.7.3.3 Implement Baby-Friendly Hospital Initiative, including implementation of the International Code of Marketing Breast-milk Substitutes	Facilities demonstrate exclusive breastfeeding among mothers at discharge and successful implementation of the Ten Steps to Successful Breastfeeding	MoH	X	X	X	X	X
	Strategy 3.8: Institutionalize child death audit and review (CDAR)	3.8.1 Implement child death audit and review (CDAR) at all levels	3.8.1.1 Advocacy meeting on child death audit and review (CDAR) with relevant stakeholders	Consensus reached by child health stakeholders on Implementation of WHO's Operational guide for facility-based audit and review of paediatric mortality	MoH	X				

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Strategy 3.8: Institutionalize child death audit and review (CDAR)	3.8.1 Implement child death audit and review (CDAR) at all levels	3.8.1.2 Develop and disseminate CDAR guidelines	National guidelines for CDAR developed and disseminated	MoH	X	X	X	X	X
	Strategy 3.8: Institutionalize child death audit and review (CDAR)	3.8.1 Implement child death audit and review (CDAR) at all levels	3.8.1.3 Develop and disseminate CDAR data collection and reporting tools	Data collection and reporting tools for CDAR developed	MoH	X			X	
	Strategy 3.8: Institutionalize child death audit and review (CDAR)	3.8.1 Implement child death audit and review (CDAR) at all levels	3.8.1.4 Train health workers on CDAR	Health workers trained on CDAR	MoH	X		X		
	Strategy 3.9: Advocate for safe environment and against harmful traditional practices around breastfeeding	3.9.1 Promote safe environment and cessation of harmful traditional practices that negatively impact breastfeeding	3.9.1.1 Conduct a dvocacy meeting to ensure safe environment and against harmful traditional practices around breastfeeding with relevant stakeholders	Advocacy meeting on e xclusive breastfeeding among mothers at discharge and successful implementation of the Ten Steps to Successful Breastfeeding held	MoH	X		X		
	Strategy 3.9: Advocate for safe environment and against harmful traditional practices around breastfeeding	3.9.1 Promote safe environment and cessation of harmful traditional practices that negatively impact breastfeeding	3.9.1.2 Develop IEC materials for safe environment and cessation of harmful traditional practices affecting children	IEC materials available on exclusive breastfeeding among mothers at discharge and successful implementation of the Ten Steps to Successful Breastfeeding	MoH	X		X		
	Strategy 3.9: Advocate for safe environment and against harmful traditional practices around breastfeeding	3.9.1 Promote safe environment and cessation of harmful traditional practices that negatively impact breastfeeding	3.9.1.3 Conduct regular technical working group (TWG) meetings on safe environment and against harmful traditional practices	TWG on exclusive breastfeeding among mothers at discharge and successful implementation of the Ten Steps to Successful Breastfeeding in place and functional	MoH	X	X	X	X	X
Strategic objective 4: Institutionalized multisectoral response for healthy ageing	4.1 Combat ageism (attitudes and stereotypes to ageing)	4.1.1 Create awareness and sensitization on healthy ageing	4.1.1.1 Utilize existing forums at facility level (CMEs, staff meetings) to sensitize healthcare providers on healthy ageing and age-friendly service provision	Healthcare workers sensitized on healthy ageing	MoH	X	X	X	X	X
	4.1 Combat ageism (attitudes and stereotypes to ageing)	4.1.1 Create awareness and sensitization on healthy ageing	4.1.1.2 Utilize community platforms to create awareness of healthy ageing	Public awareness of healthy ageing	MoH	X	X	X	X	X
	4.1 Combat ageism (attitudes and stereotypes to ageing)	4.1.1 Create awareness and sensitization on healthy ageing	4.1.1.3 Develop, print and disseminate promotional material on healthy ageing	Promotional material on healthy ageing developed, printed and disseminated	MoH	X	X	X	X	X
	4.1 Combat ageism (attitudes and stereotypes to ageing)	4.1.1 Create awareness and sensitization on healthy ageing	4.1.1.4 Commemorate International Day of Older Persons (October 1)	International Day of Older Persons (October1) commemorated annually	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	4.2 Foster age-friendly environments	4.2.1 Collaborate with other stakeholders to establish older-people-friendly social services (transportation, medical services etc.)	4.2.1.1 Convene multisectoral meetings with other ministries and stakeholders to facilitate establishment of HA-friendly health and social services	Multisectoral working group in place for collaboration on establishing HA-friendly health and social services	MoH	X	X	X	X	X
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.1 Establish age-friendly infrastructure standards to support provision of services for older people	4.3.1.1 Conduct rapid health facility readiness assessment to determine status of infrastructure and other support for service provision to the elderly	Rapid health facility readiness assessment on healthy ageing conducted	MoH	X				
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.1 Adapt the WHO generic guidance on comprehensive assessment and care pathways for declines in intrinsic capacity to local context and print	WHO generic guidance on comprehensive assessment and care pathways adapted to the local context and printed.	MoH	X				
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.2 Disseminate Integrated Care of People of Grace (ICPOGA) guidelines	Integrated Care of People of Grace Age (ICPOGA) guidelines disseminated	MoH	X				
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.3 Train health workers on ICPOGA guidelines	Health workers trained on ICPOGA guidelines	MoH	X	X	X		
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.4 Implement comprehensive integrated assessment of older people in non-communicable disease (NCD) corners	Comprehensive integrated assessment of older people in non-communicable disease (NCD) corners ongoing	MoH	X	X	X	X	
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.5 Ensure continuous availability of essential medicines for chronic illnesses affecting people of grace age (NCDs, neurologic disorders) in public health services	Medicines for chronic illnesses (NCDs, neurologic disorders) available at all times in public health services and no stockouts	MoH	X	X	X	X	X
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.6 Establish routine ICOPE assessment for POGA at health facilities	Routine ICOPE assessment of POGA established at health facilities	MoH	X	X	X	X	X

