WEST AFRICAN HEALTH ORGANISATION (WAHO)

STRATEGY FOR THE ACCELERATED REDUCTION OF MATERNAL AND UNDER-FIVE MORTALITY IN ECOWAS

2009 - 2013

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PREFACE

The African Union (AU) prepared a Road Map for the reduction of maternal and neonatal mortality and made it available for member states to adapt to their circumstances. The preparation of the WAHO strategy for Accelerated Reduction in Maternal, Peri-neonatal, and Under-five Mortality, was therefore informed by this AU Road Map, and incorporates all previously existing and relevant strategies. It will serve as a complement to currently existing country strategies and thereby assist them to accelerate the implementation of their strategies.

In preparing this strategy document, (in accordance with the existing strategy's 'Mid-Term Review' Recommendations) the Steering Committee focused on newborns and under-fives, who have not always received the required attention.

Indeed, neonatal deaths currently constitute nearly 40% of all under-five deaths. The majority of these deaths are preventable or treatable using available cost-effective and evidence-based interventions, which do not require expensive technology or highly qualified medical specialists. Neonatal mortality reduction must become a priority if the child survival-related Millennium Development Goals are to be achieved in the sub-region.

In West Africa, women and under-fives especially newborns requiring medical care, do not often get access to health centres and hospitals for several reasons including cost, cultural and social barriers, and quality of care. As a result, decision-makers urgently need to develop contextually appropriate and comprehensive strategies that can integrate essential care for mothers, newborns and under-fives into existing health systems and encourage good, home-based maternal and neonatal care

This document is by no means exhaustive It focuses on high priority and impact interventions that will accelerate the attainment of the sub-regional goals related to this important issue.

Far from replacing existing national documents on this problem, it only provides a guide which, if used wisely, can generate awareness about some neglected aspects of maternal, newborn, and child health care. We therefore call on Member States to use it to strengthen their existing national strategies on maternal, neonatal, and under-five health and survival.

Dr Placido Cardoso
Director General

ACKNOWLEDGEMENTS

We would like to commend the commitment and hard work of the WAHO team that prepared this important document. It will undoubtedly help to improve the health of the people of West Africa.

Special thanks go to the WAHO Director General for his own commitment to the preparation of this important document and for his immense support to the team.

Our sincere thanks also go to the members of the Steering whose diverse expertise contributed to the preparation of a document of this quality.

We would also like to thank the partners of WAHO: WHO, UNICEF, and UNFPA for honouring our invitation to participate in the preparation of this strategy document. Their active participation has reassured us of their commitment to improving the health of the people of the ECOWAS sub-region and their readiness to support the implementation of this new West African strategy.

We cannot also fail to acknowledge the immense role played by the team of interpreters, without whom the discussions which culminated in the preparation of this document would have been almost impossible.

Finally, we would like to express our gratitude to the facilitator, an expert who painstakingly guided the working sessions to ensure the successful conduct of the meeting.

Dr Johanna Austin Benjamin
Director of Primary Health Care and Disease Control

ACRONYMS AND ABBREVIATIONS

AHM –	Assembly of Health Ministers
AIDS	Acquired Immunodeficiency Syndrome
AMS	Assembly of Ministers of Health
BEOC	Basic Essential Obstetric Care
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
ECOWAS	Economic Community of West African States
EOC –	Essential Obstetric Care
EONC	Emergency Obstetric and Newborn Care
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD –	International Conference on Population and development
IMCI	Integrated Management of Childhood Illness
IPAS	International Projects Assistance Services
IPPF	International Planned Parenthood Federation
ITC	Information Technology and Communication
JHPIEGO	John Hopkins Program for International Education in Gynaecology and Obstetrics
KAP	Knowledge, Attitude and Practice
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MPM	Maternal and Perinatal Mortality
MPMR	Maternal and Perinatal Mortality Rate
MPNU5H	Maternal, Peri-Neonatal, and Under-Five Health
MPNU5MR	Maternal, Peri-Neonatal, and Under-Five Mortality Rate
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PMR	Perinatal Mortality Rate
PNC	Post-natal care
PNMR –	Perinatal Mortality Rate
RA	Representative Activities
RH	Reproductive Health
RMPM	Reduction of Maternal and Perinatal Mortality
RMPNU5M	Reduction of Maternal, Peri Neonatal, and Under-Fives Mortality
SAGO	Society of African Gynaecologists and Obstetricians
SMI	Safe Motherhood Initiative
SO	Strategic Objective
SP	Statement of the Problem
TBA	Traditional Birth Attendants
TFR –	Total Fertility Rate
TOR	Terms of Reference
UNAPSA	Union of National African Paediatric Societies and Associations
UNFPA	United Nations Fund for Population Activities

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAHO	West African Health Organisation
WARP	West African Regional Programme
WB	World Bank
WHO	World Health Organisation

SUMMARY

The 2009-2013 Strategy for Accelerating the Reduction of Maternal, Peri-Neonatal, and Under-five Mortality (RMPNU5M) in West Africa aims to coordinate and support ECOWAS member countries in their efforts to accelerate the implementation of national strategies for the RMPNU5M. The objective is for these countries to attain a 75% reduction in maternal mortality and a two-thirds reduction in under-five deaths by 2015, in accordance with Millennium Development Goals (MDG) and 4 and 5 and those of the New Partnership for Africa's Development (NEPAD).

This acceleration strategy was prepared by the Steering Committee for the implementation of the WAHO 2004-2008 Strategic Plan for the Reduction of Maternal and Perinatal Mortality (RMPM). The Committee integrated newborn and under-five health components into the 2004-2008 Strategic Plan, in conformity with the Strategic Plan's mid-term review recommendations.

This document is made up of 3 (three) parts.

Part 1 contains an overview of the MPNU5M in the sub-region. It presents a picture of the scope of the problem. This is followed by a brief summary of all the work done by national and international maternal and child health care organisations in the sub-region. The process of developing this strategic plan is then described in detail. Recommendations from a series of workshops, meetings, and conferences have also been incorporated into this final document. The objectives and missions as presented are underpinned by the core principles of WAHO.

Part 2 describes the five (5) main areas (Advocacy, Resource Mobilisation, Capacity Building, Partnership Development, and Dissemination of Best Practices/approaches) of the Strategy, the five-year operational implementation plan, as well as the Monitoring and Evaluation plan.

The description of each main area begins with an introduction followed by a problem statement the corresponding strategic objective, and a list of activities or interventions.

The WAHO 2009-2013 Operational Plan provides more details on the activities, expected outcomes, indicators, time lines, required resources, and funding sources. This plan consists of a total of 36 activities and 40 indicators distributed amongst the five main strategy areas.

A time period for activity implementation is also proposed.

Part 3 of this document contains:

- **Funding Strategy**
- **Partnerships**
- **Recommendations**
- **Conclusion**

INTRODUCTION AND JUSTIFICATION

Maternal, peri-neonatal, and under-five mortality is a worldwide tragedy. Since the Safe Motherhood Initiative (SMI) was launched in 1987, there have been several efforts to reach the set objective to reduce Maternal Mortality ratio by 50% by the Year 2000. The situation in Africa is such that rather than a reduction, an increase in Maternal Mortality Ratio (MMR) has been observed in a number of countries. In the Year 2000, there were 510,000 maternal deaths globally; 238,000 of these deaths, or 42%, were in Africa, with the highest rate in the West African sub-region. Similarly, of the 9.4 million perinatal deaths occurring annually in the world, 98% is in Africa and again, West Africa records the highest rate.

The total fertility rate (TFR) in the sub-region is high, averaging 5.8; the contraceptive prevalence rate is low at 14%, and more than 60% of deliveries are home-based, primarily in rural areas, without skilled assistance. Consequently, at the United Nations' Millennium Summit in 2000, another global appeal was launched: this time for a 75% reduction in maternal mortality ratio and a two-thirds reduction in under-five deaths, between 1990 and 2015. The New Partnership for African Development (NEPAD) also made a similar appeal.

The West African Health Organisation (WAHO) was formed in 1987 as a specialised agency of ECOWAS and is uniquely positioned to influence health policy and to co-ordinate sustainable integrated responses to major health problems in and amongst ECOWAS Member States. It has a primary mission to attain the highest possible standard and protection for the peoples of West Africa with a population of about 250 million. Its mandate covers all the Member States of ECOWAS namely Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

Concerned about the maternal health situation in the West African sub-region, WAHO had included a plan for the reduction in maternal and perinatal mortality rates in ECOWAS Member States through advocacy and training of trainers under its child survival programme of the 2003-2007 Strategic Plan. At the Assembly of ECOWAS Health Ministers held in July 2002, WAHO was asked to develop a comprehensive plan for the sub-region to reduce maternal and perinatal mortality along the Millennium Development Goal (MDG) and the NEPAD Goals. This led to the development of the 2004-2008 WAHO Strategy for the Reduction of Maternal and Perinatal Mortality in West Africa.

This strategy, whose preparation was informed by the AU Road Map and NEPAD objectives, was adopted in 2004. However, its implementation only began at the end of 2005. The mid-term review of this strategy, in September 2007, noted that 86.9% of programmed activities during the first two years had been carried out. Gaps were, however, identified and proposals for improvement made by the Steering Committee. Among other things, the review recommended integrating newborn and under-five health components into the strategy. The current document, titled Strategy to Accelerate the Reduction of Maternal, Peri-neonatal, and Under-five Mortality in West Africa 2009-2013 addresses this recommendation.

1.0 BACKGROUND

1.1. STATUS OF MATERNAL, PERI- NEONATAL AND UNDER-FIVES MORTALITY IN THE SUB-REGION

1.1.1 Maternal Mortality

Pregnancy and childbirth are events that ought to bring joy and happiness, and yet continue to be associated with many deaths and misery in many developing nations.

Global estimates of maternal mortality over the past 10 years have shown minimal changes. From these estimates, in the Year 2000, approximately 510,000 maternal deaths occurred. Of these, about 90% were in sub-Saharan Africa and Asia, 9% in other developing countries, and 1% in developed countries.

In the West African region, maternal mortality ratio (MMR) estimates vary from 110 to 2000 per 100,000 live births. The estimated average of 1,100 is 40 times higher than in developed countries.

Available records show that the chances of a woman dying from complications of pregnancy, childbirth or during an unsafe abortion is highest in Africa (1/15), followed by Asia (1/105); while it is very low in Europe (1/1,895) and North America (1/3,750).

Furthermore, for every maternal death that occurs in West Africa, there are approximately more than 30 women who would suffer short or long term disabilities such as chronic anaemia, infertility, incontinence, fistula, chronic pelvic pains, depression, and social exclusion. Another striking finding is the timing of maternal deaths: 24% of the deaths occur during pregnancy, 16% during labour, and the majority, 60%, in the immediate post-partum period; 72% of which occur in the first week after delivery.

Medical reasons for maternal deaths are similar all over the world: 80% of all deaths result from complications arising during pregnancy, childbirth, and the post-partum period. They include haemorrhage, (25%) septicaemia (15%), unsafe abortion (13%), eclampsia (12%), dystocia (8%), and other direct causes (ectopic pregnancies, rupture of the uterus, etc…) (8%).

The other 20% of maternal deaths result from pre-existing conditions aggravated by the pregnancy or its management. These include anaemia, malaria, viral hepatitis, heart problems, and HIV/AIDS.

Although a MMR of only about 0-11 per 100,000 live births may be attributed to these medical causes in developed countries, the same causes lead to an average of 1,100 deaths per 100,000 live births in West Africa, for several reasons-

-Firstly, in West Africa, several underlying non-medical factors (Table 1) create an environment that makes it more likely for these causes to lead to maternal death or a critical health condition. This is compounded by the prevailing poor socioeconomic status of women and some harmful socio-cultural practices in the sub-region.

Secondly, in West Africa, health services are poorly distributed, especially in rural areas where the majority of the population lives, limiting access to quality healthcare that is often required to manage pregnancy and childbirth-related complications.

Table 1: Non-medical causes for maternal mortality

(1) Early age at marriage
(2) High premium on childbearing
✓ High fertility rate
✓ Low contraceptive prevalence rate
✓ High % of Grande Multipare
✓ Poor family planning
(3) Low status of women
✓ High illiteracy rate
✓ Work force – High % women
✓ Poor nutrition in childhood
(4) Lack of decision making power
✓ Women require male authority to access medical treatment
(5) Poor access to resources
✓ High home delivery rate
(6) Lack of knowledge
(7) Poor health facilities
✓ Poor citing of health facilities
✓ Low staff morale
✓
✓ Poor equipments and supplies

Global concern about the high maternal mortality ratio in developing countries compared to developed countries, led to the 1st Global Conference in Nairobi – Kenya in 1987. The meeting was co-sponsored by a group of International agencies known as Safe Motherhood Interagency Group (I.A.G), which included(1) UNICEF, (2) UNFPA, (3) World Bank, (4) WHO, (5) IPPF and (6) Population Council.

