GEORGIA Action Plan 2017-2019 on Maternal & Newborn Health and Immediately Related RH Issues

1. Introduction

The government of Georgia has decided that a long term vision and related strategic framework should be developed in the field of maternal and newborn health, and immediately related Reproductive Health themes, for the period 2017-2030. Two immediately related \reproductive Health fields have a high impact on Maternal and Newborn Health. First, the quality of family planning determines both the incidence of induced abortion and of high risk pregnancies, and both determine maternal and newborn health to a large extent. Secondly, young people are the most important group at risk of poor maternal and newborn health. Therefore these two themes are integrated in Strategy and Action Plan.

This long term strategy should be accompanied by a three year Action Plan for the years 2017-2019, which is presented here. Both policy documents are released simultaneously. This Action Plan outlines short term objectives, interventions and targets, as well as their implementation costs.

This Action Plan is aligned to several national frameworks, including the Georgian Healthcare System State Concept for 2014-2019 which includes the fundamental principles for the development of the healthcare sector of the country; as well as to the Universal Health Coverage (UHC), a pillar for the development of the health system in the country which prioritizes Maternal and Child Health.

Additionally, the strategy that is linked to this Action Plan is firmly based on immediately related internationally agreed strategic documents. The most important one concerns the Sustainable Development Goals (SDGs) that have been adopted in 2015, and that succeeds the Millennium Development Goals (MDGs; 2000-2015). Another core document is the Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind, adopted by the 66th session of the World Health Organisation (WHO) Regional Committee for Europe in September 2016. This Action Plan, covering the period 2017-2021, includes not only Maternal and Neonatal Health (MNH), but also the immediately related fields of Family Planning (FP) and Youth Sexual and Reproductive Health (Youth SRH) that are also addressed in the present National Action Plan. The Government of Georgia has actively participated in the development of the Action Pan for Europe, and the Action Plan for Georgia presented here is an application of it to the context and most urgent needs in the country.

Other important international commitments and frameworks/strategies that have been taken into account are: the ICPD Program of Action (1994); the Report of the fourth World Conference on Women (1995); the WHO Global Reproductive Health Strategy (2004), the WHO European Regional Strategy on SRH (2001); the WHO European Region Report, Health 2019; and finally the Global Strategy for Women's, Children's and Adolescents' Health, 2017-2030 (2015).

The Strategy and the related Action Plan, presented here, is the guide for all MNH, FP and Youth SRH programming for the government across all sectors, development and implementing partners. It details the necessary program activities and costs associated with achieving national goals, providing clear program-level information on the resources the country must raise domestically and from partners. It also formulates relevant indicators for monitoring and evaluation of progress made and, where possible and feasible, it includes concrete targets to be reached at the end of the Action Plan. The most crucial indicators are: Maternal Mortality Ratio (MMR), Neonatal Mortality Rate (NMR), Contraceptive Prevalence Rate (CPR), Induced Abortion Rate (IAR), unmet need for contraception, and Teenage Pregnancy Rate (TPR).

2. Guiding Principles

The background documents mentioned above all stress the importance of principles related to the quality of approaches and interventions and to human rights. These principles are in particular:

- Human rights based (i.e. right to health, non-discrimination, gender equality, solidarity, social justice, etc.)
- Evidence-based, action-oriented, and sustainable interventions and services.
- Services that are people centered, accessible, affordable, of good quality, and that guarantee continuity of care.
- Ensuring inter-sectoral collaboration and accountability to improve quality of care and equity.
- Emphasis on prevention, health promotion, community participation and empowerment.

3. Vision, Goal, and Strategic Objectives

The vision of this Georgia Maternal & Newborn Health Action Plan 2017-2019 (and the related long term strategy) is that avoidable maternal and newborn mortality will be eliminated, that related morbidity will be reduced, and that the quality of life of mothers and newborns will be optimised through the provision of evidence-based high quality care during the entire pre-pregnancy, pregnancy, delivery and post-partum period.

The goal of the strategy is to maintain and expand the coverage of evidence-based, high impact and cost-effective interventions for maternal and newborn survival, as well as for immediately related reproductive health fields, and to guarantee access to those services for all who need them.