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	4.3 Deliver integrated care and primary health services responsive to older people (Integrated Care of Older People – ICOPE)	4.3.2 Align the health system and integrate healthy ageing actions across all departments and programmes of the MoH	4.3.2.7 Avail assistive devices for people of grace age with declines in intrinsic capacity in collaboration with other sectors	Assistive devices available for elderly clients as needed	MoH	X	X	X	X	X
	4.4 Strengthen community-based Integrated Care of Older People – ICOPE	4.4.1 Establish community-based health services for older people	4.4.1.1 Initiate community ICPOGA (home-based care, community support – social, financial, psychosocial, spiritual, support for daily living activities)	Community ICPOGA initiated (home-based care, community support – social, financial, psychosocial, spiritual, support for daily living activities)	MoH	X	X	X	X	X
	4.4 Strengthen community-based Integrated Care of Older People – ICOPE)	4.4.1 Establish community-based health services for older people	4.4.1.2 Engage community members in identification and support to residential-care-dependent elders	Communities sensitized and mobilized in identifying and supporting residential-care-dependent elders	MoH	X	X	X	X	X
	4.4 Strengthen community-based Integrated Care of Older People ICOPE Care of Older People – ICOPE)	4.4.1 Establish community-based health services for older people	4.4.1.3 Train home care givers (family members, friends, relatives, volunteers and care-takers), social workers and physiotherapists	Home care givers, social workers and physiotherapists trained on home-based care for people of grace age	MoH	X	X	X	X	X
	4.5 Improve strategic information, monitoring and evaluation, research, and innovation for healthy ageing	4.5.1 Monitor and evaluate healthy ageing initiatives	4.5.1.1 Stimulate data disaggregation in DHIS-2 to reflect those aged above 65 years by age and sex cohorts	DHIS-2 data disaggregated by age and sex across the life course and for persons aged above 65 years	MoH	X				
	4.5 Improve strategic information, monitoring and evaluation, research, and innovation for healthy ageing	4.5.1 Monitor and evaluate healthy ageing initiatives	4.5.1.2 Generate and avail routine data for people of grace age in HMIS	Data for ageing is available in HMIS	MoH	X	X	X	X	X
	4.5 Improve strategic information, monitoring and evaluation, research, and innovation for healthy ageing	4.5.1 Monitor and evaluate for healthy ageing	4.5.1.3 Develop monitoring framework with clear indicators for healthy ageing programme	Monitoring framework for healthy ageing programme available	MoH	X	X			
	4.6 Strengthen governance and leadership for the healthy ageing programme	4.6.1 Establish healthy ageing programme at Zoba and sub-Zoba levels	4.6.1.1 Constitute multisectoral TWGs for healthy ageing at national and Zoba levels	Multisectoral TWGs for healthy ageing constituted at national and Zoba levels	MoH	X	X	X	X	X
	4.6 Strengthen governance and leadership for the healthy ageing programme	4.6.1 Establish healthy Ageing programme at Zoba and sub-Zoba levels	4.6.1.2 Designate healthy ageing focal points at Zoba and sub-Zoba levels	Healthy ageing focal points at Zoba and sub-Zoba levels	MoH	X	X			

Supplementary Table for Accelerated High-Impact Nutrition Interventions

(NB. These actions are already reflected in the AHINI strategy but are repeated here since they are implemented by the MCH programme. For details see AHINI strategy.)

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
Accelerated High-impact Nutrition interventions	Accelerated High-impact Nutrition interventions	Promote optimal breastfeeding practices	Provide counselling during antenatal care on the benefits of breastfeeding for mother and baby	Provision of counselling during antenatal care on the benefits of breastfeeding for mother and baby	MoH	X		X		X
	Accelerated High-impact Nutrition interventions	Promote appropriate complementary feeding for 6–24-month-olds	Increase access to appropriate complementary foods, especially for vulnerable households	Access to appropriate complementary foods, especially for vulnerable households increased	MoH	X	X	X	X	X
	Accelerated High-impact Nutrition interventions	Promote appropriate complementary feeding for 6–24-month-olds	Promote appropriate diversified foods for complementary feeding through cooking demonstrations and other interventions	Appropriate diversified foods for complementary feeding through cooking demonstrations and other interventions promoted	MoH	X			X	
	Accelerated High-impact Nutrition interventions	Promote appropriate complementary feeding for 6–24-month-olds	Promote the production and utilization of micronutrient-rich foods in collaboration with the Ministry of Agriculture (MoA), especially for vulnerable households	Use of a micronutrient powder to enrich complementary foods	MoH	X	X	X	X	X
	Accelerated High-impact Nutrition interventions	Promote appropriate complementary feeding for 6–24-month-olds	Promote continued feeding, including breastfeeding, during illness	Continued feeding, including breastfeeding, during illness promoted	MoH	X			X	
	Accelerated High-impact Nutrition interventions	Prevent and control micronutrient deficiencies	Provide vitamin-A supplementation twice per year for children aged 6–59 months	Provision of vitamin-A supplementation twice per year for children aged 6–59 months	MoH	X	X	X	X	X
	Accelerated High-impact Nutrition interventions	Prevent and control micronutrient deficiencies	Promote the production, distribution and utilization of iodized salt at a national level by advocating for universal salt iodization; promote iodized salt consumption at the household level	Production, distribution and utilization of iodized salt at a national level by advocating for universal salt iodization; iodized salt consumption at the household level promoted	MoH	X			X	

Strategy	Sub strategy	Priority interventions	Key activities	Outputs	Responsible body	Year 1	Year 2	Year 3	Year 4	Year 5
	Accelerated High-impact Nutrition interventions	Link food-insecure households with children under 24 months of age to social protection services and nutrition-sensitive livelihood and economic opportunities	Establish a social protection programme for the most vulnerable households, especially those with children under 2 years	Social protection programme for the most vulnerable households, especially those with children under 2 years, established	MoH	X				X
	Accelerated High-impact Nutrition interventions	Link food-insecure households with children under 24 months of age to social protection services and nutrition-sensitive livelihood and economic opportunities	Increase access to income-generating activities	Access to income-generating activities increased	MoH	X	X	X	X	X
	Accelerated High-impact Nutrition interventions	Link food-insecure households with children under 24 months of age to social protection services and nutrition-sensitive livelihood and economic opportunities	Promote homestead production of vegetables and fruits and small-animal rearing through the provision of agricultural inputs to vulnerable households	Homestead production of vegetables and fruits and small-animal rearing promoted through the provision of agricultural inputs to vulnerable households	MoH	X			X	
	Accelerated High-impact Nutrition interventions	Early detection and management of acute malnutrition and common childhood infections	Ensure community GMP to identify acutely malnourished children and those at risk of becoming malnourished	Community GMP to identify acutely malnourished children and those at risk of becoming malnourished	MoH	X	X	X	X	X