At this meeting, the Safe Motherhood Initiative (SMI) was launched with a call to reduce the high maternal mortality by 50% by the year 2000. By this initiative, all the nations of the world were urged to take action to reduce MMR through better maternal health services and to assist developing countries reduce the high MMR.

The global SMI was more focused on advocacy with no specific measurable action in health care to be taken by developing countries. As a result, it was later broadened to include a range of activities aimed at improving women's health and status such as empowerment, improved education and nutrition for women, family planning and reduction of unsafe abortion. Although these were laudable activities, they were not capable of reducing MMR especially within a short period. In the West African region, several national and zonal safe motherhood committees were set up and through these, several advocacy meetings and conferences were held, which greatly sensitised the people and governments about the high MMR.

One major part of the safe motherhood effort in the West African sub-region was the large scale training of Traditional Birth Attendants (TBA), who were then supplied with delivery

kits for cleanliness during deliveries. Risk screening during antenatal care was also adopted as a strategy.

Nevertheless, after fifteen years of SMI, it has not succeeded in reducing maternal mortality in the West African sub-region for several reasons:

Firstly, there was too much focus on risk screening in antenatal care and training of traditional birth attendants. Evidence showed that formal risk assessment is not effective in developing countries and that every pregnancy must be considered to have inherent risks. What is therefore essential is for all women to have access to high quality obstetric care throughout their pregnancy especially during and immediately after childbirth when most complications arise. Also the most critical single intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth. The percentage of skilled attendants at delivery has remained below 50% in the West African Sub-region *(Table 2)*.

Table 2: Maternal Mortality and coverage of assisted deliveries by qualified personnel

ECOWAS Member State	MMR (100,000 live births	Birth attended by skilled person (% of all births) (Estimated)+	% deliveries in health facilities	No of health personal per 100,000 population		
				Physicians *	Nurses *	Midwives *+
Benin	**397** (EDS, 2006)	78 (EDS, 2006)	NA	1,34 ***(SNIGS, 2008 ; per 10.000)***	2,44 ***(SNIGS, 2008 ; per 5.000)***	5,46 ***(SNIGS, 2008, per 10.000***)
Burkina Faso	**484** (EDS, 2003) **307,3** (RGPH, 2006)	38 (EDS, 2003) 54 (SEM UNICEF, 2009)	65,2 (Ann.Statistiques MS, 2008)	3.9*	19.6*	3.9*
Cape Verde	**14,5** (EDS, 2005)	77,7 (EDS, 2005)	77,7 (EDS, 2005)	17.2*	55.6*	NA
Ivory Cost	**543** (EDS, 2005)	**60** (Statist Sanit Nat,, 2008)	**60** (Statist Sanit Nat,, 2008)	9.0*	32.2*	15.0*
The Gambia	**556** (NDHS, 2006)	55*	56*	3.5*	12.5*	8.2*
Ghana	**510***	50*	NA	6.2*	72.0*	53.2*
Guinea	**980** (EDS, 2005)	38 ((Statist San Nat, 2007)	NA	13.0*	55.7*	5.2*
Guinea-Bissau	**818 (2006, MOH)**	39	NA	16.6*	109.4*	12.7*
Liberia	**994** (LDHS, 2007)	46 (LDHS, 2007)	37 (LDHS, 2007)	2.3*	5.9*	5.3*
Mali	**464** (EDS, 2006)	**61** (Stat San Nat,, 2008)	NA	9.7*	13.2*	3.0*
Niger	**648** (EDS, 2006)	33*	NA	3.5*	22.9*	5.5*
Nigeria	**461** (MICS3, 2007)	38,9 (MICS3, 2007)	40.5 (MICS3, 2007)	7.5*	22.1*	6.6*
Senegal	**401** (EDS, 2005)	52 (EDS, 2005)	61,8 (EDS, 2005)	ND	ND	DN
Sierra Leone	**857** (EDS, 2008)	42,40 (EDS, 2008)	24,60 (EDS, 2008)	7.3*	33.0*	4.7*
Togo	**478** (EDS, 1998)	62,9 (MICS 3, 2006)	NA	7.6*	79.7*	10.9*

Sources: * The state of the world's children, 2009, NA =Information not available

Secondly there has been a significant increase in indirect causes of maternal deaths. HIV/AIDS is increasingly diagnosed in pregnant women in the sub-region, with prevalence rates reaching 8% in some countries. Mother-to-child transmission (MTCT) in the sub-region ranges from 20 to 40%. Malaria continues to cause anaemia in mothers, low birth weight, and neonatal deaths. Tuberculosis kills an average of 600,000 women aged 15 – 45 years in Africa.

Thirdly, the sub-region has had more than its share of civil conflicts, epidemics, and natural disasters such as floods. These, coupled with crippling financial and economic policies have further impoverished the sub-region.

Fourthly, adolescent health has received little attention in the sub-region; up to 13% of all maternal deaths in the sub-region occur in adolescents mainly as a result of abortion-related complications. Most of the disabilities resulting from childbirth-related complications especially fistulae occur among adolescents. In Africa, up to 2.8 million adolescents give birth annually. Delaying marriage and first birth until women are physically, emotionally and economically prepared to become mothers is important for safe motherhood. Family planning services have suffered a setback in the sub-region because of reduced funding by donors. Total fertility rate (TFR) in the sub-region is high at an average of 5.8% while Contraceptive Prevalence Rate (CPR) is low with an average of 14% (Table 3).

Fifthly, non-medical causes of maternal mortality (Table 1) continue to fuel MMR increases. Inadequate political and financial commitments, the low status of women, in particular weak decision-making power, low financial base, and poor access to health services (home-based deliveries vary from 40% to 60%) remain barriers to attaining health-related MDGs.

Table 3: West Africa Population and Health Indicators

ECOWAS Member State	Total population (x 1000)	Total fertility rate	Contraceptive Prevalence Rate CPR (modern methods) %	GNI per inhabitant ($ EU)
Benin	8224,643 (INSAE, 2008)	5,7 (EDS, 2006)	6,2 (EDS, 2006)	570*
Burkina Faso	14784*	6,2 (EDS, 2003)	10 (EDS, 2003)	430*
Cap-Verde	478, 167 (Statist. Nat. 2005)	2,9 (EDS, 2005)	61,3 (EDS, 2005)	910*
Ivory Cost	1709*	4,6 (EDS, 2005)	13 (EDS, 2005)	320*
The Gambia	23478*	4,8*	18*	590*
Ghana	9370*			400*
Guinea	1695*	5,5*	6 (EDS, 2005)	200*
Guinea-Bissau	3750*	7,1*	10*	150*
Liberia	12337*	5,2 (LDHS, 2007)	11 (LDHS, 2007)	500*

ECOWAS Member State	Total population (x 1000)	Total fertility rate	Contraceptive Prevalence Rate CPR (modern methods) %	GNI per inhabitant ($ EU)
Mali	3124*	6,6 (EDS, 2006)	8,2 (EDS, 2006)	840*
Niger	14809,3*	7,1(EDS, 2006)	12 (EDS, 2006)	930*
Nigeria	140000 (2006)	5,7 (MICS3, 2007)	14 (MICS3, 2007) 15 (NHS, 2008)	820*
Senegal	11600 (EDS, 2005)	5,3(EDS, 2005)	10,3 (EDS, 2005)	260*
Sierra Leone	5400 (EDS, 2008)	5,1 (EDS, 2008)	8,2 (EDS, 2008)	360*
Togo	5 649,550 (NS, 2008)	5,17 (AS-SR, 2003	11 (MICS 3 (2006)	ND

Sources: * The state of the world's children, 2009, NA =Information not available

Consequently, the Prevention of Maternal Mortality Network (PMMN) composed of a multi-sectoral and multidisciplinary research team with funding from Carnegie Cooperation of New York was established. The PMMN planned and executed interventions in several West African countries including Ghana, Nigeria, and Sierra Leone, to reduce maternal mortality as a model that could be adapted for developing countries. It evolved several strategic models as basis for the attainment of the objective of specifically reducing maternal mortality within a short period of time (Maine, 1997; Rosenbfield, 1997).

The interventions were based on the concept that serious complications, which result in maternal death, may be difficult to prevent or predict, but with timely treatment, the likelihood of this complication resulting in death may be averted or reduced. In order to reduce maternal death, all parturient must be provided with access to good obstetric care at a health facility, which is the best place for handling all complications.

There are several factors which affect access and use of services. Thaddeus and Maine in 1990 developed the three delay models to describe the different stages at which access to appropriate care can be impeded. These delays include: (i) delay in seeking care from the home or community (delay 1), (ii) delay in reaching the facility due to distance, bad roads etc… (delay 2) and (iii) delay in starting the effective treatment after reaching the facility (delay 3). These delays contribute to the high mortalities associated with obstetric complications (Thaddeus & Maine, 1990).

The PMMN successfully demonstrated through its projects that reducing maternal mortality in these West African countries was possible through improvement in availability, quality and utilisation of emergency obstetrics' care for women with serious complications in these countries. It has been demonstrated that strategies for reducing maternal mortality must consist of:

- Family planning services to reduce fatality and lifetime risk of maternal death,
- A safe abortion service to reduce the incidence of abortion related complications, and
- Emergency obstetric care to treat pregnancy related complications and reduce the likelihood of these complications leading to maternal death.

Out of these three strategies, the intervention that will easily ensure reduction of maternal mortality especially in a short period is wide access to emergency obstetric care to treat complications when they occur. This has been clearly demonstrated in this sub region by the PMMN.

The efficient vehicle for bringing emergency obstetric care to the populace is through the primary health care system. This system ensures that for every four primary health care facilities, there is a comprehensive health care centre capable of delivering emergency obstetric services as shown in (Table 4) (NPHCDA 2001).

Table 4 : Basic Obstetric Care and Complete Obstetric Care Packages

BASIC EMERGENCY OBSTETRIC CARE (BEmOC)
1. Injectable antibiotics 2. Injectable oxytoxics 3. Injectable anticonvulsants 4. Manual removal of placenta 5. Removal of retained products (Curettage) 6. Assisted vaginal delivery 7. Essential care for new-borns
COMPREHENSIVE EMERGENCY OBSTETRIC CARE (CEmOC)
1. All basic EmOC functions 1 – 7 plus 2. Caesarean section 3. Blood transfusion

UNICEF/WHO/UNFPA Guidelines

The Primary Health Care approach provides basic obstetric care composed of antenatal, delivery and postnatal care in addition to providing the emergency obstetric care. This arrangement is known as Basic Health Unit (BHU) of the Primary Health Care System adopted at the Alma Ata Conference of 1978 and called the Alma Ata Declaration of 1978. The Basic Health Unit is expected to provide preventive, promotive and curative services and obstetric care.

For this system to be effective, there must be adequate communication and transportation between primary health care centre and comprehensive health care centres on the one hand and between the comprehensive health care and other immediate levels like the secondary and tertiary levels.

Primary health care level is usually the first level of contact between women and the health care system. At this level, skilled attendant must be provided. It is also desired that this level of health care must be able to deliver a full package of maternal, newborn and child health care including family planning services and the Integrated Management of Childhood and Neonatal Illness (IMCNI).

WAHO uses the life-cycle approach for maternal, perinatal, and infant mortality reduction. This approach helps women access the entire package of reproductive health services they desire and need throughout their lives.

Young boys and girls should be educated about gender parity, sexuality, and reproduction. Girls should be properly fed for growth and development to prevent stunting. Information, advice, and services related to sexuality and contraception should be offered to adolescent girls and boys. For sexually-active men and women, information and services to help prevent unwanted pregnancies and sexually-transmitted diseases, including HIV/AIDS, should be provided. Post-abortion services should be available when a manual vacuum aspiration (MVA) is performed where permitted by local laws. Advice and services after a miscarriage or a manual vacuum aspiration are also available. Women of child-bearing age should receive prenatal care and other services to ensure good health throughout the pregnancy. They should be able to benefit from professional assistance during delivery and receive family planning services for birth spacing. They should also receive information on the prevention and treatment of sexually-transmitted diseases. For elderly women, they should have access to uterine or other types of cancer screening services. They should also receive assistance to prepare them for menopause.

All these services should be delivered by midwives trained in public and private health service delivery. WAHO believes that this life-cycle approach can be properly integrated into the maternal and perinatal mortality reduction action plan.

1.1.2 Peri-Neonatal and Under-five Mortality

Of the 9.4 million peri-natal deaths that occur globally, 98% occur in developing countries, the highest rates being in Africa. The current status of newborn health in African region is characterised by high neonatal morbidity and an average mortality rate estimated at around 45 per 1000 live births and (Table 5). The Perinatal Mortality Rate (PNMR) estimated at 76/1000 live births is also unacceptably high.

Forty-four percent of under-five deaths throughout the world occur in the African Region where 4.6 million children under five years of age are estimated to die each year. Nearly 40% of these deaths occur during the first month of life and almost as many infants in the region are still-born every year.