4. Strategic Objectives

This Action Plan briefly outlines directions, approaches and concrete priority interventions, that should be implemented by 2020, and that are needed to reach the stated goal. The priority interventions should be implemented in three closely related fields. The objectives for these fields are:

1. *Maternal Health & Newborn health*
   - *Objective 1*: By 2020 women's access to and utilisation of evidence-based preconception, antenatal, obstetric, neonatal, and post-partum care that meet their needs will be increased substantially.
   - *Objective 2*: By 2020 the quality of maternal and neonatal health services will be improved and standardized along with full integration of these services.
   - *Objective 3*: By 2020 awareness and knowledge in the general population about healthy behaviours and medical standards of high quality care and the rights of patients who use this will be substantially improved.
2. *Family Planning and Youth SRH*
   - *Objective 4*: By 2020 accessibility of family planning services will be improved substantially for target groups.

It should be stressed that the combined interventions listed in the Action Plan *only partially* contribute to reaching the longer term (2030) objectives that are included in the Strategy. Reaching those longer term objectives requires additional interventions during the period 2020-2030. Therefore some interventions included in the 2030 MNH Strategy are not yet included in this Action Plan; some interventions are only started but not completed; and some can be started and completed. Criteria for including interventions in this Action Plan are in particular that interventions are already prepared and implementation is starting, or that preparation will not require much time.

Meeting these objectives requires measures and interventions at different levels and through different approaches. Key strategic actions will be implemented in the following areas:

1. Governance and stewardship
2. Quality and accessibility of service
3. Human recourses
4. Health financing
5. Health Information Management System
6. Community awareness

5. Targets to be reached by 2020 and 2030

As this Action Plan represents only the first steps in reaching the longer term objectives defined in the related strategy target values are given for 2019 and 2030.

- Reduction of Maternal Mortality Ratio from the current 32 per 100,000 live births to 25 in by 2020 and to 12 in 2030.
- Reduction of Neonatal Mortality Rate from the current 6.1 per 1,000 live births to well under 6 by 2020 and to 5 in 2030.
- Reduction of the unmet need for modern contraception from the current 31% to 25% by 2020 and below 15% by 2030.
- Reduction of the Total Induced Abortion Rate (TIAR; i.e. average number of abortions during a woman's lifetime) from the current 1.6 to less than 1.3 by 2020, and to below 0.5 by 2030.
- Reduction of the Teenage Pregnancy Rate (TPR) from the current 51.5 per 1,000 women aged 15-19 to < 40 by 2020 and to < 20 by 2030.

6. Responsibilities and roles of different stakeholders

Implementation of this Action Plan requires concerted efforts of different stakeholders, of which the main ones will be:

- Government of Georgia: MoLHSA, other ministries (Education, Justice, Economy, Finance), Parliament of Georgia, local authorities
- NCDC&PH
- National NGO's
- National professional organizations
- Research & Academia
- Media
- Private sector
- International Donors

Objective 1: By 2020 women and newborns will have increased access and will enhance utilization of evidence-based preconception, antenatal, obstetric, neonatal, and postpartum care that meet their needs

Outcome 1: Women and newborns use evidence-based preconception, antenatal, obstetric, neonatal, and postpartum care services

Indicators:

1: % of women who received preconception care

Baseline: 0% **Target:** 30%

2: % of women who received at least one visit/4 or more antenatal care visits

Baseline: 88.3% **Target:** ≥ 95%

3. % of women who have postpartum contact with a health provider within 6 weeks of delivery.

Baseline: 0% **Target:** ≥ 60%

4. % of newborns who have postnatal contact with a health provider within first week of discharge from maternity.

Baseline: N/A **Target:** ≥90%

5. % of out-of-pocket health expenditure on RMNCAH as a share of out-of-pocket expenditure

Baseline: 6.0% **Target:** 1.5%

Output	Output indicator	Activity	Implementing Agency	Timeframes	Budget
1.1. Mechanisms for creating an enabling environment for the implementation of the MNH and FP National Response is established	1.1a. Approved National MNH Strategic Plan 2017-2030 and an Action Plan 2017-2019 are in place **Baseline:** No **Target:** Yes 1.1b. Number of advocacy meetings with target audience conducted **Baseline:** None **Target:** 10	1.1.1. Approve a National MNH Strategic Plan 2017-2030 and an Action Plan 2017-2019	Ministry of Labor Health and Social Affairs of Georgia (MoLHSA)	2017-2019	
		1.1.2. Develop and use evidence-based advocacy toolkits to reach out to parliamentarians, national and local level government and development partners for technical and resource assistance and political and social commitment for MNH.			
		1.1.3. Review the legal framework governing the protection and rights of mothers and children: 1.1.3.1 Identify and foster policy and regulations to remove the legislative barrier affecting protection and rights of mothers and children.			
		1.1.4. Foster collaborative partnership and accountability for promoting MNH: 1.1.4.1. Involve relevant governmental bodies, local authorities, communities, civil society in support of the implementation of the			