Annex 2
Results - Monitoring Framework

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
Impact (goal) Indicators								
Maternal mortality ratio	Number of women who die of causes related to pregnancy (pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration) in a given period per 100,000 live births	All maternal deaths occurring in a given period	Total number of live births occurring in the same period	EDHS/EPHS, LQAS	Every 5 years	184		114
Institutional maternal mortality ratio	Proportion of women who die in health facilities of causes related to pregnancy in a given period per 100,000 live births	Number of women who die in health facilities of causes related to pregnancy in a given period per 100,000 live births	Total number of live births occurring in the same period	HMIS	Annually			
Neonatal mortality rate	Number of deaths occurring during the first 28 days of life per 1,000 live births	Number of children who die within the first 28 days of life	Total number of live births	EDHS/EPHS, LQAS	Every 5 years	16		14
Institutional neonatal mortality rate	Number of deaths occurring in health facilities during the first 28 days of life per 1,000 live births	Number of children who die in health facilities within the first 28 days of life	Total number of live births	HMIS	Annually			
Stillbirth rate	Number of stillbirths in a given period per 1,000 total births	Number of stillbirths in a given period	Total number of births in a given period	EDHS/EPHS, LQAS	Every 5 years	25		17
Infant mortality rate	Number of infants who die before completing the first year of life per 1,000 live births	Number of deaths within the first year of life	Total number of live births	EDHS/EPHS, LQAS	Every 5 years	29		24
Under-5 mortality rate	Number of children who die within the first 5 years of life per 1,000 live births	Number of deaths within the first 5 years of life	Total number of live births	EDHS/EPHS, LQAS	Every 5 years	40		33
Eritrea life expectancy index	Number of years a person can expect to live					66.44		
Adolescent birth rate	Number of live births per 1,000 women aged 15 to19	Number of live births per 1,000 women aged 15 to19	Estimated or enumerated population of women aged 15 to 19	EDHS/EPHS, LQAS	Every 5 years			
Adolescent maternal mortality ratio	Number of adolescents 15–19 years old who die of causes related to pregnancy (pregnancy, childbirth or within 42 days of termination of pregnancy, irrespective of the duration) in a given period per 100,000 live births	Number of adolescents 15–19 years old who die of causes related to pregnancy in a given period	Total number of live births occurring in the same period	EDHS/EPHS, LQAS	Every 5 years	184		114

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
Per centage of women and girls subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	Proportion of ever-partnered women and girls aged 15 years and older who have experienced physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months.	Number of ever-partnered women and girls aged 15 years and older who have experienced physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months.	Total ever-partnered women and girls aged 15 years and older	EDHS/EPHS, LQAS	5 years			21 per cent
Proportion of girls and women aged under 5 and under 15 years who have undergone female genital mutilation/cutting, by age (SDG 5.3.2)	Proportion of girls and women aged 15-49 years who have undergone female genital mutilation.	Number of girls and women aged 15 to 49 years who have undergone FGM.	Total number of girls and women aged 15 to 49 years in the population.	EPHS	5 years			
SO1: HSS Indicators								
Ratio of doctors (excluding specialists) to population	Doctors (excluding specialists) per 1,000 population	Number of doctors (excluding specialists)	Total population	Health workforce reports	Annually	0.08	0.3	0.5
Ratio of nursing staff (including midwives and associate nurses) to population	Nursing staff (including midwives and associate nurses) per 10, 000 population	Number of nursing staff (including midwives and associate nurses)	Total population	Health workforce reports	Annually	12	16	18
HMIS accuracy and completeness of reporting by facilities	HMIS data accuracy and completeness rate	Number of health facilities with HMIS data submitted that is accurate and complete	Total number of health facilities using HMIS	HMIS	Quarterly			
HMIS data timeliness	HMIS data timeliness rare	Number of health facilities with HMIS data submitted on time	Total number of health facilities using HMIS	HMIS	Quarterly			
Per centage of facility maternal deaths notified within 24 hours by Zoba and national level	Proportion of facility maternal deaths notified within 24 hours by Zoba and national level	Number of facility maternal deaths notified within 24 hours by Zoba and national level	Total facility maternal deaths	HMIS	Quarterly			
Per centage of health facilities that experienced a stockout of essential RMNCAH commodities at any point during a given period	Proportion of health facilities that experienced a stockout of essential RMNCAH commodities at any point during a given period	Number of health facilities that experienced a stockout of essential RMNCAH commodities at any point during a given period	Total number of health facilities	LMIS	Quarterly			
SO2A MNH Indicators								
ANC coverage: at least 1 ANC contact	Proportion of pregnant women who made at least one ANC contact	Number of pregnant women who made at least one ANC contact	Estimated number of pregnant women	HMIS	Annually			
ANC coverage during the first trimester	Proportion of pregnant women who had their first ANC during the first trimester	Number of pregnant women who made first ANC contact during the first trimester	Estimated number of pregnant women	HMIS	Annually			
Pregnant women attending 4 ANC contacts	Proportion of pregnant women who made at least 4 ANC contacts	Number of pregnant women who made at least 4 ANC contacts	All 1st ANC clients	HMIS	Annually	64 per cent	75 per cent	85 per cent

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
Pregnant women attending 8 ANC contacts	Proportion of pregnant women who made at least 8 ANC contacts	Number of pregnant women who made at least 8 ANC contacts	Total 1st ANC clients	HMIS	Annually			
Pregnant women with Hb <10 g/dl at 1st ANC contact	Proportion of pregnant women with Hb <10 g/dl at 1st ANC contact	Total pregnant women with Hb <10 g/dl at first ANC contact	Total 1st ANC contacts	HMIS	Annually			
Pregnant women with Hb <10 g/dl at 4th contact	Proportion of pregnant women with Hb <10 g/dl at 4th contact	All pregnant women with Hb <10 g/dl at fourth contact	Total ANC 4	HMIS	Annually			
Skilled birth attendance	Proportion of births assisted by a skilled birth attendant	Number of births assisted by skilled health personnel	Total live births during the specified period	EDHS/EPHS, LQAS HMIS	Every 5 years Annually	71 per cent	75 per cent	85 per cent
Facility deliveries	Proportion of deliveries taking place in health facilities	Total deliveries during a specified period	Expected live births in a specified period	EDHS/EPHS, LQAS HMIS	Every 5 years Annually	71 per cent	75 per cent	85 per cent
Caesarean section rate	Proportion of deliveries by caesarean section	Total deliveries by caesarean section	Total live births	EDHS/EPHS, LQAS HMIS	Every 5 years Annually			
CEmONC health facilities	Proportion of health facilities providing CEmONC	Hospitals providing all 9 signal functions for CEmONC	Total hospitals	HFA EmONC Assessment		85 per cent	100 per cent	100 per cent
BEmONC health facilities	Proportion of facilities providing BEmONC	Number of facilities providing all 7 BEmONC signal functions	Total health facilities offering delivery services	HFA EmONC Assessment		100 per cent	100 per cent	100 per cent
Newborns initiated breast feeding within half an hour of birth	Proportion of newborns who initiated breast feeding within half an hour of birth	Number of newborn-initiated breast feeding within half an hour of birth	Total live births	HMIS	Annually			
Health facilities implementing KMC for management of low birth weight	Proportion of health facilities implementing KMC for management of low birth weight	Number of health facilities implementing KMC for management of low birth weight	Total number of health facilities	HMIS	Annually			
Preterm/low birth weight newborns who were provided with KMC or KFC	Proportion of preterm/low birth weight newborns who were provided with KMC or KFC	Preterm/low birth weight newborns who were provided with KMC or KFC	Total number of preterm/low birth weight	HMIS	Annually			
Mothers and newborns who have postnatal contact with a health provider within 24 hours of delivery at facility	Proportion of women or babies who have postnatal contact with a health provider within 24 hours of delivery at facility	Total postnatal contacts within 24 hours (separate for mothers and for babies)	Total births	EDHS/EPHS, LQAS HMIS	Every 5 years Annually			
Women who have postpartum contact with a health provider within 3 days of delivery at home	Proportion of women who have postpartum contact with a health provider within 3 days of delivery at home	Total postnatal contacts within 3 days	Total births	EDHS/EPHS, LQAS HMIS	Every 5 years Annually			