Table 5: Health indicators of under five in West Africa Countries

ECOWAS Member State	Under five morality rate (per 1000 live births	Infant mortality rate (per 1000 live births)	Neo natal mortality rate (per 1000 live births)	Number of annual births (x 1000)	Number of annual deaths of under fives (x 1000)	4th ANC coverage %
Benin	**125** ((EDS, 2006)	**67** ((EDS, 2006)	32 ((EDS, 2006)	365*	45*	ND
Burkina Faso	**184** (EDS, 2003)	**81** (EDS, 2003)	31 (EDS, 2003)	654*	125*	17,6
Cap Verde	**22,6** (EDS, 2005)	**20,2**	12,9 (EDS, 2005)	ND	ND	72,3 (EDS 2005)
Ivory Cost	**125** (EDS,	**84** (EDS, 2005)	41(EDS,	687*	87*	ND

	2005)		2005)			
The Gambia	**99** (NHS, 2003)	**75** (NHS, 2003)	31,2 (NHS, 2001)	60*	7*	ND
Ghana	**115***	**73***	43*	703*	81*	ND
Guinea	**163** (EDS, 2005)	**91** (EDS, 2005)	39 (EDS, 2005)	377*	57*	ND
Guinea Bissau	**198***	**118***	47*	84*	17*	ND
Liberia	**110** (LDHS, 2007)	**71** (LDHS, 2007)	32 (LDHS, 2007)	189*	25*	ND
Mali	**191** (EDS, 2006**)**	**96** (EDS, 2006)	46 (EDS, 2006)	595*	117*	ND
Niger	**198** (EDS, 2006**)**	**ND**	33 (EDS, 2006)	701*	123*	ND
Nigeria	**138** (MICS3, 2007)	**86** (MICS3, 2007)	47*	5959*	1126*	ND
Senegal	**121** (EDS, 2005)	**61** (EDS, 2005)	35 (EDS, 2005)	439*	50*	39,8 (EDS, 2005)
Sierra Leone	**140** (EDS, 2008)	**89** (EDS, 2008)	36 (EDS, 2008)	268*	70*	
Togo	**100***	**65***	42 (EDS II, 1998)	245*	25*	53,5 (AS-SR de 2003)

Sources: * The state of the world's children, 2009, NA =Information not available

Four million neonatal deaths are reported to occur annually, but due to under registration of births, this may not be an accurate representation of the true situation. The two-thirds rule clearly illustrates the unique needs of newborns that must be addressed in the context of maternal and child health services. Nearly two-thirds of infant deaths occur during the first month of life. Two-thirds of these die in the first week and two-thirds of those die within the first 24 hours. The common causes of these deaths are:

1. Birth asphyxia– 30 - 40%
2. Prematurity and low birth weight (LBW) – 29%
3. Infections – 20%
4. Birth trauma-10%

Annually at least 1.2 million newborns die from complications during delivery. About 60% of deliveries take place in the communities and most of the deaths occur at home, in rural areas and in disadvantaged urban communities. The vast majority of the deaths are preventable through appropriate health care. Skilled care before, during and immediately after childbirths can make a critical contribution to the prevention of maternal and perinatal death and disabilities. A mother's death is often fatal to her newborn and the surviving children are 3–10 times more likely to die within 2 years than those whose mothers survive.

Efforts have been directed towards increasing the proportion of births assisted by skilled attendants. The poor human resources development, lack of management plan and the brain drain of skilled personal within and outside Africa and from public to private sector have hampered progress. This situation is worsened in many WAHO countries by the HIV pandemic, disasters such as civil conflicts and natural emergencies, which divert resources and erode the gains in health.

Under-Five Mortality and Priority Interventions

Over the past 20 years, efficient public health interventions and economic and social gains worldwide have spurred improvements in the field of child survival. Yet, about 10.6 million under-fives continue to die each year, 4.6 million of whom die in the African region. Nearly three quarters of these deaths occur during the first month of life, whilst two-thirds occur during the first seven days of life. Most under-five deaths are caused by a small number of common conditions (infections such as malaria, diarrhoea, pneumonia, and increasingly, HIV/AIDS in high-prevalence countries), malnutrition and neonatal conditions. These cases may occur singly or jointly and they are largely preventable or treatable using available low cost interventions.

Among the priority survival interventions for every newborn and under-five in every Health District, are newborn care, from the perspective of the life cycle and a continuum of care approach; proper feeding practices for under-fives, particularly through exclusive and optimal breastfeeding, micronutrient supplementation and de-worming; immunisation services, including the use of new vaccines; prevention of mother-to-child transmission of HIV/AIDS, and the use of Integrated Management of Childhood Illness (IMCI). In order for effective and low cost interventions to have a high impact, they must be implemented on a large scale.

Tableau 6: Health indicators for under-fives in the ECOWAS Member States

ECOWAS Member State	DTP 3	OPV3*	Measles *	% Under Wight at birth *	% Infants exclusively breastfed for 6months *	%under-fives suffering from moderate and severe stunting (NCHS/WHO) *	Vit A supplementation coverage rate (6–59 months) *full coverage*	% under fives sleeping under a treated mosquito net *
Benin	67	64	61	15	43	7	73	54
Burkina Faso	99	99	94	16	7	23	73	48
Cap Verde	81	81	74	13	57	ND	ND	ND
Ivory Cost	76	75	67	17	4	7	4	36
The Gambia	90	85	85	20	41	6	82	63
Ghana	94	94	95	9	54	5	77	61
Guinea	75	62	71	12	27	9	94	44
Guinea Bissau	63	64	76	24	16	7	64	46
Liberia	88	84	95	ND	35	6	85	59
Mali	68	62	68	19	38	13	89	32
Niger	39	55	49	27	9	10	95	33
Nigeria	28,1 *(MICS, 2007)*	27,5 *(MICS, 2007)*	38,4 *(MICS, 2007)*	13,73 *(MICS, 2007*	11,7 *(MICS, 2007)*	34,19 *(MICS, 2007)*	36 *(MICS, 2007)*	3,5 *(MICS, 2007)*
Senegal	74,1	68,9	61,2	6,3	34*(EDS,*	7,6 *(EDS, 2005)*	75 *EDS,*	7,1 *EDS,*

	(EDS, 2005)	*(EDS, 2005)*	*(EDS, 2005)*	*(EDS, 2005)*	*2005)*		*2005)*	*2005)*
Sierra Leone	*60 (EDS, 2008)*	50 *(EDS, 2008)*	60 *(EDS, 2008)*	24	11,20 *(EDS, 2008)*	36,4 *(EDS, 2008)*	86	25,80 *(EDS, 2008)*
Togo	88	78	80	11,5 *(MICS 3, 2006)*	28 *(MICS3, 2006)*	14	96 *(NS, 2008)*	48
CWA	**69**	**71**	**69**	**15**	**23**	**10**	**67**	**38**

Sources: * The state of the world's children, 2009, NA =Information not available **(CWA) = Central and West Africa**

However, to attain MDG 4 by 2015, the African region, especially sub-Saharan Africa, must achieve a mortality rate from1% to 8.2%. Governments, and especially those of the West African sub-region, must fully play their roles as stakeholders in the efforts to promote an integrated life-cycle approach for the growth and development of under fives, and a significant reduction of neonatal and under-five mortality.

Table 7: Trends in U5MR from 1990 to 2005, progress accomplished and required levels for 2015 in ECOWAS countries

ECOWAS Member State	U5MR 1990	U5MR 2000	U5MR 2003/2008	MDG 4 target 2015	Progress 1990-2006	Progress required 2007-2015	Progress towards MDG4
Benin	185	160	**125** (EDS, 2006)	62	1.4	9.7	Inadequate
Burkina Faso	210	198	**184** (EDS, 2003)	69	0.1	12.1	None
Cape Verde	45	30	**22,6** (EDS, 2005)	20	3.5	5.9	Ongoing
Côte d'Ivoire	155	173	**125** (EDS, 2005)	52	1.2	10.1	Inadequate
Gambia	154	128	**99** (NHS, 2003)	51	1.9	8.8	Inadequate
Ghana	126	102	**115***	42	1.9	12.2	None
Guinea Conakry	240	175	**163** (EDS, 2005)	84	2.4	8.0	Inadequate
Guinea Bissau	253	245	**198***	80	1.01	10.2	Inadequate
Liberia	235	235	**110** (LDHS, 2007)	78	0	12.2	None
Mali	254	233	**191** (EDS, 2006**)**	83	0.9	10.6	None
Niger	320	270	**121** (EDS, 2005)	107	1.5	9.6	Inadequate
Nigeria	230	184	**140** (EDS, 2008)	77	1.2	10.1	Inadequate
Senegal	148	138	**100***	50	1.6	9.4	Inadequate
Sierra Leone	302	316	**125** (EDS, 2006)	101	0.4	11.4	None
Togo	152	142	**125** (EDS, 2006)	51	2.0	8.6	Inadequate

Source: HDR, 2003,WHO Statistics, 2007,UNICEF,2007, Progress for children Nr6

Of the 15 ECOWAS countries, five (Burkina Faso, Ghana, Liberia, Mali, and Sierra Leone,) have made no progress towards achieving MDG 4 and only Cape Verde is on track. Other countries have made inadequate progress. In order to attain the 2015 targets the rate of progress has to increase from 5.6 to 12.2 times with an average of 8.2 times. There is therefore the need to accelerate and sustain the efforts at attaining the goals in all countries in the sub-region.

1.2. BRIEF REVIEW OF OTHER STRATEGIES IN THE SUB-REGION

Many other initiatives aimed at improving maternal, newborn, and child health situations have been implemented in the region under the auspices of different institutions, structures, and partners. The major ones are: Vision 2010, Initiative of the Foundations of Planning and Action Networks (CAPA), and the "Save Newborn Lives" initiative.

1.2.1 World Health Organisation (WHO) Safe Motherhood initiative (SMI)

A joint meeting of the safe Motherhood Interagency Group was held in 1997 in Colombo, Sri Lanka to review the lessons learnt over the ten years of the SMI. The meeting proposed ten action messages for Safe Motherhood. WHO has set up a Regional Reproductive Health (RH) Task Force in Africa. The Task Force, together with other Partners, has recommended the development of a road map for the reduction of maternal and perinatal mortality (RMNM). This was actualised in Harare February 2004.

1.2.2 Prevention of Maternal Mortality Network (PMMN)

This is a regional prevention of maternal mortality project involving 20 countries including 8 in the West African sub-region. The main objectives of the Network are:

(i) To strengthen the capacity of African Institutions in a variety of settings,

(ii) To foster networking of all cadres of professionals experienced in the field of maternal mortality,

(iii) To develop operational research methods for use in maternal mortality projects,

(iv) To inform decision makers about the importance of maternal mortality and to share information on most effective strategies to reduce it.

1.2.3 Making Pregnancy Safer (MPS) Initiative

This initiative was launched in 2000 by the WHO/AFRO to enhance WHO's efforts in Safe Motherhood. The Initiative states that both improvement of the health services and actions at

the community level are required to ensure that women and their newborns have access to the skilled care they need, when they need it.

This project is operational in some countries including two (Senegal and Nigeria) in West Africa.

1.2.4 Vision 2010 Initiative

In May 2001, the First Ladies of West and Central African States agreed to the Bamako Declaration which was the result of the Vision 2010 Forum, a two- day forum on Reduction Of Maternal and Neonatal Mortality in West and Central Africa. In the Declaration, the First Ladies committed themselves to develop a plan of action by the end of 2001 and requested countries of the two regions to designate an annual day for observance to draw attention to maternal and neonatal mortality reduction in Africa. The Vision 2010 Forum not only raised awareness of the magnitude of maternal and neonatal mortality in Africa, but also argued for policies that promote the right of every woman to expect that her baby will be born alive and healthy and the right of every baby to be a living and healthy mother. They agreed that the knowledge and technology needed to save the lives of mothers and newborn infants are already available. It was also recognised that much had not been achieved since the launching of the Safe Motherhood Initiative in 1987 and the World Summit for Children in 1990. The First Ladies from West African Countries of Benin, Burkina Faso, Ghana, Guinea, Mali, Nigeria and Representatives of the First Ladies of Gambia and Togo attended the forum.

1.2.5 Basics – Catchment Areas Planning and Action (CAPA) Initiatives

This is a community-based approach to child health services, whose main focus is catchment areas of a primary health centre. Partnerships are developed between members of the community, public and private sector providers.

The CAPA process:

(i) Provides a forum for discussion and identification of felt needs in the community,

(ii) Supports the community to identify their health problems, rights and responsibilities,

(iii) Develops a practical plan to complement government efforts,

(iv) Implementation of the plan by the community,

(v) Monitoring and supervision by the community.