	1.1.c. Reproductive Health Minimum Initial Service Package (MISP) package integrated into MoLHSA Preparedness and Response Plans to Disaster and Emergency Situations. **Baseline:** None **Target:** Yes	national MNH action plan; 1.1.4.2. Orient all relevant partners on MNH Strategic Plan, create awareness and commitment for suitable actions by ensuring broad stakeholder engagement in the accountability process; 1.1.4.3. Enhance the role and responsibility of the MoLHSA's MCH Council for improved inter-sectoral/interagency coordination and collaboration in planning, implementation and monitoring and evaluation of MNH action plan; 1.1.4.4. Build the capacity of Health Department as a secretariat of MCH Council; 1.1.4.5. Publish an annual country report on implementation of MNH action plan to make it accessible to all suitable stakeholders and general public.			
		1.1.5. Allocate resources for implementation of the National MNH Action Plan 2017-2019: 1.1.5.1. Establish System of Health Accounts (SMA) to regularly monitor MNH/FP expense data and generate reports.			
		1.1.6. Integrate Reproductive Health Minimum Initial Service Package (MISP) package into the MoLHSA Preparedness and Response Plans to Disaster and Emergency Situations.			
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
1.2. Mechanisms for the reduction of geographic, socio-cultural and financial barriers to quality maternal and neonatal services are developed and established	1.2a. Number of special studies conducted **Baseline:** No **Target:** At least 2	1.2.1. Conduct an analysis of obstacles to achieving full-scale, high rates of coverage of effective intervention packages for quality MNH care within the health system and community (at least one special study).	MoLHSA NCDC&PH	2017-2019	
	1.2b. Number (%) of women and newborns who received MNH home care (antenatal, postpartum, postnatal) **Baseline:** None **Target:** 10 %	1.2.2. Develop and implement home-based MNH care programs by enhancing primary health care workers' role to promote and provide preventive care, antenatal care, birth preparedness, postpartum care and early childhood development activities particularly in rural/remote areas: 1.2.2.1. Design and implement effective training programs and supervision mechanisms for PHC providers on implementation of home-based MNH program; 1.2.2.2. Develop and maintain a registry for home-based MNH	MoLHSA NCDC&PH UNICEF	2017-2019	

		program; 1.2.2.3. Provide support to PHC providers for making designated home visits through travel and transport allowance.			
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
1.3. Mechanisms for strengthening community mobilization and participation to increase access to MNH services within the community are developed and established	1.3a. Number of orientation meetings with target audience **Baseline:** None **Target:** 11	1.3.1. Engage with local governments, city majors and municipalities to ensure their participation in multi-stakeholder response. 1.3.2. Orient/sensitize communities to raise awareness of MNH needs and to solicit their commitment for strengthening connections between households and health system: 1.3.2.1. Conduct awareness raising meetings with local, district and regional authorities, NGOs/CBOs, private sector, health care providers and managers and religious leaders to identify priority problems and local solutions.	NCDC&PH	2017-2019	

Objective 2: By 2020 quality of maternal and neonatal health services will be improved and standardized along with integration of these services

Outcome 2: Quality of maternal and neonatal health services is improved and standardized, as measured by indicators listed below, that should be included in the standard monitoring system. (for each indicator the baseline and target still have to be defined)

Indicators:

1. % of pregnant women whose first antenatal care visit occurs before 12 weeks gestational age

Baseline: 82.7% **Target:** ≥95%

2.% of pregnant women who receive the recommended number of iron/folate supplements during pregnancy

Baseline: 22% (2016) **Target:** ≥95%

3. Prevalence of HIV in pregnant women (disaggregated by age group)

Baseline:

Age group	15-49	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Prevalence (%)	0.1	0	0.1	0.1	0.1	0.1	0	0

Numerator: Number of pregnant women who tested HIV positive (including those who already know their HIV positive status) who attended antenatal clinics

Denominator: Number of women tested for HIV at antenatal clinics (including those who already know their HIV positive status).