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
SO2B SRH Indicators								
Family planning								
Contraceptive prevalence rate (modern methods)	Proportion of women of reproductive age (15–49 years old) at risk of pregnancy who are currently using or whose sexual partner is using a modern method of contraception	Number of women of reproductive age at risk of pregnancy who are using or the sexual partner is using a contraceptive method at a given point in time	Total number of women of reproductive age who are at risk of pregnancy at the same point in time	EDHS/EPHS LQAS,	Every 5 years	13.5 per cent		
Demand satisfied for modern contraception (per cent) - women of reproductive age	Proportion of women of reproductive age (15–49 years old) who are married or in-union who have their need for family planning satisfied with modern methods	Number of women of reproductive age (15-49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method	Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning)	EDHS/EPHS LQAS,	Every 5 years	31 per cent	35 per cent	40 per cent
Need for family planning satisfied with modern methods in women aged 15-49 who are married or in a union	Proportion of women of reproductive age who are married or in a union who have their contraception need met	Number of women of reproductive age who are married or in a union who have their contraception need met	Total number of women of reproductive age who are married or in a union	EDHS/EPHS LQAS,	Every 5 years	31 per cent	35 per cent	40 per cent
Number of individuals newly accepting contraceptives (new acceptors)	Number of persons who accept a contraceptive method for the first time in their lives in a particular period	N/A	N/A	HMIS	Quarterly			
Couple Years of Protection (CYP)	The estimated protection provided by family planning services during a one-year period, based upon the volume of contraceptives	N/A	N/A	HMIS	Quarterly			
Cancer Screening and management								
per cent Health facilities providing cervical cancer screening	Number of health facilities providing cervical cancer screening	Number of facilities providing cervical cancer screening	Total health facilities expected to provide cervical cancer screening	HMIS	Annually	5 per cent	30 per cent	50 per cent
per cent Women aged 30–49 years screened for cervical cancer with positive result	Proportion of women aged 30–49 screened for cervical cancer with positive result	Number of women aged 30–49 screened for cervical cancer with positive result	Total women aged 30–49 who came for cervical cancer screening	HMIS	Annually			
per cent Screen-positive women who were treated	Proportion of screen-positive women who were treated (cryotherapy, LEEP)	Proportion of screen-positive women who were treated (cryotherapy, LEEP)	Total screen-positive women	HMIS	Annually			
per cent Clients who had overt cancer cases picked up during screening	Proportion of screened clients who have overt cervical cancer	Number of screened clients who had overt cervical cancer	Total number of screened clients	HMIS	Annually			
PAC Indicators								
per cent Health facilities providing comprehensive post-abortion care (PAC) services	Number of health facilities providing post-abortion care services	Number of facilities providing post-abortion care services	Total health facilities expected to provide post-abortion care services	HMIS	Annually	5 per cent	30 per cent	50 per cent

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
Infertility indicators								
per cent Clients seen in outpatient clinic with infertility	Proportion of clients seen in outpatient clinic with infertility	Number of clients seen in outpatient clinic with infertility	Total clients seen in outpatient clinic	HMIS	Annually			
GBV Indicators								
per cent Hospitals meeting the minimum criteria to conduct GBV clinical enquiry	Proportion of hospitals meeting the minimum criteria to conduct GBV clinical enquiry	Number of Hospitals meeting the minimum criteria to conduct GBV enquiry	Total number of hospitals	HMIS	Annually			
Fistula indicators								
per cent Hospitals providing obstetric fistula services	Proportion of hospitals providing obstetric fistula services	Number of hospitals providing obstetric fistula services	Total number of hospitals	HMIS	Annually	5 per cent	30 per cent	50 per cent
Adolescent Health Indicators								
Facilities providing adolescent-and-young-people-friendly health services	Proportion of health facilities providing adolescent-and-young-people-friendly health services	Number of health facilities providing adolescent-and-young-people-friendly health services	Total number of health facilities	HMIS	Annually	16 per cent	50 per cent	75 per cent
Women aged 20–24 years who were married or in a union before age 15 and before age 18 (SDG 5.3.1)	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	Women aged 20–24 years who were married or in a union before age 15 and before age 18	Total number of women aged 20–24 years	EPHS	5 years			
Ever-partnered women and girls aged <24 years subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (SDG 5.2.1)	Proportion of partnered women and girls aged under 24 years subjected to physical, sexual or psychological violence by a current or former intimate partner	Number of partnered women and girls aged under 24 years subjected to physical, sexual or psychological violence by a current or former intimate partner	Total number of partnered women and girls aged under 24 years	EPHS	5 years			
SO3: Child Health Indicators								
Health facilities providing IMNCI	Proportion of health facilities providing IMNCI	Number of health facilities providing IMNCI	Total number of health facilities	HMIS Special surveys	Annually	100 per cent	100 per cent	100 per cent
Health facilities with 60 per cent healthcare providers trained in IMNCI	Proportion of health facilities with 60 per cent healthcare providers trained in IMNCI	Number of health facilities with 60 per cent healthcare providers trained in IMNCI	Total number of health facilities	HMIS Special surveys	Annually			
Children with diarrhoea receiving oral rehydration salts (ORS) and zinc	Proportion of children with diarrhoea receiving ORS and zinc	Children with diarrhoea receiving ORS and zinc	Total number of children with diarrhoea	HMIS Special surveys	Annually			