1.2.6 UNFPA Strategy

UNFPA strategy focuses at global and national levels on improved partnerships, advocacy, national capacity building, resource mobilisation, sustainability and technical support

1.2.7 Save The Children – Saving Newborn Lives Initiative

The strategy proposed includes:

(i) Research to promote best practice
(ii) Promotion of partnership
(iii) Strengthening of newborn programme
(iv) Strengthening and offering of effective health service
(v) Strengthening capacity building to provide essential care for newborn

1.2.8 JHPIEGO – Strategy

(i) That all pregnant women are at risk
(ii) Prepares mother and family to manage emergency complications
(iii) Ensures efficient and effective health care facilities

1.2.9 UNICEF – Strategy

(i) Strengthening communication
(ii) Supporting the Bamako Consensus
(iii) Community approaches

1.2.10 Family care International

Works in the area of family planning, unsafe abortion and gender violence. It has particular emphasis on (1) Safe Motherhood with a Skilled Care Initiative SCI and (2) Adolescent sexual and reproductive health.

1.2.11 I.P.A.S.

The programme includes training, research, advocacy, distribution of equipment and supplies for reproductive health care and information dissemination. It has several projects on post abortion care in the sub-region.

1.2.12 Initiative For Maternal Mortality Programme Assessment

IMMPACT is a global 5 – 7 year (2002 - 2009) research initiative for evaluation of safe motherhood programmes. It is coordinated by the University of Aberdeen (Scotland) and involves 5 pilot countries among which 3 are in the ECOWAS region (Burkina Faso, Ghana and Mali) with that of Burkina Faso implemented by Centre MURAZ in Bobo- Dioulasso. The IMMPACT objectives are to:

i) Identify improved methods and tools for measuring the results of maternal health programmes;
ii) Provide scientific proof of the efficacy of the strategies identified as most effective in reducing maternal and perinatal mortality and morbidity;
iii) Ensure a better capacity for evidence-based decision making in developing countries for the evaluation of proposed health programmes.

IMMPACT builds partnerships with twelve major international or bilateral agencies and foundations.

1.2.13 Emergency Obstetric and Neonatal Care (EONC)

Initiated by the Society of African Gynaecologists and Obstetricians (SAGO), the Emergency Obstetric and Neonatal Care (EONC) programme is introduced into the training sessions of health workers and curricula of the health institutions. This is with the collaboration of JHPIEGO, UNFPA-etc…

1.3. WAHO STRATEGY DEVELOPMENT PROCESS

The WAHO 2004-2008 Maternal and Perinatal Mortality Reduction (MPMR) strategy was developed as recommended by the Assembly of ECOWAS Health Ministers. This strategy was drawn up after a lengthy planning process. However, the Child Health component was not adequately taken into consideration. This is the gap that the current 2009-2013 strategy will fill.

1.4 THE STRATEGY TO ACCELERATE MATERNAL, PERI- NEONTAL AND UNDER-FIVE MORTALITY REDUCTION

1.4.1 Objective

To contribute to a 75% reduction in maternal mortality and a two-thirds reduction in under-five mortality using the 1990 baseline data by the MDG target of – 2015, using a life cycle approach.

1.4.2 Mission Statement

The strategy to accelerate maternal, peri-neonatal, and under-five mortality reduction shall focus on:

Advocacy

Develop advocacy targeting groups identified for the purposes of Maternal, Peri-Neonatal, and Under-Five Mortality Reduction (MPNU5MR).

Social mobilisation

Support existing Maternal, Newborn, and Child Health (MNCH) social mobilisation programmes.

Capacity building

Support country capacity building processes.

Partnership development

Mobilise partners and build partnerships throughout the region.

- *Dissemination of best practices/approaches*

Enable dissemination of evidence - based approaches in maternal, perinatal and child health care.

1.4.3. Core principles of WAHO

In the implementation of the strategic plan, the following core principles of WAHO will remain the guiding principles:

- WAHO will act as an enabler rather than a provider. WAHO will strengthen, connect and synchronise existing health organisations, intervention and services. It would act as an enabler, building capacity and developing information networks in order to maximise the effectiveness of all health related interventions in the sub-region.

- WAHO will support community – focused, evidence- based interventions. Acknowledging that change is good only if it improves the quality of life of West Africans, WAHO is committed to introducing smart innovations in health. This involves maintaining and applying up-to-date information on the health – related needs of its target population and on proven approaches and best practices within the sub-region.

- WAHO will promote the transfer and sharing of sub-regional health resources. Ensuring continuous access to the best available health resources in the sub region (including information, medicines and vaccines, equipment and medical manpower) is one of the most effective means of improving the overall standard of health of West Africans. By building networks for information exchange and human resource sharing between ministries, colleges, universities, practitioners, NGO's and other health entities, WAHO seeks to strengthen capacity building throughout the sub-region, thereby ensuring that West Africans receive the best available care and treatment regardless of their location.

2.0 DESCRIPTION OF THE STRATEGY FOR THE ACCELERATED REDUCTION OF MATERNAL, PERINEONATAL AND UNDER-FIVE MORTALITY (RMPNU5M) IN WEST AFRICA 2009-2013

2.1 THE STRATEGIC FRAMEWORK FOR THE MAIN ACTION AREAS (SEE ANNEX 1 FOR MORE DETAILS)

2.1.1 Advocacy

Narrative: Maternal, Newborn and Child Health (MNCH) is a human right and the legal, social, economic factors, and the health care system depriving women, newborns, and under-fives from accessing their rights should be addressed. Advocacy shall be an efficient tool throughout the region to accelerate the reduction of maternal, peri-neonatal, and under-five mortality. There are nine major areas where advocacy shall be effectively utilised: namely; (1) Legislation, (2) Resource Mobilisation, (3) Multi-sectoral Approaches (4) Policy Development, (5) Maternal Health, (6) Maternal and under-five Nutrition, (7) Newborn and under-five Health, (8) Adolescent Heath, and (9) Family Planning Services.

2.1.1.1. Legislation

Statement of the Problem (S.P.): There are laws, policies and cultural practices in the sub-region that mitigate against maternal, newborn and child health including their survival.

Strategic Objective (S.O)
Engage in political advocacy to change the laws, policies or cultural practices impacting on MNCH.

Representative Activities (R.A)

- Advocate for the promotion of laws that protect mothers and children and guarantee their health and survival
- Involvement in political advocacy to promote maternal, newborn, under-fives' health, and reduction of MPNU5M in the sub-region
- Encourage women and girls' education
- Encourage laws against early marriage and safe abortion,
- Combat female genital mutilation
- Work to promote and implement the Convention on the Rights of Children

2.1.1.2. Resource Mobilisation

.S.P: Resource allocation remains inadequate for maternal, neonatal and child health programmes for the reduction of MPNU5M in the sub-region

S.O: Mobilise resources throughout the sub-region for the reduction of MPNU5M.

Representative activities:

- Encourage inclusion of a budget line for MMR/PNMR in national budgets,
- Ensure a sector-wide approach to generate programme funds
- Provide a special WAHO fund for MPNU5M reduction programmes

2.1.1.3. Multi-sectoral Approach

S.P: Resources are available in other sectors but remain inadequate in the health sector.

S.O.: Seek resources for health from other sectors in the sub-region and elsewhere.

R.A.: Solicit for resources from other sectors and international partners for programmes.

2.1.1.4. Policy Development

S. P.: National policy may not specifically support the attainment of MNCH goals

S.O.: Ensure the development of national policies that promote maternal, neonatal, and under- five health

R.A

- Ensure that countries develop policies on maternal, peri-neonatal, and under-five health
- advocate for ECOWAS countries to develop laws that recognise the reduction of maternal, peri-neonatal, and under-five mortality as a national priority
- advocate for the creation of a budget line for the reduction of maternal, peri-neonatal, and under-five mortality in each country
- Promote family life education that includes subjects on maternal, neonatal and child health
- Promote the institutionalised and systematic implementation of maternal, newborn and under-five death audits
- Promote universal basic education in member countries,
- Develop national policies to promote the use of family planning services.

2.1.1.5. Women and Child Nutrition

S P.: Poor and inadequate nutrition for women and the girl child affects their reproductive performance. Additionally, malnutrition contributes significantly to under-five mortality.

S. O.: Advocate for adequate nutrition for females throughout the life cycle. Promote safe infant and young child feeding practices

R.A

.

- Encourage nutrition campaigns in the sub-region
- Promote exclusive breast feeding, and safe infant and young child feeding practices
- Address cultural food taboos in the sub-region that mitigate against adequate female and under-five nutrition

2.1.1.6. Pregnant Women and Maternal Health

S. P. Maternal mortality remains a major concern. Maternal mortality ratios remain high in all countries in the West African sub-region. They range from 110 to 2000 per 100,000 live births. Confronted with this situation, each country, based on the recommendations of Vision 2010 for The Reduction of Maternal and Neonatal Mortality, and the African Union (AU) Road Map, was expected to develop its Road Map and National Strategy for the Reduction of Maternal and Neonatal Mortality. Nevertheless, not all countries are at the same level of implementation of MNMR strategies.

S.O. : Support scale up of the Road Map/MNMR Strategies in countries of the West African sub-region.

R.A

- Advocate for budgetary allocation to the health sector to be increased to 15% and, at best, to US$ 34 per capita
- Advocate for a RH budgetary allocation
- Advocate for the allocation of 5% of the RH budgetary allocation for ensuring sustainable RH product delivery
- Promote the introduction of Emergency Obstetric and Newborn Care (EmONC) in training curricula

2.1.1.7. Newborn and Under-Five Health

S. P.: Neonatal and under-five mortality rates remain very high in the West African sub-region with a neonatal mortality rate of 45/1000 live births and under-five mortality rate of 169/1000 live births. Most deaths are from preventable causes and resource allocation for the promotion of the health of under-fives has been minimal.
S.O. : Promote newborn and child health in the sub-region

R.A.:

- Develop an advocacy document focusing on the 0-5 age group, including newborns,
- Advocate for free emergency care for children aged 0-5, including newborns
- Advocate for increased resource allocation to newborn and child health
- Advocate for scaling up of efficient, evidence-based interventions for newborns and under-fives.

2.1.1.8. Adolescent Health

S. P.: Adolescent pregnancies and abortions contribute to the sub-region's high

maternal mortality ratios. Unfortunately, few health services have been established in these countries to provide effective care for this target group. Adolescent health services need to be expanded in the sub-region.

S.O.: Facilitate the expansion of health facilities that can provide adolescent health care.

R.A :

- Advocate for laws on the minimum age at marriage for adolescents
- Promote family life education that includes subjects on maternal, perinatal and child health
- Promote peer education
- Promote the establishment of youth friendly centres
- Advocate for the scaling up school health programmes

2.1.1.9 Family Planning Services

S. P: The low level of uptake of Family Planning (FP) services contributes to the high maternal mortality levels in the sub-region.

S.O.: Facilitate the establishment of accessible and quality FP services in the sub-region. Promote sustainable provision of FP/RH products

R.A :

- Promote the marketing of FP services
- Promote community-based distribution of RH products
- Promote male involvement in family planning
- Promote the sustainable provision of Family Planning/RH products

2.1.2. Social Mobilisation

In the sub-region, women lack access to quality pre- and postnatal services and during delivery that are critical for their survival. The same applies to children. Community health care is inadequate and some cultural practices contribute to the poor maternal and child health indices in the region. Women and children, additionally suffer from many nutritional problems that further adversely affect their health. Barriers to access include poor roads, long distances, cost of care and limited capacity of health care providers. Many of these problems can be overcome through practical and low-cost solutions, developed with and by the community. In order to improve access to care, social mobilisation shall be used in the following action areas (1) *health insurance schemes* /community cooperatives, (2) cost sharing, (3) community governance / community management committees, (4) male participation, and (5) female decision-making power.

2.1.2.1. Health insurance schemes

S. P: Health insurance schemes are very poorly developed in the sub-region.

S.O.: Promote the establishment of community health cooperatives / Health insurance schemes and their funding contribution to maternal and under-five health programmes.

R.A

- Encourage individuals and families to adopt health insurance policies
- Encourage community participation in the provision of transport for pregnant and parturient women and post partum mothers and sick children
- Promote community participation in the provision of emergency care to pregnant women, mothers and children,
- Promote community participation in health services management.

2.1.2.2. Cost Sharing

S P.:
The high cost of health care is currently borne by poor families and prevents timely access to quality health care.

S.O.: Promote cost sharing between the family and the community.

R**.A.**

- Organise cost sharing (transport to health centre for emergency cases) between the community, the family, local authorities, the State.
- Organise adequate supplies of equipment, drugs, and medical consumables to health facilities
- Promote emergency care delivery without user fees (without pre-payments, no cost).

2.1.2.3. Community Health Management

S. P.: In the sub-region, communities are not sufficiently involved in health management.

S.O.: Ensure community participation in the management of health issues, particularly those of the mother and child.

R.A.

- Promote community identification of mother and child health problems
- Encourage community involvement in managing maternal, newborn, and under-five health problems
- Encourage community involvement in managing health facilities (Establish co-management committees that are accountable to the community)
- Promote community participation in monitoring activities at the health facility.