Target:

Age group	15-49	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Prevalence (%)	0.05	0	<0.05	<0.05	<0.05	<0.05	0	0

4. Prevalence of Syphilis in pregnant women (disaggregated by age group)

Baseline:

Prevalence (%)	0.2

Disaggregated data are not available

Numerator: Number of antenatal care attendees who tested positive for syphilis

Denominator: Number of antenatal care attendees who were tested for syphilis

Target:

Prevalence (%)	0.1

5. % of births at level appropriate facilities

Baseline: N/A **Target:** ≥90%

6. Maternal mortality by specific cause (impact)

Baseline: 57.9 **Target**: ≥90%

7. Neonatal mortality by specific cause (impact)

Baseline: 98.1% **Target:** 99%

Causes of neonatal deaths (Dollfus Classification)

8. Congenital syphilis case rate (a stillbirth, live birth, or fetal loss at >20 weeks of gestation or >500 grams to a syphilis seropositive mother without adequate syphilis treatment) per 100 000 live births (impact)

Baseline: 26.4

Numerator: Number of reported congenital syphilis cases in defined year

Denominator: Number of live births

Target: ≤ 10 cases per 100 000 live births

9. Case rate of new pediatric HIV infections due to MTCT per 100 000 live births (impact)

Baseline: 1.7 (2015 1 case)

Target: ≤ 1 case per 100 000 live births

10. Institutional Neonatal mortality rate disaggregated by birth weight: (impact)

>4000 g, 2500–3999 g, 2000–2499 g, 1500–1999 g, 1000–1499 g, <1000 g

Baseline:

>4000 g	2500–3999 g	1500–1999 g	1000–1499 g	<1000 g
0.7	1.1	2.3	178.6	662.7

Target:

>4000 g	2500–3999 g	1500–1999 g	1000–1499 g	<1000 g
0.35	0.5	(20% reduction)	(15% reduction)	(5% reduction)

11. Intrapartum stillbirth rate (impact)

Baseline: 14% **Target:** 10%

12. Cesarean sections as a percent of all births

Baseline: 41.4% **Target:** 31%

13. % of low-risk primary caesarean birth

Baseline: N/A **Target:** 25%

14. Prevalence of low birth weight from total number of livebirth

Baseline: 6.1% **Target**: 5% reduction

15. % of newborns who were exclusively breastfed at the hospital discharge

Baseline: 95% **Target**: 98%

16. % of newborn babies born in the hospital admitted into the neonatal special care unit

Baseline: N/A **Target:** 18%

17. % of pregnant women satisfied with the ANC services they receive

Baseline: N/A **Target:** 80%

Output	Output indicator	Activity	Implementing Agency	Timeframes	Budget
2.1. Mechanisms for strengthening the continuum of care for MNH through enhancing preconception, antenatal, intrapartum and postpartum/ postnatal care connected with effective referral system to improve pregnancy outcomes are established	2.1a. % of PHC facilities providing preconception care services within the basic benefit package **Baseline:** No **Target:** 15% 2.1b. Number (%) of facilities providing ANC services according to the assigned levels of care per perinatal region **Baseline**: Not applicable **Target**: ≥70% 2.1c. % of women with preterm deliveries received antenatal corticosteroids **Baseline**: N/A **Target:** ≥90% 2.1d. % of pregnant women who were tested for HIV	2.1.1: Integrate preconception care package into PHC basic benefit package: 2.1.1.1. Revise financing mechanisms to integrate preconception care into PHC basic benefit package. 2.1.1.2. Build capacity of PHC providers on provision of preconception (pre-pregnancy) care (timely diagnosis and treatment of non-communicable and communicable diseases, provision of nutrition services (folic acid, Iron supplementation), and information on the effects of tobacco, alcohol and illicit drugs on pregnancy outcomes) through trainings conducted with the national PHC strategy.	MoLHSA: Health Department SSA NCDC&PH	2017-2019	
		2.1.2. Review and update existing minimum ANC package ensuring women receive WHO recommended visits and all the evidence-based interventions, including identification and management of pre-existing health conditions (non-communicable and communicable diseases), early detection and treatment of pregnancy complications, health promotion and disease prevention (recognize danger signs, good nutrition with folate and iron supplementation, risky behaviors, etc.), birth preparedness and complication readiness planning. 2.1.3. Revise financing of updated ANC package.	MoLHSA: Health Department Professional associations SSA State Regulation Agency for medical Activities	2017-2019	