Indicator	Indicator Definition	Numerator	Denominator	Source	Frequency Of Measurement	Baseline	Mid Term	End Term
Antibiotic treatment for pneumonia and dysentery	Proportion of children treated with antibiotics for pneumonia and dysentery	Number of children treated with antibiotics for pneumonia and dysentery	Total number of children with diarrhoea and dysentery	HMIS	Annually	100 per cent	100 per cent	100 per cent
Exclusive breastfeeding under 6 months	Proportion of infants under 6 months who are fed exclusively with breast milk	Number of infants under 6 months who are fed exclusively with breast milk	Total number of infants under 6 months	EDHS/EPHS, LQAS	Every 5 years			
Nutrition indicators								
Children under 5 who are underweight	Proportion of under-5 children who are underweight (weight for age)	Number of children who are underweight (weight for age less than 2SD of the WHO child growth standards median)	Number of children under 5 years of age	HMIS	Annually			
Children under 5 who are stunted	Proportion of under-5 children who are stunted (height for age)	Number of children who are stunted (height for age less than 2SD of the WHO child growth standards median)	Number of children under 5 years of age	HMIS	Annually	45	40	35
Severe acute malnutrition treatment coverage	Proportion of children 0–59 months with severe acute malnutrition receiving treatment	Number of children 0–59 months with severe acute malnutrition receiving treatment	Estimated number of new cases of SAM among children 0–59 months	HMIS	Annually			
SO4: Healthy Ageing Indicators								
Health facilities providing comprehensive Integrated Care for People of Grace Age (ICPOGA)	Proportion of Hospitals providing Integrated Care of People of Grace Age (ICPOGA)	Number of Hospitals providing Integrated Care of People of Grace Age (ICPOGA)	Total number of hospitals	HMIS	Monthly	0 per cent	10 per cent	50 per cent
Health facilities providing palliative care	Proportion of hospitals providing palliative care	Number of hospitals providing palliative care	Total number of hospitals	HMIS	Monthly	0 per cent	10 per cent	50 per cent
per cent Of non-communicable disease (NCD) clients who are above 60 years	Proportion of non-communicable disease (NCD) clients who are above 60 years	Number of non-communicable disease (NCD) clients who are above 60 years	Total number of NCD clients	HMIS				
per cent Of visual impairment above 60 years	Proportion of clients with visual impairments who are above 60 years	Number of clients above 60 years with visual impairments	Total number of clients with visual impairments	HMIS				
per cent Of clients above 60 years with hearing impairment	Proportion of clients with hearing impairments who are above 60 years	Number of clients above 60 years with hearing impairments	Total number of clients with hearing impairments	HMIS				
per cent Of clients who are above 60 years with cognitive decline and other mental health issues	Proportion of clients above 60 years with cognitive decline and other mental health issues	Number of clients above 60 years with cognitive decline and other mental health issues	Total number of clients with cognitive decline and other mental health issues	HMIS				
per cent Deaths due to non-communicable disease (NCD) among clients above 60 years	Per centage of NCD-related deaths which occur in persons over 60 years old	Deaths in persons over 60 years old whose underlying cause is an NCD	Deaths in total population whose underlying cause is an NCD					
Top-10 causes of mortality ranking in older adults aged 60 years and over	The top-10 causes of mortality in adults over 60 years old in order	-	-					
per cent Of healthcare providers (HCP) trained in ICPGA	Proportion of HCP trained in ICPGA	Number of HCP trained in ICPGA	Total HCP	Programme data	Annually			

Annex 3
RMNCAH & HA SP Logical Framework

	Project Summary	Indicators	Baseline	Mid Term	End Term	Meansof Verification	Risks/ Assumptions
GOAL	Accelerated progress towards ending all preventable deaths of women, newborns, children and realization of the health and wellbeing of adolescents and elders	1. Maternal mortality ration per 100,000 live births	184		114	Survey reports (EDHS/EPHS, LQAS)	Surveys and assessments are conducted regularly Good data quality
		2. Neonatal mortality rate per 1,000 live births	16		14		
		3. Infant mortality rate	29		24		
		4. Under-5 mortality rate per 1,000 live births	40		33		
		5. Stillbirth rate	25		17		
OUTCOME	**MNH**						
	2A.1 Increased number of women accessing ANC services	2A.1: Proportion of pregnant women completing at least 4 ANC contacts	64%	75%	85%	Survey reports (EDHS/EPHS, LQAS) HMIS data	Sustained community mobilizations Sustained supply of commodities, equipment and supplies Availability of skilled staff
	2A.2 Increased number of women who deliver at a health facility with a skilled attendant	2A.2: Proportion of births assisted by skilled birth attendants	71%	75%	85%		
	2A.3 Increased number of mothers who receive PNC within 48 hours	2A.3: Proportion of mothers receiving postnatal care within 48 hours	100%	100%	100%		
	SRH						
	2B.1 Increasing number of women using modern methods of family planning	2B.1 Contraceptive prevalence rate for modern FP methods	13.5%			Survey reports (EDHS/EPHS, LQAS) HMIS data	Sustained community mobilizations Sustained supply of commodities, equipment and supplies Availability of skilled staff
	2B.2 Increasing number of women of reproductive age who are married or in a union who have their contraception needs met	2B.2 Proportion of women of reproductive age who are married or in a union who have their contraception needs met	31%	35%	40%		
	2B.3 Increased number of women 30-49 years screened for cancer of cervix	2B.3 Number of women 30-49 years screened for cancer of cervix					
	CHILD HEALTH						
	3.1 Increased number of preterm/low-birth-weight newborns managed with KMC or KFC	3.1 Proportion of preterm/low-birth-weight newborns who were managed with KMC or KFC				HMIS data	Sustained community mobilizations Sustained supply of drugs, commodities, equipment and supplies Availability of skilled staff
	3.2 Increased number of children with diarrhoea who received ORS and zinc	3.2 Proportion of children with diarrhoea receiving ORS and zinc					
	3.3 Increased number of children treated with antibiotics for pneumonia and dysentery	3.3 Proportion of children treated with antibiotics for pneumonia and dysentery					