2.1.2.4. Male Participation

S P.: In the West Africa sub-region, men are not sufficiently involved in maternal, neonatal, and under-five health (MMNU5H).

S.O.: Increase the level of engagement of men in maternal, neonatal, and under-five health

R.A

- Sensitise men to get them more involved in maternal, neonatal, and under-five health
- Promote behavioural change activities
- Encourage peer education
- Create a conducive environment for male participation in caring for maternal, neonatal, and under-five health problems

2.1.2.5. Empowerment of Women

S. P.: In the sub-region, low levels of decision-making power and female poverty are two major social factors responsible for the high maternal, peri-neonatal and under-five mortality.

S.O.: Guarantee more autonomy and equality of access to resources for women

R.A.

- Improve women's status within the community and the family regarding decision-making
- Promote the establishment of women's cooperatives and Economic Interest Groups (EIG) through income-generating activities
- Ensure the equitable representation of women in all levels of decision-making

2.1.3 Capacity Building

Human resources development is essential in order to provide good quality maternal, perinatal and child health care in the sub-region. Institutions in the sub-region need to be developed and curricula revised and adapted to meet the new training requirements. Additionally, managerial training is required for effective leadership, and monitoring of the programmes. Three areas of action where capacity building will be effectively utilised to improve maternal, peri-neonatal and under-five health include, (1) human resources development (2) institutional development (3) management and leadership.

2.1.3.1 Human resources development

S. P.: Human resources development is inadequate in the sub-region to provide quality maternal, peri-neonatal and child health care services

S.O.: Promote the development of competent human resources in the sub-region.

R A.

- Train trainers and practitioners to care for maternal, newborn, and under-fives at all levels of health care.

- Delegate certain tasks to midwives, nurses, and community health workers in order to mitigate problems created by staff shortages
- Ensure equitable distribution of staff dedicated to maternal, newborn, and under-five health care

  Ensure career development incentives and sufficient motivation for health workers to avoid brain drain.

2. 1.3.2 Institutional Development

S P.: In the sub-region the number and quality of health training institutions are inadequate.

S.O.: Promote the establishment and strengthening of health training institutions.

R.A

- Develop harmonised training curricula, adapted to maternal, newborn, and under-five health needs
- Provide technical support and assistance to training institutions for maternal, newborn, and under-fives
- Promote youth/adolescent-friendly health services
- Decentralise training institutions
- Develop partnership agreements between the various training institutions
- Strengthen care facilities for the provision of quality care
- Encourage accreditation and re-accreditation for training / care institutions

2.1.3.3 Management and Leadership

S P.: Health care services at district and community levels require good managers and leaders to maximise resource utilisation and improve service delivery for maternal, perineonatal and under-five health care.

S.O.: Ensure training in management for health care providers. Develop community leadership skills to care for MNU5H.

R.A

- Train care-givers in health services management to care for mothers, newborns, and under-fives, and to assume leadership roles
- Ensure sustainable product delivery,
- Promote effective decentralisation of MNU5H health services
- Develop efficient monitoring and evaluation programmes for MNU5H
- Facilitate leadership development at the community level

2.1.4 Partnership Development

Reduction of MPNU5 M should be a priority for governments, policy makers, health care providers and all civil societies. There is the need to form alliances among various groups- men's group, religious groups, NGOs, donors, different sectors of government,

media and youth groups. WAHO would encourage formation and sustainability of partnership within the region. The main areas of intervention for partnership development to improve maternal and child health include:

- Strengthening partnerships
- Resource mobilisation with partners
- Partners' forums
- Monitoring/Evaluation

2.1.4.1. Strengthening partnerships

S. P.: Efforts to reduce MPNU5M require active partnerships throughout the sub-region.

S.O.: Strengthen sub-regional partnerships

R.A.

- Identify new partners who work in the MNU5 health field
- Review memoranda of understanding and conventions in order to adapt them to new requirements,
- Set up partnership coordination mechanisms
- Involve the entire civil society in accelerating the reduction of MPNU5 mortality (forging alliances amongst different groups).

2.1.4.2. Partners' Forum

S. P.: No forum exists as yet in the sub-region to coordinate interventions amongst partners in the area of MPNU5H.

S.O.: Promote the coordination of activities amongst partners in the sub-region

R.A

- Establish an Inter-Agency Committee to coordinate partners' activities in the field of MPNU5H
- Ensure an annual income
- Promote information sharing network.

2.1.4.3. Financial Resource Mobilisation

P.S.: Financial resources allocated to MPNU5 health in the sub-region are inadequate.

S.O.: Mobilise additional financial resources at the local and national levels, and in the public and private sectors.

R.A

- Recommend cost sharing for MPNU5 health-related activities
- Promote integrated, multi-sectoral financial management activities.

2.1.4.4. Monitoring and Evaluation

S. P.: Monitoring and Evaluation (M&E) mechanisms for MPNU5 in the sub-region are inadequate.

S.O.: Set up an efficient M & E system for interventions in the MPNU5 health field.

R.A

- Harmonise M & E indicators and tools in the sub-region
- Prepare M & E logical frameworks for MPNU5 health in the sub-region
- Share data related to MPNU5 health issues

2.1.5. Dissemination of Best Practices and approaches

Best practices/approaches are useful for the reduction of MMNU5 mortality. There are best practices globally and within the sub-region that can be shared to improve MPNU5 health. There is a need to collect and disseminate data on such practices and approaches, and support research to identify best practices and approaches.

2.1.5.1 Data Collection

S. P.: Best practices and approaches are under-utilised in the sub-region due to inadequate data.

S.O.: Promote the use of best practices/approaches.

R, A

- Identify best practices and approaches,
- Evaluate these best practices and approaches,
- Ensure documentation of these best practices and approaches.

2.1.5.2 Dissemination

S. P.: Best practices are not sufficiently and properly disseminated.

S.O.: Promote the dissemination of best practices among health workers and the community.

R.A

- Use all possible dissemination channels-newsletters, professional journals, websites, e-list, etc
- Encourage targeted studies
- Promote scientific meetings and other supports for best practices
- Promote ICT use
- Support countries to adapt and use best practices
- Promote scaling up of the application of best practices and approaches.

2.1.5.3 Research

S. P.: There is not enough research on best practices in the sub-region.

S.O. : Promote research into best practices in the sub-region.

R.A.

- Identify areas to explore
- Carry out operational research on best practices
- Disseminate research findings

2.2.ACTION OPERATIONAL PLAN

The timelines for the implementation of the Strategy for the accelerated reduction of Maternal, Perineonatal and under-five Mortality in West Africa 2009-2013 is presented in annex 2.

3.0 MONITORING AND EVALUATION

3.1. MONITORING AND EVALUATION FRAMEWORK

The development of the Strategy for Accelerated Reduction of MPNU5M was based on the priority areas of intervention set out in the global implementation framework of the "*Child Survival: A Strategy for the African Region*", which are:

- Policy Development
- Capacity Building
- Communication and Social Mobilisation
- Advocacy and Partnership Development
- Operational Research
- Documentation
- Development of a Framework for Monitoring and Evaluation.

These are the key areas of the framework for Monitoring and Evaluation in the new strategy on which the Monitoring and Evaluation plan presented in annex3 is based. The indicators for measuring progress are set out by activity and by priority area. For each indicator, the data that would need to be gathered, the compilation methods and tools for data collection, as well as their levels and frequencies are clearly spelt out.

4.0 FUNDING STRATEGY

WAHO will source for funding for these programmes from the following sectors:

4.1. FUNDS FROM WAHO

WAHO will begin with the implementation of the easier activities. It will need to strengthen its advocacy to resolve some of its problems and secure funding for this from ECOWAS.

4.2. PARTNERS' FORUM

Several international organisations have capacities in certain sectors and WAHO should explore such sectors. For example Family Care International, JHPIEGO and IPAS would be interested in the capacity building; UNFPA, USAID and DFID will be interested in the social mobilisation; USAID and DFID in partnership development and UNICEF, newborn health.

4.3. FUND MOBILISATION FROM THE PRIVATE SECTOR

The private sector in the Member States should be approached for funding. Banks such as the Agricultural Development Bank and oil companies like Mobil and Shell are potential sources of funding.

4. 4. GOVERNMENT BUDGET (ALL SECTORS)

In the Member States, Ministries of Finance, Education, Economic Development, Women's Affairs, Youth and Sports are also possible funding sources. The West African First Ladies Forum could offer a means to pressure these sectors to provide funding.

Substantial amount of money is available under special programmes such as the poverty alleviation/reduction programme, the MDG fund, etc and these could be potential sources of funds.

5.0 PARTNERSHIP

5.1 EXISTING PARTNERSHIPS

It is crucial for WAHO to forge partnerships at sub-regional and international levels. In the WAHO FY 2004-2008 Strategic Plan, a number of entry points for durable partnerships was defined, and these include (i) Facilitation of evidence-based cost – effective interventions (ii) Dissemination of health information of specific relevance to the sub-region, and (iii) provision of consultative services to exogenous and international organisations. Given WAHO's position as a sub-regional organisation in a region with the highest number of maternal, peri-natal and under-five deaths, it should seek partnerships with international organisations concerned with the issue of maternal and under-five health. WAHO's strategic Plan for the acceleration of the reduction of maternal, peri-neonatal and under-five mortality is a potential starting point for collaboration and partnership with sub-regional and international organisations such as WHO, UNICEF, JHPIEGO, UNFPA, BASICS, USAID, DFID, UNESCO, and certain national and regional training and professional institutions such as universities, schools of health, CAMES, UNAPSA, IRSP, SAGO, etc… Below is a list of the partners and their areas of interest (see Annex I).

WAHO should take advantage of the regional and global interests in maternal, peri-neonatal and child mortality to establish mutually beneficial and sustainable partnerships.

The partnership development component of the strategic plan is unique and, if properly applied, will help to forge strong partnerships for WAHO and position it to serve as a vital source of information and knowledge specific to the West African sub-region.

6.0 RECOMMENDATIONS

6.1. WAHO

1. The Strategy for the Accelerated Reduction of MPNU5M should be viewed as a priority because if successful, it will provide a framework for many other health programmes in the sub-region, for example the HIV/AIDS programme.

2. The operational structures of the strategic plan (coordination committee, regional and national database, information and communication systems and partnerships) should be established speedily, before the end of 2009.

3. WAHO should actively support countries that have not yet developed their strategy for reducing MMPNU5 to do so.

4. WAHO and the countries should encourage partners to make substantial financial contributions towards the implementation of the strategy for accelerating the reduction of MPNU5M.

5. WAHO, taking cognisance of the inequitable distribution of skilled health manpower in the region, should support countries to improve the situation.

6.2. COUNTRIES

Should:

1. Make the reduction of MPNU5M a national priority.

2. Take ownership of the strategy for accelerating the reduction of MPNU5 proposed by WAHO

3. Use this strategy as a guide to accelerate their implementation of national MPNU5 mortality reduction strategies, or to develop theirs if none exists.

4. Pass laws on protection of MPNU5 and adolescent health

5. Secure an allocation for the RMPNU5M in national budgets

6. Establish lasting partnerships with local authorities and community organisations to put in place community health interventions and services for the RMPNU5M.

7. Use the Monitoring and Evaluation Plan of the Strategy for accelerated RMPNU5M as a Road Map for the monitoring-evaluation of national RMPNU5M strategies.

8. Collaborate with the WAHO liaison officers for the implementation, monitoring and review of national RMPNU5MR strategies.

9. Upgrade the infrastructure and equipment in health establishments

10. Secure RH commodities, including drugs, consumables, and contraceptives

11. Put the best practices in the RMPNU5M disseminated by WAHO to the best possible use

12. Establish and maintain a dialogue and proactive and continuous communication with WAHO

7.0. CONCLUSION

The Strategy for the accelerated reduction of MPNU5 is a guide being proposed to the countries in the ECOWAS sub-region to strengthen and accelerate the implementation of national MPNU5M reduction strategies. Its underlying aim is to help improve the health of mothers, newborns and children under-five in the sub-region by 2013.

WAHO, true to its basic principles, will act more as a facilitator than a provider – and will reinforce information and communication systems to establish new partnerships, and coordinate their activities. There would be a shift to involving the community in the growing number of health interventions, which would improve health systems in the sub-region.

This strategy proposed by WAHO is realistic and feasible, and has the potential of being fully funded and implemented.