	and received their result during pregnancy, labour and delivery, and the postpartum period (within 72 hours of delivery), including those with a previously known HIV status **Baseline:** 93.8% **Target:** ≥95% 2.1e. % of HIV-infected pregnant women who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission (PMTCT) **Baseline:** 95% **Target:** ≥95% 2.1f. % of pregnant women tested for syphilis at the first antenatal care visit/at least once/ever **Baseline:** 93.4% **Target:** ≥95% 2.1g. % (estimated) of syphilis-seropositive pregnant women who are adequately treated at or before 24 weeks of gestation **Baseline:** N/A (will be available from 2017) **Target:** ≥95% 2.1h. Number of perinatal regions where regionalization of perinatal	2.1.4. Introduction of the adapted online educational modules on *new WHO guidelines on pregnancy and ante-natal care*, which offers the flexibility and advantages of an online learning environment through Continuous Medical Education system. 2.1.5. Develop and implement integrated congenital syphilis and mother-to-child transmission (MTCT) of HIV elimination plan at the country level. 2.1.6. Stratify the ANC service provision: 2.1.6.1. Develop the criteria and regulations for the levels of ANC services; 2.1.6.2. Conduct an assessment of the existing ANC services against the levels of care; 2.1.6.3. Assign the ANC service level to each facility.	(SRAMA) UNICEF UNFPA		
		2.1.6. Institutionalize perinatal care regionalization project and scale-up country-wide: 2.1.6.1. Harmonize perinatal facility licensing/permit with the requirements of perinatal service levels; 2.1.6.2. Assess the needs of facilities in a perinatal region for achieving the desirable/achievable level of perinatal service required according to the regionalization standards; 2.1.6.3. Strengthen facility human/technical resources for meeting perinatal service provision requirements set by regionalization; 2.1.6.4. Assign a perinatal service level to the facility; 2.1.6.5. Build capacity of MoLHSA staff by training human resources on facility assessment and level of care designation, data analyses, monitoring and follow-up supervision; 2.1.6.6. Monitor the compliances and level appropriate care provisions by the facilities; 2.1.6.7. Revise/elaborate and approve norms and regulations on mother and newborn transport system; 2.1.6.8. Monitor the compliance of existing mother and newborn transport system with developed norms and regulations; 2.1.6.9. Develop the mother and newborn transport information system.	MoLHSA: Health Department SRAMA Professional Associations UNFPA, UNICEF, Donors	2017-2019	

	services are implemented **Baseline:** 2 **Target:** 11 2.1i. Number (%) perinatal care facilities providing MNH services according to the assigned level of care per perinatal region **Baseline:** 18% **Target:** 100% 2.1j. Number (%) of MNH service facilities with established EMR system integrated into the national EMR **Baseline:** No **Target:** ≥95% 2.1k. % of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth **Baseline:** 100% **Target:** 100% 2.1l. % of infants born to HIV-infected mothers receiving ARV prophylaxis for PMTCT in the first 6 weeks **Baseline:** 100% **Target:** 100% 2.1m. % of infants born to syphilis-seropositive women who received serological test for evidence of congenital syphilis at delivery	2.1.7. Integrate the private sector Electronic Medical Record (EMR) systems into the national EMR system as a way to exchange the patient information and improve the quality of MNH care.	MoLHSA: Health Department IT Department SSA NCDC&PH	2017-2019	
		2.1.8. Review and update existing postpartum/postnatal care package to promote healthy behaviors, to identify maternal and newborn complications, and to facilitate referral, as well as to provide quality extra care for small and sick newborns: 2.1.8.1. Review financial mechanisms for postpartum care; 2.1.8.2. Strengthen the linkage of small and preterm newborn care with early intervention program.	MoLHSA: Health Department SSA Professional Associations	2017-2019	
		2.1.9. Promote, support and protect early and exclusive breastfeeding: 2.1.9.1. Evaluate the implementation of the Law of Georgia on Protection and Promotion of Breastfeeding; 2.1.9.2. Develop and implement the Law enforcement mechanisms.	MoLHSA: Health Department SRAMA	2017-2019	
		2.1.10. Forecast demand, procure and supply essential supplies, medicines for MNH services, specifically folic acid, Iron, micronutrient supplements and surfactant	MoLHSA MNH service providers	2017-2019	