	Project Summary	Indicators	Baseline	Mid Term	End Term	Meansof Verification	Risks/ Assumptions
OUTCOME	**HA**						
	4.1 Older members of society's access to geriatric-responsive services	4.1 Proportion of older members of society accessing geriatric-responsive services				HMIS data	Availability of age-friendly environments Supportive families and communities Sustained supply of commodities, equipment, and supplies Availability of skilled staff
OUTPUTS	**MNH**						
	2A. Increased availability of quality MNH services	2A.1 Proportion of health facilities providing quality ANC	100%	100%	100%	HMIS data HFA data	Equipment available and functional Good documentation Availability of commodities and supplies
		2A.2.1 Proportion of health facilities providing BEmONC	100%	100%	100%		
		2A.2.2 Proportion of hospitals providing CEmONC	85%	100%	100%		
		2A.3 Proportion of health facilities offering PNC	100%	100%	100%		
	SRH						
	2B. Increased availability of quality SRH services	2B.1 Proportion of health facilities providing the full range of FP methods				HMIS data	Skilled staff, equipment and supplies available
		2B.2 Proportion of health facilities providing cervical cancer screening services	5%	30%	50%		
	AYP						
		2B.3 Proportion of health facilities providing adolescent-and-young-people-friendly health services	16%	50%	75%	HMIS data	Skilled staff, equipment and supplies available
	Child Health						
	3. Increased availability of effective child health interventions	3.1 Proportion of health facilities implementing KMC for management of preterm/low birth weight 3.2 Proportion of health facilities providing IMNCI				HMIS data	Skilled staff, equipment and supplies available
	4. Increased availability of older-people-responsive services	4.1 Proportion of health facilities providing Integrated Care for Older Persons (ICOPE)					

	Project Summary	Indicators	Baseline	Mid Term	End Term	Meansof Verification	Risks/ Assumptions
ACTIVITIES	**MNH**						
	2A.1 Update MNH guidelines, protocols, and tools	2A.1 MNH guidelines, protocols and tools updated				Programme reports	Funds available
	2A.2 Training of HCP on MNH guidelines, protocols and tools	2A.2 HCP trained on MNH guidelines, protocols and tools				Training reports	Funds available
	2A.3 Community sensitization and mobilization for MNH services	2A.3 Community sensitization and mobilization events conducted for MNH services				Programme reports	Responsive community
	2A.4 Scale up MPDSR across all levels of care including community	2A.4 Per centage of EmOC Health facilities with Functional MPDSR committees in place				Meeting reports	Responsive health workers
	SRH						
	2B.1.1 Conduct high-level advocacy for an enabling environment and resource allocation for FP commodities	2B..1.1 Number of high-level advocacy meetings held for resource mobilization and allocation for FP commodities and services				Meeting reports	Funds available
	2B.1.2 Build capacity of healthcare providers (HCPs) in counselling and provision of quality FP services at facility and community level	2B.1.2 Number of HCPs trained in counselling and provision of family planning at facility and community levels				Training reports	Funds available
	2B.1.3 Generate demand for FP services	2B.1.b Number of new FP users				HMIS data	Responsive community
	Child Health						
	3.1 Scale up provision of quality IMNCI services at facility and community	3.1 Coverage of IMNCI services				HMIS data	Funds available
	3.2 Increase coverage of Integrated outreach services, especially in hard-to-reach areas	3.2 Integrated outreach conducted, especially in hard-to-reach areas				Programme reports	Funds available
	Healthy Ageing						
	4.1.1 Create awareness on healthy ageing among health care providers (HCPs)	4.1.1 proportion of health workers sensitized on healthy ageing				Training reports	Funds available
	4.1.2 Create awareness on healthy ageing at community level	4.1.2 Number of healthy ageing community-awareness-creation activities by type and mode or media				Programme reports	Communities supportive of the older population
	4.2.2 Align the health system and integrate healthy ageing interventions across all departments and programmes of the MoH	4.2.2 Proportion of MoH departments and programmes that have integrated healthy ageing interventions in their strategies and plans				HMIS data	Department's support HAA programme

Annex 4
Programme Costing by One Health Categories

Baseline Scenario (ERN)

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
Adolescent health	6,159,668	1,752,975	4,064,807	1,932,655	3,715,657	17,625,762
2.2 Training of Trainers	1,715,808	285,600	299,880	314,874	827,881	3,444,043
2.3 Development of Training Programmes and Materials	1,054,180	367,500	385,875	405,169	615,873	2,828,596
3.2 National Staff Visiting Local Staff	120,000	126,000	132,300	138,915	145,861	663,076
4.4 Data Collection and Analysis	429,780	110,250	115,763	121,551	127,628	904,971
7. Communication, Media & Outreach	569,200	597,660	627,543	658,920	691,866	3,145,189
7.3 Printed Materials	821,600	-	905,814	-	998,660	2,726,074
9. General Programme Management	1,347,300	159,075	1,485,398	175,380	184,149	3,351,303
9.2 Development and Review of Annual Work Plan	101,800	106,890	112,235	117,846	123,739	562,509
Child health	16,869,476	12,068,045	18,094,909	12,795,711	19,026,825	78,854,966
2. Training	2,132,400	2,239,020	2,350,971	2,468,520	2,591,946	11,782,856
2.1 In-service/Refresher Training	2,938,080	3,084,984	3,239,233	3,401,195	3,571,255	16,234,747
3. Supervision	241,932	106,294	111,608	117,189	123,048	700,071
3.1 Coordination Meetings	155,000	162,750	170,888	36,118	37,924	562,679
3.2 National Staff Visiting Local Staff	340,928	357,974	375,873	394,667	414,400	1,883,842
4. Monitoring and Evaluation	445,536	467,813	491,203	515,764	541,552	2,461,868
4.4 Data Collection and Analysis	3,456,000	3,628,800	3,810,240	4,000,752	4,200,790	19,096,582
4.5 Quality Control/Quality Assurance	167,200	175,560	184,338	193,555	203,233	923,886
7.4 Social Outreach Activities	998,900	1,048,845	843,126	885,282	929,546	4,705,699
8.2 Advocacy Activities	492,600	517,230	543,092	570,246	598,758	2,721,926
8.3 Advocacy Materials	4,714,000	119,700	5,106,780	37,044	5,630,225	15,607,749
9. General Programme Management	786,900	159,075	867,557	175,380	184,149	2,173,062