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ANNEXES

ANNEX 1: FIVE YEARS (2009 – 2013) OPERATIONAL PLAN FOR THE ACCELERATED RMPNU5M

INTERVENTION AREAS	ACTIVITIES	EXPECTED OUTCOME	TIME FRAME	INSTITUTION RESPONSIBLE	OTHER SUPPORTING PARTNERS	INDICATORS	SOURCE OF FUNDING
1- ADVOCACY	**1-**1. Develop TOR for the situational analysis of laws that promote, MPNU5 and adolescent health	T.O.R developed	Year 1 (2009)	WAHO	ECOWAS Parliament Countries Parliaments	Proportion of countries that have developed situational analysis TOR	WAHO ECOWAS Partners
	1.2 Conduct analysis and validate the situation of each country on MPNU5 and adolescent health	Situational analysis per country available	Year 1 (2010)	WAHO	ECOWAS Parliament Countries Parliaments	Proportion of countries that have conducted the situational analysis	WAHO Partners
	1.3. Develop advocacy tools for maternal, newborn, under-five and adolescent health	Advocacy tools available	Year 1 (2010)	WAHO	*ECOWAS Parliament* *Countries Parliaments* *Ministers of health*	Proportion of countries that have developed advocacy tools	WAHO Partners
	1.4. Organise sensitisation meetings for policymakers at all levels about maternal, neonatal, under-five and adolescent health	Commitments from Decision Makers obtained	2010 and 2011	Countries Ministries of Health	WAHO	Number of sensitisation meetings held with policymakers	Partners ECOWAS WAHO

5 YEARS OPERATIONAL PLAN

INTERVENTION AREAS	ACTIVITIES	EXPECTED OUTCOME	TIME FRAME	INSTITUTION RESPONSIBLE	OTHER SUPPORTING PARTNERS	INDICATORS	SOURCE OF FUNDING
2-SOCIAL MOBILISATION	**2.1. Community management of MPNU5 health issues** **-1.** Involve the population in identifying health problems	Health problems identified with populations	2009-2010	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities that have carried out community diagnosis	WAHO ECOWAS
	-2. Strengthen the Community Health committees	Community health committees strengthened	2010 à 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities with functional Community health committees	WAHO ECOWAS
	-3. Establish RMPNU5M monitoring committees	RMPNU5M monitoring committees established	2010 à 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities with RMPNU5M monitoring committees	WAHO ECOWAS Partners
	2.2. Establish community health insurance schemes	Community health insurance schemes established	2009- 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of the population (of a clinic area, health district..) covered by the health insurance schemes.	WAHO ECOWAS
	2.3. Organise cost-sharing						
	-1. Organise emergency transport	emergency transport Organised in each community	2009- 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities that have developed strategies to support the transportation of emergency cases to health centres	

	-2. Support the provision of emergency care without user fees	Emergency care without user fees provided	2009- 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities that have provision for free emergency care service	
	2.4. Increase male participation						
	Sensitise men about danger signs in women, newborns and under-fives	Men in communities are informed about danger signs in women, newborns and under-fives	2009 - 2013	Countries Ministries of Health Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of men who can recognise danger signs in women, newborns and under-fives	
	2.5. Female empowerment						
	-1. Create women's cooperatives and economic interest groups	women's cooperatives and economic interest groups created in communities	2009 - 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of communities with functional women's cooperatives and economic interest groups	
	-2. Create awareness within communities about the gender approach in the management of health problems	Women members involved in policymaking bodies	2009 - 2013	Countries Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of policymaking bodies that have women members	
						Proportion of communities that have integrated measures to promote maternal, neonatal and under-five health into their development plans	
	2.6. Promotion of health care interventions for mothers, newborns and under-fives at community level						
	Provide training at the community level on the 17 family practices essential for maternal, newborn and under –five health:	Training at the community level on the 17 family practices essential for MNU5H provided	2009 - 2013	Ministries of Health Local authorities	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Proportion of people in the community familiar with the essential practices (*men, women, children*)	

						Proportion of communities where community IMCI is being implemented	
3. CAPACITY BUILDING	**3-** 1. Update the database of regional health experts for MPNU5	Data Base of regional experts is operational	2009 - 2013	WAHO	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	An updated database of regional experts exists	ECOWAS Partners WAHO
	3.2. Constitute an updated pool of regional trainers in MPNU5 care	Updated Pool of trainers at ~~r~~egional levels is operational	2009 - 2013	WAHO	WAHO UNICEF FNUAP USAID WHO WARP Others NGOs	Pool of trainers set up at ~~r~~egional levels The proportion of countries' requests that WAHO is able to satisfy	Partners ECOWAS
	3.3. Harmonise training curricula on the management of maternal, newborn and under-five health cases	System of training for treatment of mothers and newborns harmonised	2010	WAHO	MINISTRIES OF HEALTH AND EDUCATION Training Institutions JHPIEGO OMS	Proportion of countries where harmonised training curricula on MPNU5 health management available and in use	WAHO Partners
	3.4. Develop appropriate training materials for maternal, newborn and under-five health care	Professional organisations identified and accredited	2010	WAHO	MINISTRIES OF HEALTH AND EDUCATION Training Institutions JHPIEGO OMS	Proportion of countries where training manuals, guidelines and protocols are available and in use	Partners WAHO ECOWAS
	3.5. Conduct training of community health workers to care for MPNU5 health within communities	Training sessions of community health workers to care for MPNU5 health are conducted	2009-2011	MINISTRY OF HEALTH	WAHO OSC	Proportion of communities that have trained and are using community health workers (CHW)	Partners ECOWAS WAHO

	3.6. Strengthen infrastructure and equipment for maternal, newborn and under-five health care	infrastructure and equipment for maternal, newborn and under-five health care are strengthened in ECOWAS Countries	2009-2012	MINISTRY OF HEALTH	Partners	Level of satisfaction of infrastructure needs	WAHO Partners
						Proportion of health establishments with functional equipment that meet national standards	
						Proportion of health establishments that have essential medicines and consumables	
	3.7. Identify and accredit public and private training/professional institutions for capacity building for health workers	Professional institutions for capacity building for health workers are accredited	2011	WAHO	RELEVANT MINISTRIES IN COUNTRIES	Proportion of professional organisations accredited for capacity building of health workers	WAHO Partners
	3.8. Support training sessions on MPNU5H at national level and in the West African sub-region	Country request for training sessions on MPNU5H are submitted to WAHO	2009-2011	RELEVANT MINISTRIES IN COUNTRIES	WAHO, Partners	Proportion of country requests that WAHO is able to meet	
	3.9. Support the strengthening of countries' MPNU5 health information and communication systems	Countries information and communication systems are strengthened with WAHO support	2009-2011	WAHO	Partners	Proportion of countries that have received WAHO support towards strengthening their information and communication system	

INTERVENTION AREA	ACTIVITIES	EXPECTED OUTCOME	TIME FRAME	INSTITUTION RESPONSIBLE	OTHER SUPPORTING PARTNERS	INDICATORS	SOURCE OF FUNDING
4. PARTNER-SHIP DEVE - LOPEMENT	**4.1.** Create a database of partners according to their areas of interest in MPNU5 health	Database on partners available	December 2009	WAHO	Countries Partners Private Sector	An updated database of partners exists	Partners
	4.2. Revise and sign memoranda of Understanding with partners	Protocol agreements elaborated and signed	2009-2013	WAHO		Proportion of Memoranda of Understanding that have been revised and signed	WAHO Partners
	4.3. Organise a sub-regional partners' forum with a view to establishing a coordination committee at sub-region level	Forum meets regularly / annual	2010	WAHO	All Partners	A functional regional coordination committee exists at national and sub-regional level	Partners
	4.4. Harmonise the MPNU5 health indicators	MPNU5 health indicators are harmonised	2011	WAHO	All Partners	Existence of a list of MPNU5 health indicators used in the countries	Partners
	4.5. Create a sub-regional data sharing network on MPNU5 health	a sub-regional data sharing network on MPNU5 health created	2011	WAHO	All Partners	Functionality of the sub-regional network	
	4.6. Mobilise	additional financial resources for MPNU5 health mobilised	2009 :10% 2011 : 40% 2013 : 80%	WAHO	All Partners	Proportion of additional financial resources mobilised for MPNU5 health in countries	

INTERVENTION AREA	ACTIVITIES	EXPECTED OUTCOME	TIME FRAME	INSTITUTION RESPONSIBLE	OTHER SUPPORTING PARTNERS	INDICATORS	SOURCE OF FUNDING
5- DISSEMINA-TION OF BEST PRACTICES	**5.1.** Identify and document existing best practices and approaches.	Best practices and approaches identified and documented	2009-2013	WAHO	COUNTRIES MINISTRIES OF HEALTH	Number of best practices and approaches documented	Partners
	5.2. Validate best practices	Validated practices and approaches available	2009-2013	WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of best practices validated	Partners
	5.3. Disseminate validated best practices	Validated best practices are disseminated	2009-2013	WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of countries where validated best practices are known	Partners
	5.4. Support demonstration projects on application of best practices and approaches	Projects for implementation of best practices available	2009-2013	WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of demonstration projects supported by WAHO in countries	Partners
	5.5. Support the upgrade of validated MPNU5 health related best practices	Research on best practice available.	2009-2013	WAHO	COUNTRIES MINISTRIES OF HEALTH	Level of extension of best practices in the countries	Partners

ANNEX 2: TIMELINES FOR IMPLEMENTATION OF THE STRATEGY FOR ACCELERATED RMPNU5M

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD										RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
		2009		2010		2011		2012		2013				
ADVOCACY	1.1.Develop TOR for the situational analysis of laws that promote, MPNU5 and adolescent health											WAHO	*ECOWAS* *Countries Parliaments*	Proportion of countries that have developed TOR for the situation analysis
	1.2 Conduct and validate the situations for each country relative MPNU5 and adolescent health											COUNTRY MINISTRY OF HEALTH	*ECOWAS Countries Parliaments* *WAHO*	Proportion of countries that have conducted the situational analysis
	1.3. Develop advocacy tools for maternal, newborn, under-five and adolescent health											WAHO/ countries member	*ECOWAS Countries Parliaments* *Ministries of health*	Proportion of countries that have developed advocacy tools
	1.4. Organise sensitisation meetings for policymakers at all levels about maternal neonatal, under-five and adolescent health											Countries Ministries of Health	WAHO	Number of sensitisation meetings held with policymakers
MOBILISATION SOCIALE	**2.1 Community management of MPNU5 health issues**											Countries Local authorities	WAHO UNICEF FNUAP USAID	Proportion of communities that have carried out community diagnosis

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	Involve the population in identifying health problems		Countries	WHO WARP Others ONGs	Proportion of communities that have carried out community diagnosis
	Strengthen the Community Health committees				Proportion of communities where functional Community health committees are in place
	Establish RMPNU5M monitoring committees				Proportion of communities that have created RMPNU5M monitoring committees
	2.2. Establish community health insurance schemes Insurance schemes		Local Countries authorities	WAHO UNICEF FNUAP USAID WHO WARP Others ONGs	Proportion of population (of a clinic area, health district..) covered by the insurance schemes.
	2.3. Organise cost-sharing.		Local Countries authorities		
	Organise emergency transport			WAHO UNICEF FNUAP USAID WHO WARP Others ONGs	Proportion of communities that have developed strategies to support the transportation of emergency cases to health centres
	Support the provision of emergency care without user fees y				Proportion of communities that have provision for free emergency care service
	2.4. Increase male participation		Local authorities Countries Ministries of Health		Proportion of men who can recognise danger signs in women, newborns and under-fives

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	Sensitise men about danger signs in women, newborns and under-fives		Local authorities Countries Ministries of Health	WAHO UNICEF FNUAP USAID WHO WARP Others ONGs	Proportion of men who can recognise danger signs in women, newborns and under-fives
	2.5. Female empowerment				
	Create women's cooperatives and economic interest groups		Local authorities Countries	WAHO UNICEF FNUAP USAID WHO WARP Others ONGs	Proportion of communities with functional women's cooperatives and economic interest groups
	Support the provision of emergency care without user fees				Proportion of communities that have provision for free emergency care service
	Create awareness within communities about the gender approach in the management of health problems				Proportion of policymaking bodies that have women members
			Local authorities NATIONAL MINISTRIES OF HEALTH	WAHO UNICEF FNUAP USAID WHO WARP Others ONGs	Proportion of communities that have integrated measures to promote maternal, neonatal and under-five health into their development plans

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	2.6. Promotion of health care interventions for mothers, newborns and under-fives at community level		Local authorities MINISTRIES OF HEALTH		Proportion of people in the community familiar with the essential practices (*men, women, children*) Proportion of communities where community IMCI is being implemented
	Provide training at the community level on the 17 family practices essential for maternal, newborn and under –five health:				
CAPACITY BUILDING					
	3.1. Update the database of regional health experts for MPNU5		WAHO	Partners	An updated database of regional experts exists
	3.2. Constitute an updated pool of regional trainers in MPNU5 care		WAHO	Partners	A pool of regional trainers on MPNU5 care exists
					The proportion of countries' requests that WAHO is able to satisfy
	3.3. Harmonise training curricula on the management of maternal, newborn and under-five health cases		WAHO	MINISTRIES OF HEALTH EAND EDUCATION Training Institutions	Proportion of countries where training manuals, guidelines and protocols are available and in use