	Baseline: N/A **Target:** 100%				
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
2.2. Measures for fostering quality of MNH care through process improvement efforts and also through advocacy, legal, and accountability mechanisms with both private and public sector providers are developed and implemented	2.2a. Number (%) of facilities collecting data on the selected perinatal care quality indicators **Baseline:** 0 **Target:** 90% 2.2b Number (%) of facilities that conduct case review/audits into maternal death/near miss **Baseline:** 6 (5%) **Target:** 40% 2.2c. % of maternal and perinatal deaths (institutional) for which mortality auditis conducted **Baseline:** 100% **Target:** 100%	2.2.1. Periodically update and approve guidelines and protocols for pre-conception care, antenatal care, obstetrics and neonatal care, and postpartum/postnatal care.	MoLHSA: Health Department Professional Associations	2017-2019	
		2.2.2. Develop and introduce the MNH quality indicators: 2.2.2.1. Select a core set of MNH care quality indicators; 2.2.2.2. Develop and implement standard operating procedures (SOP) for collecting data on the MNH care quality indicators; 2.2.2.3. Report on facility ranking based on the data analysis and communicate the results with all facilities including through the MoLHSA website.	MoLHSA: Health Department SSA NCDC&PH	2017-2019	
		2.2.4. Standardize the maternal and perinatal mortality/near miss audit practice: 2.2.4.1. Develop and implement a SOP for medical records audit in MNH service providers; 2.2.4.2. Communicate the audit results and recommendations among the perinatal facilities.	MoLHSA: Health Department Professional Associations	2017-2019	
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
2.3. Mechanisms for building the competency of health providers, and promote policies, budgets, and regulations to address the needed skill level mix, appropriate health worker deployment, retention, and motivational efforts, including task shifting are	The policy is developed and mandatory continuing medical education (CME) and relicensing/ recertification system for physicians is established. **Baseline**: No **Target:** Yes 2.3b. Number of mandatory continuing medical education (CME) courses	2.3.1. Develop policy and establish mandatory continuing medical education (CME) and relicensing/ recertification system for physicians: 2.3.1.1. revise/elaborate and approve regulations for mandatory continuing medical education (CME) and relicensing/recertification of physicians including: • Update core competencies • Develop/revise accreditation criteria and policies for CME • Develop/revise credit system for CME • Develop/revise standards for commercial support for CME • Develop/revise CME program administration requirements and	MoLHSA: Health Department SRAMA Donors Professional	2017-2019	

established	approved **Baseline:** 0 **Target:** TBD	institutional mechanisms 2.3.1.2. Support the development and implementation of CME courses by professional associations.	Associations		
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
2.4. Innovative mechanisms for MNH care financing are introduced	2.4a. Number (%) of ANC facilities enrolled in P4P system **Baseline:** 0 **Target:** TBD	2.4.1. Develop and implement P4P system for improving antenatal care in selected regions. 2.4.2. Develop and implement obstetric and neonatal DRG system.	MoLHSA: Health Department SSA	2017-2019	
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
2.5. Mechanisms for strengthening Health Management Information System and research capacity to improve quality of data for evidence-based informed decision-making and resource allocation for MNH are developed/established	2.5a. Number (%) of facilities where Data Quality Audit System is implemented. **Baseline:** 0 **Target:** TBD 2.5b. Number of special studies conducted **Baseline:** 0 **Target:** 1 2.5c. Number (%) personnel trained on cause-of-death certification and ICD-10 coding **Baseline:** 10% **Target:** 25%	2.5.1. Establish a minimum perinatal dataset and ensure that all pregnancy and birth outcomes are collected, with consistent definitions and cross-links to databases for birth registry, vital registration and UHC.	MoLHSA NCDC&PH	2017-2019	
		2.5.2. Develop and Introduce Data Quality Audit (DQA) system at the national and facility level, based on the evaluation of the various MNH data registries: 2.5.2.1. Develop/adapt the "Routine Data Quality Assessment Tool" (RDQA); 2.5.2.2. Trace and verify (recount) selected indicator results based on the RDQA protocol(s); 2.5.2.3. Develop and share the audit findings and recommendations with respective facilities.	NCDC&PH SSA	2017-2019	
		2.5.3. Support multiple data collection efforts through demand targeted research, including household surveys, facility assessments, operational research and other efforts for tracking maternal and newborn health processes and outcomes.	NCDC&PH	2017-2019	
		2.5.4. Improve the capture and quality of death records in civil registries and other information sources, including: 2.5.4.1. Develop and implement cause-of-death certification and ICD-10 coding in-service training programs for physicians, medical coders, data providers, statisticians, etc. to standardize and improve	NCDC&PH Civil Registration and Vital Statistics	2017-2019	