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
Health systems	14,740,568	12,653,569	11,919,412	11,016,142	13,433,663	63,763,354
2. Training	1,886,520	1,980,846	229,011	240,462	252,485	4,589,324
2.1 In-service/Refresher Training	1,750,680	1,446,228	1,546,719	1,191,891	1,705,258	7,640,776
2.2 Training of Trainers	608,300	559,965	426,778	361,295	470,522	2,426,860
3.1 Coordination Meetings	302,400	317,520	269,892	283,387	297,556	1,470,755
3.2 National Staff Visiting Local Staff	2,665,632	2,798,914	2,938,859	3,085,802	3,240,092	14,729,299
4.2 Design of Quality Control and Assurance	2,510,110	2,635,616	2,620,102	2,751,107	2,888,663	13,405,598
4.3 Design/Review of Data Management Systems	3,092,480	1,229,550	2,118,873	1,157,393	2,493,830	10,092,126
4.4 Data Collection and Analysis	110,850	-	-	-	134,739	245,589
5.1 Situational Assessment	75,300	-	-	87,169	-	162,469
7.4 Social Outreach Activities	1,008,000	1,058,400	1,111,320	1,166,886	1,225,230	5,569,836
8.2 Advocacy Activities	580,856	609,899	640,394	672,413	706,034	3,209,596
9.2 Development and Review of Annual Work Plan	133,600	-	-	-	-	133,600
Other	15,840	16,632	17,464	18,337	19,254	87,526
Healthy ageing	15,432,308	14,876,925	16,052,290	15,763,264	16,546,808	78,671,595
2. Training	142,600	149,730	157,217	-	-	449,547
2.1 In-service/Refresher Training	41,600	43,680	45,864	48,157	50,565	229,866
3.1 Coordination Meetings	1,256,800	1,319,640	1,385,622	1,454,903	1,527,648	6,944,613
4.1 Design of M and E Frameworks and Systems	100,000	105,000	-	-	-	205,000
5.1 Situational Assessment	41,220	43,281	45,445	47,717	50,103	227,767
6.1 Situational Assessment	309,508	305,550	320,828	-	-	935,886
7.3 Printed Materials	2,640,000	2,100,000	2,205,000	2,315,250	2,431,013	11,691,263
8.2 Advocacy Activities	923,330	893,477	938,150	985,058	1,034,311	4,774,325
8.3 Advocacy Materials	9,251,250	9,713,813	10,199,503	10,709,478	11,244,952	51,118,996
9. General Programme Management	678,900	177,975	728,642	175,380	184,149	1,945,047

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
9.1 Design and Review of Country Strategy	23,500	-	-	-	-	23,500
9.4 Programme Coordination Meetings	23,600	24,780	26,019	27,320	24,067	125,786
Maternal, newborn and reproductive health	43,947,002	36,645,353	48,072,645	27,559,069	41,423,067	197,647,136
2. Training	8,250,328	9,591,464	10,022,329	8,705,710	8,767,447	45,337,279
2.1 In-service/Refresher Training	6,090,808	8,357,257	8,720,215	5,603,720	3,544,445	32,316,445
2.2 Training of Trainers	-	416,325	54,905	293,921	-	765,150
2.3 Development of Training Programmes and Materials	1,271,100	748,020	77,947	5,557	5,834	2,108,458
3.1 Coordination Meetings	57,450	581,753	54,408	57,129	59,985	810,725
4.2 Design of Quality Control and Assurance	2,709,880	685,104	1,134,142	-	1,042,540	5,571,665
4.3 Design/Review of Data Management Systems	944,950	926,258	919,650	965,633	1,013,915	4,770,405
4.4 Data Collection and Analysis	3,331,636	3,498,218	3,673,129	3,856,785	4,049,624	18,409,392
4.5 Quality Control/Quality Assurance	968,100	909,405	1,246,464	25,584	26,863	3,176,416
5. Infrastructure and Equipment	100,000	2,100,000	1,212,750	2,199,488	-	5,612,238
5.1 Situational Assessment	317,100	332,955	-	-	-	650,055
5.3 Equipment Upgrade for Hospitals	3,550,000	3,780,000	3,417,750	1,273,388	4,315,047	16,336,185
7.2 Mass Media	352,000	369,600	388,080	407,484	427,858	1,945,022
7.3 Printed Materials	398,800	252,000	264,600	277,830	291,722	1,484,952
7.4 Social Outreach Activities	2,668,800	3,047,940	2,942,352	3,089,470	3,243,943	14,992,505
8. Advocacy	199,850	191,205	206,719	210,804	221,344	1,029,921
8.2 Advocacy Activities	11,697,300	500,483	12,902,888	408,410	14,225,434	39,734,515
8.3 Advocacy Materials	175,800	-	-	-	-	175,800
9. General Programme Management	754,350	159,075	831,671	175,380	184,149	2,104,625
9.1 Design and Review of Country Strategy	108,750	132,983	2,646	2,778	2,917	250,074
9.4 Programme Coordination Meetings	-	65,310	-	-	-	65,310

Programme Areas	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost
Nutrition	40,098,970	27,426,410	35,321,454	35,578,609	38,398,122	176,823,564
2.1 In-service/Refresher Training	9,763,260	9,858,345	10,550,109	10,644,246	11,208,791	52,024,751
2.2 Training of Trainers	1,176,270	1,156,334	1,213,489	1,274,163	1,337,871	6,158,127
2.3 Development of Training Programmes and Materials	42,000	44,100	46,305	48,620	51,051	232,077
3. Supervision	685,440	719,712	755,698	793,482	833,157	3,787,489
3.1 Coordination Meetings	7,200	-	7,938	-	-	15,138
4.4 Data Collection and Analysis	519,000	-	-	600,807	-	1,119,807
5. Infrastructure and Equipment	60,000	63,000	66,150	69,458	72,930	331,538
5.2 Equipment Upgrade for Health Centres	4,590	-	5,060	-	5,579	15,230
5.3 Equipment Upgrade for Hospitals	2,763,710	57,540	3,046,990	63,438	3,359,307	9,290,985
7. Communication, Media & Outreach	17,291,350	11,197,200	14,354,550	17,289,535	12,962,159	73,094,793
7.4 Social Outreach Activities	3,985,480	4,171,104	4,379,659	4,613,691	4,828,574	21,978,509
8.2 Advocacy Activities	150,880	-	101,210	-	-	252,090
9. General Programme Management	720,450	159,075	794,296	175,380	184,149	2,033,351
9.6 Situation Analysis	2,929,340	-	-	5,788	3,554,554	6,489,682
Grand Total	**137,247,992**	**105,423,276**	**133,525,517**	**104,645,450**	**132,544,142**	**613,386,377**