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	3.4. Develop appropriate training materials for maternal, newborn and under-five health care		WAHO	JHPIEGO OMS	Proportion of countries where training manuals, guidelines and protocols are available and in use
	3.5. Conduct training of community health workers to care for MPNU5 health within communities		MINISTRY OF HEALTH	WAHO OSC	Proportion of communities that have trained and are using community health workers (CHW)
	3.6. Strengthen infrastructure and equipment for maternal, newborn and under-five health care		MINISTRY OF HEALTH	Partners	Level of satisfaction of infrastructure needs
					Proportion of health establishments with functional equipment that meet national standards
					Proportion of health establishments that have essential medicines and consumables
	3.7. Identify and accredit public and private training/professional institutions for capacity building for health workers		WAHO	RELEVANT MINISTRIES IN COUNTRIES	Proportion of professional organisations accredited for capacity building of health workers

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	3.8. Support training sessions on MPNU5H at national level and in the West African sub-region		RELEVANT MINISTRIES IN COUNTRIES	WAHO, Partners	Proportion of country requests that WAHO is able to meet
	3.9. Support the strengthening of countries' MPNU5 health information and communication systems		WAHO	Partners	Proportion of countries that have received WAHO support towards strengthening their information and communication system
IV PARTNERSHIP DEVELOPMENT	**4.1.** Create a database of partners according to their areas of interest in MPNU5 health		WAHO	Countries Partners Private Sector	An updated database of partners exists
	4.2. Revise and sign memoranda of Understanding with partners		WAHO		Proportion of Memoranda of Understanding that have been revised and signed
	4.3. Organise a sub-regional partners' forum with a view to establish a coordination committee at sub-region level		WAHO	All Partners	A functional regional coordination committee exists at national and sub-regional level
	4.4. Harmonise the MPNU5 health indicators		WAHO	All Partners	Existence of a list of MPNU5 health indicators used in the countries

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	4.5. Create a sub-regional data sharing network on MPNU5 health		WAHO	All Partners	Functionality of the sub-regional network
	4.6. Mobilise additional financial resources for MPNU5 health		WAHO		Proportion of additional financial resources mobilised for MPNU5 health in countries
V- DISSEMINATION OF BEST PRACTICES/APPROACHES	**5.1.** Identify and document existing best practices and approaches.		WAHO	COUNTRIES MINISTRIES OF HEALTH	Number of best practices and approaches documented
	5.2. Validate best practices		WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of best practices validated
	5.3. Disseminate validated best practices		WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of countries where validated best practices are known
	5.4. Support demonstration projects on application of best practices and approaches		WAHO	COUNTRIES MINISTRIES OF HEALTH	Proportion of demonstration projects supported by WAHO in countries
	.5. Support the upgrade of validated MPNU5 health related best practices		WAHO	COUNTRIES MINISTRIES OF HEALTH	Level of extension of best practices in the countries

AREAS OF INTERVENTIONS	ACTIVITIES	PERIOD	RESPONSIBLE INSTITUTION	OTHERS SUPPORTING PARTNERS	INDICATORS
	5.6 Conduct operations research to identify new best practices		WAHO	COUNTRIES MINISTRIES OF HEALTH	Performance of countries conducting operational research on best practices *(Ratio number of new best practices / number of operational researches conducted)*
	5.7. Diversify the means and channels of disseminating information on MPNU5 mortality		WAHO	COUNTRIES MINISTRIES OF HEALTH	Countries' level of coverage in the use of different media are being used to disseminate information on MPNU5 mortality

ANNEX 3: MONITORING AND EVALUATION PLAN

I. ADVOCACY

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / *SOURCES*	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
1.1.Develop TOR for the situational analysis of laws that promote, MPNU5 and adolescent health	Proportion of countries that have developed TOR of situational analysis	**Number of countries have developed TOR of situational analysis** / *Country Report on the Situational Analysis; WAHO monitoring Reports*		Analysis and Documentary Analysis / **Quarterly**	Analysis grid							WAHO
1.2 Conduct analysis**.** and validate the situations for each country relative MPNU5 and adolescent health	Proportion of countries that have conducted the situational analysis	**Number of countries that have conducted a situational analysis** / *Country Report on the Situation Analysis; WAHO monitoring Reports*	**Number of ECOWAS countries** / *WAHO Country Repository*	Analysis and Documentary Analysis / **Quarterly**	Analysis grid							COUNTRY HEALTH MINISTRY
1.3. Develop advocacy tools for maternal, newborn, under-five and adolescent health	Proportion of countries that have developed advocacy tools	**Number of countries that have developed advocacy tools** / *Country Report on development of advocacy tools; WAHO monitoring reports*	**Number of ECOWAS countries** / *WAHO des pays*	Analysis and Documentary Analysis / **Quarterly**	Analysis grid							WAHO/ countries member
1.4. Organise sensitisation meetings for policymakers at all levels about maternal, neonatal,	Number of sensitisation meetings held with policymakers	**Number of sensitisation meetings held with policymakers on reduction of**		Analysis and Documentary Analysis / **Half-yearly from 2010**	Analysis grid							NATIONAL MINISTRY OF HEALTH

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / *SOURCES*	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
under-five and adolescent health		**MPNU5MR** / *Reports of the sensitisation meetings in each country; WAHO Monitoring Reports*										

II: SOCIAL MOBILISATION

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
2.1 Community management of MPNU5 health issues												
Involve the population in identifying health problems	Proportion of communities that have carried out community diagnosis	Number of health clinics (per country) where the population have conducted a community diagnosis / Countries reports on community diagnosis	Number of clinic areas (per country) / Most recent Country Health Statistical Yearbook	Analysis and Documentary Analysis Quarterly 2009-2010	Analysis grid							
Strengthen the Community Health committees	Proportion of communities where functional Community health committees are in place	Number of clinic areas (per country) where functional Community health committees are in place / Country reports (MS) on the functionality of their health committees	Number of clinic areas (per country) / Most recent Country Health Statistical Yearbook	Analysis and Documentary Analysis Half-yearly 2010-2013	Analysis grid							
Establish RMPNU5M monitoring committees	Proportion of communities that have created RMPNU5M monitoring committees	Number of clinic areas (per country) with RMPNU5M monitoring committees / Country reports(MS) on the creation and functionality of RMPNU5M monitoring committees; Activity Reports of RMPNU5M monitoring committees	Number of clinic areas (per country) / Most recent Country Health Statistical Yearbooks	Analysis and Documentary Analysis Half-yearly 2010-2013	Analysis grid							

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / *SOURCES*	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
2.2. Establish community health insurance schemes	Proportion of the population (of a clinic area, health district..) covered by the insurance schemes.	**Number of population of health districts or zones covered by the insurance schemes (in each country)** / *Country report (MS) on coverage of health districts in insurance schemes; Activity reports of programmes and projects that support the creation of insurance schemes in each country*	**Total percentage of the population of health districts (by country)** /*Most recent Country Health Statistical Yearbook ; DHS 2006 (or the most recent)*	Analysis and Documentary Analysis **Half-yearly 2009-2013**	Analysis grid							Local authorities Countries
2.3. Organise cost-sharing.												
Organise emergency transport	Proportion of communities that have developed strategies to support the transportation of emergency cases to health centres	**Number of clinic areas (per country) where support for the transport of ill mothers and children to health centres is available** *Activity reports of mutual health funds; Activity reports of RMPNU5M monitoring committees; Evaluation reports of the Development Plans of the Local Government*	**Number of clinic areas per country** /*Most recent Country Health Statistical Yearbooks*	Analysis / Documentary Analysis **Half-yearly 2009 – 2013**	Analysis grid							Local authorities Countries

Support the provision of emergency care without user fees	Proportion of communities that have provision for free emergency care service	**Number of clinic areas (per country) where the access to free emergency care is functional** *Activity reports of the insurance schemes; Activity reports of care centres ; Activity reports of RMPNU5MRM monitoring committees; Evaluation reports of Local authorities Development Plans*	**Number of clinic areas in each country** / *Most recent Statistical Yearbook*									
2.4. Increase male participation												
Sensitise men about danger signs in women, newborns and under-fives	Proportion of men who can recognise danger signs in women, newborns and under-fives	**Number of men aged 15+ years who can recognise danger signs in women, newborns, and under-fives (by country)** *Rapport DHS 2006 (or the most recent); Reports KAP Surveys by Health District*	**Number of men aged 15+ per country** *DHS Report 2006 (or the most recent) ; Reports of KAP Surveys in each Health District*	DHS **every 4 years (2009, 2013)** KAP Surveys in each Health District **every 2 years (2010; 2012)**	**DHS Questionnaire/ KAP Survey Questionnaires**							Local authorities NATIONAL MINISTRIES OF HEALTH
2.5. Female empowerment												
Create women's cooperatives and economic interest groups	Proportion of communities with functional women's cooperatives and economic interest groups	**Number of communities in each country that have functional women's cooperatives and economic interest groups** / *Evaluation reports on implementation of Commune Development Plans in each country; Activity reports and evaluation reports of*	**Number of communities per country** / *Administrative and Territorial Development documents; Reports of National Decentralisation Commissions*	Analysis / Documentary Analysis **Half-yearly 2009 – 2013**	Analysis grid							Local authorities Countries

		programmes or projects supporting the establishment of women's cooperatives and economic interest groups										
Create awareness within communities about the gender approach in the management of health problems	Proportion of policymaking bodies that have women members	**Number of (i)health committees, (ii) MPNU5monitoring committees, and (iii) local government social and health commissions in which women are represented** / *Activity reports of health committees; RMPNU5M monitoring committees; Activity reports of the social and health commissions of local governments; Evaluation reports of Local Authority Development Plans*	**Number of (i) health committees, (ii) RMPNU5M monitoring committees, (iii) social and health commissions Local authorities** / *Activity Reports of health committees; of RMPNU5M monitoring committees; Administrative and functional organisation and Local Authority Development Plans*	Analysis / Documentary Analysis **Half-yearly 2009 - 2013**	Analysis grid							Local authorities NATIONAL HEALTH MINISTRIES

	Proportion of communities that have integrated measures to promote maternal, neonatal and under-five health into their development plans	**Number of communities in each country that have integrated action to promote maternal, neonatal and under-five health into their development plans** / Evaluation reports of the implementation of commune development plans in each country	**Number of communities in the country** / *Administrative and Territorial Reform Documents; Reports of National Decentralisation Commissions*	Analysis / Documentary Analysis **Half-yearly 2009 - 2014**	Analysis grid							

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
2.6. Promotion of health care interventions for mothers, newborns and under-fives at community level												
Provide training at the community level on the 17 family practices essential for maternal, newborn and under –five health:	Proportion of people in the community familiar with the essential practices (*men, women, children*)	**Number of men aged 15+ who can recognise danger signs in women, newborns and under-five children (in each country)** *Rapport DHS Report 2006 (or the most recent); Reports of KAP Surveys by Health District*	**Total number of men aged 15+ in each country** *DHS Report 2006 (or the most recent) ; Reports of KAP Surveys in each Health District*	DHS **every 4 years (2009, 2013)** KAP Survey by Health District **every 2 years (2010; 2012)**	DHS Questionnaire / Questionnaires KAP Survey							Local authorities NATIONAL MINISTRIES OF HEALTH
	Proportion of communities where community IMCI is being implemented	**Number of clinic areas per country where the community IMCI is being implemented** / *Activity reports of health centres; Activity reports of programmes and projects promoting implementation of IMCI in each country*	**Number of clinic areas in each country** / *Most recent Country Health Statistical Yearbook*	Analysis / Documentary Analysis **Half-yearly 2009 - 2013**	Analysis grid							

III. CAPACITY BUILDING

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
3.1. Update the database of regional health experts for MPNU5	An updated database of regional experts exists	**Number of experts identified in the ECOWAS zone, and listed by area of expertise, in the WAHO database** / *Experts' database - Repository of liaison officers*		Analysis / Analysis of listings generated by the database / **Quarterly 2009 -2013**	Analysis grid							WAHO
3.2. Constitute an updated pool of regional trainers in MPNU5 care	A pool of regional trainers on MPNU5 care exists	**Number of regional trainers identified, by area of training, on MPNU5 WAHO** / R*epository of regional MPNU5 care trainers*		Analysis / Analysis of listings generated by the Repository / **Quarterly 2009 -2013**	Analysis grid							WAHO
	The proportion of countries' requests that WAHO is able to satisfy	**Number of requests received from countries and satisfied by WAHO** / *Repository of correspondence between WAHO and the countries; Report on trainings on MPNU5 care and Expertises in SMPNNE5 in the countries receiving WAHO support; Reports of Missions to countries receiving WAHO funding; WAHO Annual Reports*	**Number of requests received from countries** / Repository of correspondence between WAHO and the countries; WAHO Annual Reports	Analysis - Documentary Analysis / **Quarterly 2010**	Analysis grid							