		quality of cause-of-death assignment and coding practices.	System (CRVS)		
		2.5.5. Support strengthening of maternal and perinatal death surveillance and response, including notification of maternal and perinatal deaths (within 24 hours).			
Objective 3: By 2020 awareness and knowledge in the general population about the healthy behaviors and medical standards of high quality care and the rights of patients who use this will be improved.					
Outcome 3: Community and household knowledge, attitude and practices (KAP) for maternal and newborn care improved **Indicators:** 1. % of WRA who can identify maternal danger signs **Baseline:** N/A **Target:** 40% 2. % of WRA who can identify newborn danger signs **Baseline:** N/A **Target:** 40%					
Output	**Output indicator**	**Activity**	**Implementing Agency**	**Timeframes**	**Budget**
3.1. Measures to support the IEC/BCC activities to raise awareness in the general population about the maternal and household healthy behaviors and MNH programs are developed and implemented.	3.1a. Number (%) of target audience who have heard/seen MNH messages **Baseline:** N/A **Target:** 90%	3.1.1. Develop and implement national IEC/BCC campaign to improve healthy maternal and household behaviors, including the seeking of care for uncomplicated pregnancy and birth and for the prompt treatment of complications: 3.1.1.1. design/develop IEC/BCC key messages and materials for community members (women, men, and adolescents) for specific maternal and newborn issues, with emphasis on: • Advantages of early attendance to health facilities (ANC) • Birth preparedness • Essential nutritional practices and actions for maternal and newborn health • Postpartum/postnatal and Newborn care • Causes of maternal and newborn deaths and identification of danger signs • Early Care seeking and compliance • Role of men in maternal and newborn health 3.1.1.2. Disseminate key MNH messages and promote positive behaviors using a multipronged approach (TV, radio, social media, mobile phones, billboards, print media, IEC material, etc.)	NCDC&PH	2017-2019	
		3.1.2. Conduct evaluation of the impact of multimedia communication campaign.		2019	

Output	Output indicator	Activity	Implementing Agency	Timeframes	Budget
3.2. Mechanisms for strengthening advocacy and social mobilization activities to promote maternal and household healthy behaviors and MNH program are established.	3.2a. Number of Mother and Newborn Health events conducted **Baseline:** 0 **Target:** 1	3.2.1. Engage the private sector to promote zero tolerance for preventable mortality and advocate for optimal behaviors: 3.2.1.1 Provide private providers with messages and materials developed for health promotion and behavior change activities; 3.2.1.2 Orient health care providers' and managers' on using IEC materials for interpersonal communication.	MoLHSA NCDC&PH Private sector providers	2017-2019	
		3.2.2. Develop and use advocacy toolkits to facilitate dialogue with key stakeholders, development partners, NGOs, professional associations, national, district and community level policy and decision makers, religious leaders to support MNH communication activities including resource allocation.	MoLHSA NCDC&PH	2017-2019	
		3.2.3. Develop press kits and hold sensitization seminars for national and local level media (radio, TV, newspaper) representatives to increase coverage of MNH programs and issues in their respective media, and disseminate success stories of women and newborns whose lives have been saved.	NCDC&PH	2017-2019	
		3.2.4. Organize social mobilization events including Mother and Newborn Health Week activities and celebration of international Women's and Children's days.	MoLHSA NCDC&PH Local governments NGOs development agencies	2017-2019	

Objective 4: By 2020 accessibility of Family Planning services will be improved substantially for target groups.

Outcome 1: By 2020 accessibility of Family Planning services will be improved substantially for target groups.

This outcomes will positively affect the Maternal and Neonatal mortality and morbidity rates.