Annex 5
RMNCAH & HA Evidence-Based High-Impact Interventions

Package	Key Interventions
MNH	
Preconception care	Screening for anaemia, STIs, cervical cancer, HIV Counselling on safe sex, contraception, hygiene Nutritional assessment and nutritional supplementation Immunization (Tetanus, Diphtheria) as appropriate Medical consultation for those not able to get pregnant
Antenatal care	Counselling on emergency preparedness and individualized birth plan, danger signs (ANC, labour and delivery, postnatal, neonatal), use of bed nets, family planning, etc.) Monitoring maternal and foetal conditions and pregnancy progress Screening for hypertensive disease, diabetes, HIV, STIs, anaemia Iron and folate supplementation, deworming, IPTp and other preventive measures Management of obstetric complications (preterm labour, preterm rupture of membranes, antepartum haemorrhage)
Labour and delivery	Routine monitoring labour using Partograph/labour care guide (correct use and interpretation) Labour companionship, mobility, feeding as appropriate, respectful care Infection prevention (minimising vaginal examinations) Active management of the third stage of labour Assisted delivery (if needed) Caesarean section for maternal and foetal conditions Detection and prompt management of PPH
Essential newborn care	Warm chain (drying, warm clothes, skin-to-skin contact) Initiation of breastfeeding within one hour of birth Maintaining infection prevention (changing gloves) Vaccinations (BCG, OPV0) Newborn care: Vitamin. K, tetracycline, ARV provision (as appropriate) Identifying sick newborns and initiating treatment
Postnatal care	Assessment (vital signs, abdominal assessment, lochia loss, breast examination) Counselling on: exclusive breastfeeding for 6 months, cord care, nutrition, danger signs Provision of postpartum family planning, Iron and folic acid supplementation Prophylactic antibiotics Psychosocial support

Package	Key Interventions
SRH	
Family planning	Counselling on all methods of contraception (mode of action, effectiveness, benefits, side effects, follow-up) Provision of the method of choice Screening for HIV, STIs, cervical cancer, breast cancer
Reproductive tract cancers	Cervical cancer screening using visual inspection with acetic acid (VIA), Pap smear and HPV test (where available) Management of screen-positives with cryotherapy/LEEP Prostate cancer screening and management Breast cancer screening and management
Post-abortion care	Treatment of incomplete and unsafe abortion and potentially life-threatening complications (uterine evacuation, antibiotics, management of shock and anaemia) Counselling and provision of FP to minimize risk of unintended pregnancy Referral for reproductive and other health services including cancer screening, STI screening and management
Infertility	Investigation of infertility (history and physical examination, laboratory investigations, hysterosalpingography, laparoscopy) Appropriate management including education on fertility awareness Prevention of infertility through early detection and management of STIs Management of infertility (hormones, tubal surgery, assisted reproductive technologies)
Obstetric fistula	Prevention of obstetric fistula (timely and high-quality emergency obstetric care) Repair of obstetric fistula Rehabilitation and reintegration into the community
Gender-based violence	Prevention of GBV, community and male involvement Early identification through clinical inquiry First-line support and response Treatment (emergency contraception, presumptive treatment for STIs, PEP for HIV) Psychosocial counselling Linkages to other services including legal, education and protection

Package	Key Interventions
FGM	Community engagement on harmful effects of FGM Counselling and support for those who have undergone FGM De-infibulation for survivors
	Community mapping for public declaration of FGM-free communities
	Community dialogue sessions to complement community mapping
	Life skills education for adolescent girls and boys to resist FGM
	Targeted health services, including during antenatal and post-natal visits, to FGM victims and at-risk persons
	Psycho-social services to FGM victims and at-risk persons
	Legal enforcement mechanisms for FGM victims at-risk persons
CHILD HEALTH	
IMNCI	Assessing and classifying main symptoms and managing sick children Checking for malnutrition and anaemia, immunizations Assessing child's feeding and counselling mother accordingly Assessing for other problems in the child and mother Counselling on treatment, feeding, follow-up protocol
Small and sick newborns	Assessing and classifying by weight or prematurity Skin-to-skin contact through KMC Initiating breastfeeding as appropriate Assessing for possible respiratory infections and managing accordingly Early identification and management of major congenital defects
Early childhood development	Responsive caregiving during first 3 years of life Promoting early learning with parents and other caregivers during the first 3 years of life. Integrating caregiving and nutrition interventions in routine care of child from pregnancy to five years of age including nutrition, health, WASH, education and social protection Supporting maternal mental health (psychosocial interventions to support maternal mental health should be integrated into early childhood health and development services)
School health	Health education Screening and treatment for eye, ear, dental and skin conditions Nutritional assessment and micro-nutrient supplementation De-worming HPV vaccination

Package	Key Interventions
AYP	
Adolescent and young people	Promotion of healthy behaviour (nutrition, physical activity, health-seeking behaviour) Provision of Td, Meningitis and HPV vaccines to adolescents Screening and management of anaemia Counselling on menstrual hygiene, nutrition, safe sex, STI prevention, substance abuse Psychosocial support for mental health issues including intentional and unintentional injury Management of menstrual problems
HAA	
Healthy ageing	Reinforcing generic health and lifestyle practices (nutrition, exercise, social engagement, limiting alcohol/smoking/drugs, injury/accident prevention, fall prevention, healthy lifestyle, oral health, hygiene and sanitation, harmful traditional and religious practices21) Screening and management of common non-communicable diseases – NCDs (hypertension, diabetes, cancer, nutrition disorders) Prevention and control of elder abuse, social isolation and neglect Assistive devices, rehabilitation and palliative care services Long-term care of elderly people at community and facility level Counselling on harmful traditional and religious practices, hygiene and sanitation Promotion of age-friendly environments

For detailed information refer to the specific guidelines and protocols for each programme area

Annex 6

Summary of The Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030)

AT A GLANCE:

THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)

VISION

By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.

OBJECTIVES AND TARGETS aligned with the Sustainable Development Goals (SDGs)

SURVIVE *End preventable deaths*

- Reduce global maternal mortality to less than 70 per 100,000 live births
- Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country
- Reduce under-five mortality to at least as low as 25 per 1,000 live births in every country
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being

THRIVE *Ensure health and well-being*

- End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
- Ensure universal access to sexual and reproductive health care services (including for family planning) and rights
- Ensure that all girls and boys have access to good-quality early childhood development
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines

TRANSFORM *Expand enabling environments*

- Eradicate extreme poverty
- Ensure that all girls and boys complete free, equitable and good quality primary and secondary education
- Eliminate all harmful practices and all discrimination and violence against women and girls
- Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
- Enhance scientific research, upgrade technological capabilities and encourage innovation
- Provide legal identity for all, including birth registration
- Enhance the global partnership for sustainable development

Source: The Global Strategy for Women's, Children's and Adolescent's Health, 2015