3.3. Harmonise training curricula on the management of maternal, newborn and under-five health cases	Proportion of countries where harmonised training curricula on MPNU5 health management available and in use	**Number of countries where harmonised training curricula on management of MPNU5 health are available and in use** / *Reports of trainings on on MPNU5 health management by country ; Reports of training missions in countries receiving WAHO support*	**Number of countries in the ECOWAS zone** / *WAHO Country Repository*	Analysis - Documentary Analysis / **Quarterly 2010**	Analysis grid							WAHO
3.4. Develop appropriate training materials for maternal, newborn and under-five health care	Proportion of countries where training manuals, guidelines and and protocols are available and in use	**Number of countries where training manuals, guidelines and protocols are available and in use** / *Reports of training on the care of MPNU5 Health by country; Reports of training missions in countries receiving WAHO support*	**Number of countries in the ECOWAS zone** / *WAHO Country Repository*	Analysis - Documentary Analysis / **Quarterly 2010 - 2013**	Analysis grid							WAHO,

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
3.5. Conduct training of community health workers to care for MPNU5 health within communities	Proportion of communities that have trained and are using community health workers (CHW)	**Number of clinic areas (per country) where trained CHW are working** / *Country reports (MS) on training and functioning of CHW; Quarterly reports of Health Centres, and of programmes et projects on the activities of CHW*	**Number of clinic areas (per country) /** *The most recent Country Health Statistical Yearbook*	Analysis and Documentary Analysis **Quarterly 2010-2011**	Analysis grid							MINISTRY HEALTH /FAMILY
3.6. Strengthen infrastructure and equipment for maternal, newborn and under-five health care	Level of satisfaction of infrastructure needs	**Number of health establishments where infrastructure are up to national standards** / *Country Health Policy Paper under preparation; Policy Paper on Norms and Standards of Health Infrastructure; the most recent Country Health Statistical Yearbook;*	**Number of health establishments per country** / *The most recent Country Statistical Yearbook*	Analysis and Documentary Analysis **Half-yearly 2010-2012**	Analysis grid							MINISTRY OF HEALTH

	Proportion of health establishments with functional equipment that meet national standards	**Number of health establishments with health equipment that meet national standards** / *National Health Policy Paper currently under preparation; Policy Paper on Norms and Standards for Health Equipment; most recent Country Health Statistical Yearbook;*	**Number of health establishments by country** / the most recent *Country Health Statistical Yearbook*	Analysis and Documentary Analysis **Half-yearly 2010-2012**	Analysis grid							
	Proportion of health establishments that have essential medicines and consumables	**Number of health establishments with a constant stock of essential drugs and consumables in the country** / *most recent Country Health Statistical Yearbook; Reports of quarterly monitoring of health districts; Inventory reports of health district depots*	**Number of health establishments per country** / the most recent *Country Health Statistical Yearbook t*	Analysis and Documentary Analysis **Quarterly 2010-2012**	Analysis grid							

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
3.7. Identify and accredit public and private training/professional institutions for capacity building for health workers	Proportion of professional organisations accredited for capacity building of health workers	**Number of professional organisations accredited to provide capacity building for health workers** / *Report of accreditation missions ordered by WAHO; Repository of professional organisations* accredited by WAHO to provide capacity for health workers	**Number of professional organisations that specialise in training health workers that are identified in the countries** / *Repository of professional organisations specialised in training health workers in countries*	Analysis and Documentary Analysis **Quarterly 2010-2012**	Analysis grid							WAHO
3.8. Support training sessions on MPNU5H at national level and in the West African sub-region	Proportion of country requests that WAHO is able to meet	**Number of requests from countries that are satisfied by WAHO** / *Repository of correspondence between WAHO and the countries; Report of training sessions on MPNU5 care in countries and in the West African region that receive WAHO support; WAHO Annual Reports*	**Number of requests from countries for training on MPNU5 care** / *Repository of correspondence between WAHO and countries; WAHO Annual Reports*	Analysis - Documentary Analysis / **Quarterly 2010**	Analysis grid							RELEVANT MINISTRIES IN COUNTRIES

3.9. Support the strengthening of countries' MPNU5 health information and communication systems	Proportion of countries that have received WAHO support towards strengthening their information and communication system	**Number of countries provided with computer equipment and ITC by WAHO and which have benefited from training on the information and communication system** / *Inventory Reports (or Repository) of computer equipment and ITC in Ministries of Health, National health programmes of professional organisations that train health workers in countries; WAHO Annual Report*	**Number of countries in the ECOWAS zone** / WAHO *Country Repository*	Analysis - Documentary Analysis / **Quarterly 2011**	Analysis grid							WAHO

IV. PARTNERSHIP DEVELOPMENT

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
4.1. Create a data bank of partners according to their areas of interest in MPNU5 health	An updated data bank of partners exists				Analysis grid							WAHO
4.2. Revise and sign memoranda of Understanding with partners	Proportion of Memoranda of Understanding that have been revised and signed	**Number of Memoranda of Understanding that have been revised and signed** / *WAHO Database of MoUs with partners; Minutes of meetings held to review and sign MOUs with partners*	**Number of MoUs existing between WAHO and partners** / *WAHO Database of MoUs with partners*	Analysis - Documentary Analysis / **Quarterly 2009- 2013**	Analysis grid							WAHO

4.3. Organise a sub-regional partners' forum with a view to establish a coordination committee at sub-region level	A functional regional coordination committee exists and is functional at national and sub-regional level	**(i) Number of coordination meetings with partners at sub-regional level that are planned and actually take place** / *Annual work agenda of the regional coordination committee; Reports of meetings*) **(ii) Number of partners that attended all coordination committee meetings** / *Reports of meetings*; **(iii) Number of regional committee decisions that are implemented** / *Meeting reports; Monitoring and evaluation reports of the committee*		Analysis – Documentary Analysis / **Half-yearly 2010- 2013**	Analysis grid							WAHO
4.4. Harmonise the MPNU5 health indicators	Existence of a list of MPNU5 health indicators used in the countries	**Number of countries that use the harmonised list of MPNU5 health indicators validated by WAHO** / *Country Monitoring Reports; Reports of apports des liaison officers; the most recent Health Statistical Yearbook Health of each country*		Analysis - Documentary Analysis / **Half-yearly 2011- 2013**	Analysis grid							WAHO

4.5. Create a sub-regional data sharing network on MPNU5 health	Functionality of the sub-regional network	**Number of countries where the sub-regional network created by WAHO is known and used to transmit data on MPNU5 health** / *Country Monitoring Reports; Reports of liaison officers; Activity reports of network managers; WAHO Annual Reports*		Analysis - Documentary Analysis / **Half-yearly 2011- 2013**	Analysis grid							WAHO
4.6. Mobilise additional financial resources for MPNU5 health	Proportion of additional financial resources mobilised for MPNU5 health in countries	**Amount of additional financial resources for MPNU5 health mobilised in countries in the current year** / *Activity reports and Financial reports of national MMPNU5 reduction programmes and projects; Financial reports on mobilisation of additional resources for MPNU5 health; Annual Reports of Partners providing support for MPNU5 health in the countries*	**Amount of additional financial resources for MPNU5 health allocated in each country's budget for the current year** / *Countries' national budget for the current year*	Analysis - Documentary Analysis / **Annually 2009- 2013**	Analysis grid							WAHO

V. DISSEMINATION OF BEST PRACTICES/APPROACHES

ACTIVITIES	INDICATORS (DEFINITION)	NUMERATOR / SOURCES	DENOMINATORS / SOURCES	COLLECTION METHOD / PERIODICITY	COLLECTION INSTRUMENT	VALUES						RESPONSIBLE INSTITUTION
						Base value	2009	2010	2011	2012	2013	
5.1. Identify and document existing best practices and approaches.	Number of best practices and approaches documented	**Number of best practices and approaches documented in the countries in the West African sub-region** / *Documents on best practices from the countries; WAHO Repository on best practices*	**Number of best practices identified in the countries in the West African sub-region** / *WAHO Repository on best practices*	Analysis - Documentary Analysis / **Quarterly 2009- 2013**	Analysis grid							WAHO
5.2. Validate best practices	Proportion of best practices validated	**Number of best practices in the West Africa sub-region validated by WAHO** / *Validation reports of best practices validated by WAHO; WAHO Repository on best practices documented and validated*	**Number of best practices identified in countries in the West African region** / *WAHO Best Practice Repository*	Analysis - Documentary Analysis / **Quarterly 2009- 2013**	Analysis grid							WAHO
5.3. Disseminate validated best practices	Proportion of countries where validated best practices are known	**Number of countries in the West African sub-region where best practices validated by WAHO are known and in use** / *Dissemination reports on validated best practices; Reports of country monitoring by WAHO Country monitoring Reports*	**Number of countries in the West African sub-region** / *Country Repository in the ECOWAS zone*	Analysis - Documentary Analysis / **Quarterly 2009- 2013**	Analysis grid							WAHO
5.4. Support demonstration projects on	Proportion of demonstration projects	**Number of best practices demonstration projects receiving WAHO support in countries** /	**Number of best practices demonstration**	Analysis - Documentary Analysis /	Analysis grid							WAHO

application of best practices and approaches	supported by WAHO in countries	*Activity Reports demonstration projects; Project monitoring reports by liaison officers and WAHO; Evaluation reports; WAHO Annual reports*	**projects IDENTIFIED in countries** / *Basic documents on demonstration projects; Half-yearly monitoring reports in Health Districts; Monitoring Reports of liaison officers and WAHO*	**Quarterly 2009- 2013**								
5.5. Support the upgrade of validated MPNU5 health related best practices	Level of extension of best practices in the countries	**Number of best practices upgraded in the countries**		Analysis - Documentary Analysis / **Quarterly 2009- 2013**	Analysis grid							WAHO
5.6 Conduct operations research to identify new best practices	Performance of countries conducting operations research on best practices *(Ratio number of new best practices / number of operational researches conducted)*	**Number of new best practices identified through operations research in the countries** / *Reports of research on best practices; Documentation on new best practices identified; Monitoring reports by the experts and WAHO*	**Number of operational research carried out in the countries** / *The operational research programmes by Ministries of Health and partners in the countries; Protocols of operational research on best*	Analysis - Documentary Analysis / **Quarterly 2009- 2014**	Analysis grid							WAHO

			practices in countries ; reports of operational research									
5.7. Diversify the means and channels of disseminating information on MPNU5 mortality	Countries' level of coverage in the use of different media are being used to disseminate information on MPNU5 mortality	**Number of countries in the West African sub-region where a variety of channels are being used simultaneously to disseminate information on MPNU5 mortality (Meetings, ICT, Web, Journals)** / *Monitoring reports of liaison officers ; WAHO Annual Reports*	**Number of countries in the West African sub-region** / *Country Repository in the ECOWAS zone*	Analysis - Documentary Analysis / **Quarterly 2009- 2015**	Analysis grid							WAHO

ANNEXE 4: PARTNERSHIP AREAS

Areas of intervention	Partners
ADVOCACY	- AU – WAHO
SOCIAL MOBILISATION	- UNFPA - WARP - UNICEF - BASICS - IPAS - Save the Children - National Paediatric Associations and Societies - National Gynaecological and Obstetric Associations and Societies
CAPACITY BUILDING • ***Human Resources*** • ***Logistical Resources***	- WAHO - WARP - National and regional training institutions - CAMES - UNESCO - JHPIEGO - SAGO - UNAPSA
PARTNERSHIP DEVELOPMENT	- AU , - WAHO – WHO, UNFPA, UNICEF, USAID, …
DISSEMINATION OF BEST PRACTICES	- UNFPA - WARP - UNICEF - BASICS - IPAS - Save the Children - National Paediatric Associations and Societies - National Gynaecological and Obstetric Associations and Societies

This proposed list is not exhaustive

ANNEXE 5: LIST OF HEALTH RESEARCH INSTITUTIONS / PROFESSIONAL ORGANISATIONS

- Medical Research Council/Laboratories – Keneba – Gambia
- National Institute of Medical Research – Lagos – Nigeria
- Nigerian Institute of Social and Economic Research – Ibadan – Nigeria
- Council for Scientific and Industrial Research – CSIR – Accra – Ghana
- Département Mère – Enfant UFR Sciences Médicales d'Abidjan – Université d'Abidjan – Côte d'Ivoire
- Département Mère – Enfant UFR Sciences Médicales de Bouaké – Université de Bouaké – Côte d'Ivoire
- Institut National de Santé publique de Côte d'Ivoire
- 3 National training Institutes for health workers in Côte d'Ivoire.
- CRESARCI – Cellule de Réflexion sur la Santé Reproductive en CI.
- Association de Soutien à l'Auto Promotion Sanitaire Urbaine et Péri-urbaine (ASAPSU) de Côte d'ivoire
- Institut Régional de Santé Publique du Bénin
- Union of National African Paediatrics Societies and Associations (UNAPSA) – Paediatric Associations of ECOWAS member countries
- SAGO (Society of African Gynaecologist and Obstetrician)