Indicators:

1: % of women of reproductive age (aged 15-49 years) using a modern method of contraception:

Baseline: 35% (2010, RHS) **Target**: 45% (2018, MICS)

2: The Total Induced Abortion Rate (TIAR)

Baseline: 1.6 TIAR (2010, RHS) **Target**: 1.4 TIAR (2018, MICS)

Output	Output indicator	Activity	Implementing Agency	Timeframes	Budget
4.1. Stewardship role of the Government of Georgia to effectively lead, manage, and coordinate the FP programme is strengthened.	4.1a. FP counselling and provision of contraceptive supplies is included in the Basic Benefit Package of the Georgia Universal Healthcare Programme for selected target groups (including youth people). **Baseline**: No (2016) **Target**: Yes (2020) 4.1b. Essential Medicines List includes WHO pre-qualified contraceptives; **Baseline**: No (2016) **Target**: Yes (2020)	4.1.1. Elaborate identification methodology and implement a budget impact analysis for making a decision on contraceptive methods free provision for Youth and Targeted Social Assistance (TSA) program beneficiaries. 4.1.2. Include FP counselling and free provision of contraceptive supplies (*selected methods)* in the basic benefit package of the Georgia Universal Healthcare Programme for selected group of beneficiaries. 4.1.3. Revise current legislation in order to establish enabling legal base for effective integration of FP services at PHC level. 4.1.4. Elaborate appropriate packages of stratified FP service provision. 4.1.5. Develop list of modern Contraceptive methods to be included in upcoming Georgia essential drug list.	MoLHSA	2017-2020	
4.2. Stewardship role of the government to improve young people's awareness and knowledge on SRH issues is strengthened	4.2b. # of school doctors trained in Kakheti and Samegrelo regions; **Baseline**: 0 (2016) **Target**: 60 (2018)	4.2.1. Through collaboration between the MoES and NCD&PH and with the support of international partners, support trainings of school doctors on Youth SRH issues according to the accredited curriculum in this area. 4.2.2. NCDC&PH will contribute to elaboration of learning and teaching materials on Healthy Life Style and RH issues to be integrated into the formal education system.	NCDC&PH UNFPA	2017-18	
4.3. Regulatory and steering mechanisms for quality FP service delivery	4.3a. FP protocol for PHC and SOPs are developed and adopted by MoLHSA	4.3.1. Elaborate and adopt PHC Family Planning protocol and SOPs based on WHO recommendations. 4.3.2. Develop a minimum data collection tools for each level of care	MoLHSA	2017-2020	

	Baseline: No (2016) **Target**: Yes (2020) 4.3b. Tools for collection of data on FP utilization for each level of care are developed. **Baseline**: No (2016) **Target**: Yes (2020) 4.3c. MICS/RSH conducted to collect baseline data for the MNH/RH Strategy. **Baseline**: No (2016) **Target**: Yes (2018)	for collection and analysis of monitoring data on FP service quality and utilization. 4.3.3. Develop procedures for strengthening of regulatory mechanisms for quality assurance of FP services. 4.3.4. Conduct research aiming at the improvement of service delivery and identifying social barriers and administration and policies' constraints. ex. MICS-RHS.	NCDC&PH UNICEF UNFPA		
4.4. Service providers' skills and knowledge increased on FP services	4.4a. Standardized Family Doctors' training curriculum is reviewed to ensure that they include adequately the FP component and a full range of methods. **Baseline**: No (2016) **Target**: Yes (2018)	4.4.1. Update/revise undergraduate and postgraduate education curriculums for PHC and RH service providers for incretion of most modern FP topics/methods. 4.4.2. Review current in-service training curricula and modules for RH service providers and FDs to ensure they include a full and comprehensive FP section.	MoLHSA TSMU Professional Associations UNFPA	2017-2018	
4.5. Awareness and demand for the FP service increased, including among youth	4.5a. Comprehensive awareness raising strategy with evidence-based messaging is elaborated, including for youth. **Baseline:** No (2016) **Target**: Yes (2018)	4.5.1. Support elaboration of the awareness raising strategy and messages in a participatory manner; 4.5.2. Foster a dialogue with media representatives and journalists on benefits of FP and how to discuss this issue in media. 4.5.3. Launch multimedia campaigns employing television, radio, newspapers, magazines and specially prepared information booklets. 4.5.4. Develop educational tools, visual aids and method-specific leaflets for new starters of methods for distribution at medical facilities and PHC clinics. 4.5.5. Build partnership with other stakeholders and civil society organizations for promotion of FP and Youth access to friendly RH/FP information and services.	MoLHSA NCDC&PH Professional Associations UNFPA	2017-2020	