Prepared by the MOH SBA Collaborating and Responsible Committees with technical assistance from UNFPA, WHO and JICA

Vientiane, Lao PDR

Acknowledgments

The Skilled Birth Attendance (SBA) Plan has been developed under the leadership and guidance from H.E. Dr Ponemeck DALALOY and H.E Dr Eksavong Vongvichit who was chair of the high-level Committee responsible for supervision and oversight of this important plan. The initial drafting of the plan was undertaken by the Collaborating Team, with members from many Departments across the Ministry of Health and this was lead by Dr Phouthone Vangkonevilay Deputy Director of Organization and Personnel. Gratitude is expressed to all the members of both the high-level Responsible Committee and the Collaborating Team. In particular, thanks must go to the individual goal leaders who so expertly called the relevant national staff to develop the specific activities for each goal, Dr Alongkone Phengsavanh (Goal 1), Dr Chanheme Songnavong (Goal 2), Dr Bounhem Ekalath (Goal 3), Mme Phendgy Inthaphanith (Goal 4) and Dr Somchit Akhavong and Dr Kaisoine Chounramany (Goal 5).

The national team were assisted by its many development, who kindly spent time attending meetings sharing their experiences and suggestions and commenting on early draft. In particular , Dr Ornella Lincetto WHO, Dr Noda and Mrs Mayumi Hashimoto JICA and Mrs Mieko Yabuta, Ms Mariolenn Coren, Dr Doungchan Xaymounvong, Dr Boathip Phongsavath from United Nations Population Fund (UNFPA). UNFPA have played a major role in this work both by providing much of the financial support and the Technical Advisor Mrs Della R Sherratt to work closely with the goal leaders and help to bring this Plan to fruition.

The finalisation of such a comprehensive plan to increase the number and quality of Skilled Birth Attendants and provide them with the enabling environment so they can function properly has been an enormous collaborative venture. It is clear that the SBA Plan would not have been possible without the support of many people, too many to mention individually by name, but without everyone's support, hard work and commitment to saving the lives of mothers and newborns in Lao this Plan would not be possible

Foreword

In the past ten years, the Ministry of Health has been strengthening its efforts in collaboration with international development partners and International Non Government Organizations, in order to promote mother and child health and to reduce the Maternal mortality ratio (MMR) and the Infant mortality rate (IMR). If we compare MMR in Lao PDR with other ASEAN countries and other countries in general, the rate still remains high.

Therefore, the Ministry of Health, in respect to its obligations to the Lao PDR Government, have placed maternal and child health as its top priority. In addition, His Excellency the Minster of Health has appointed a high level Responsible Committee to collect and review evidence from within the country and from other countries related to reducing maternal and child mortality. The data shows that in order to solve the problem of high deaths associated with childbirth is to have a comprehensive development plan to achieve *Skilled Birth Attendance* (SBAce).

By now the SBAce development plan has been finalised and endorsed. The plan contains the goal, expected results, strategic objectives and the many activities that are just one part of what is needed to decrease MMR and IMR in order to achieve the MDGs by 2015, and to allow Lao PDR to graduate from the list of least developed countries by 2020.

On behalf of the Ministry of Health I would like to express my sincere appreciation and thanks to the dedicated committee and to UNFPA, WHO, JICA and other international agencies for their respective technical cooperation and financial support for accomplishing this SBAce development Plan.

Finally, I would like to call on all stakeholders, national and international, to continue their collaboration and assistance to make the SBAce plan a reality.

Dr Ponmek DALALOY
Minister of Health, Lao PDR

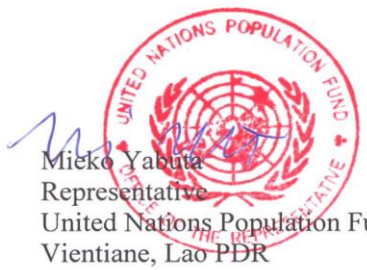
Foreword by UNFPA

Maternal mortality continues to be the major cause of death among women of reproductive age in Lao PDR. It is estimated that more than two women die in Laos every day. Behind this tragic statistic however lies an equally sad fact - for every woman who dies, about 30 women suffer from maternal morbidity. Some of them are permanent damages. Death of a mother and wife is a tremendous loss for the family socially, emotionally and economically. If a mother dies, the survival of the remaining children becomes difficult and even if they survive, their physical and psychological well-being would not be the same. Moreover, such deaths are above all a human tragedy – a sign that society has failed to protect the most vulnerable, because almost all maternal deaths are avoidable. The same can be said for death of newborns.

It is now well known that pregnancy and birth complications in the woman and or her newborn cannot be predicted, or even in some instances not prevented, but can be managed and most maternal deaths and a significant proportion of newborn deaths could be averted if births were attended by a qualified professional backed up with quality referral services. However, according to the Lao Reproductive Health Survey 2005, almost 85% of all childbirths took place at home and only about 18% were assisted by trained health personnel -making it difficult to recognize a problem and causing delay in the decision to take the woman to a hospital. In the case of haemorrhage, which is the most frequent cause of maternal death in Laos, most women die within 4 hours. So the quick recognition, quick decision-making and timely treatment can separate life and death.

Reducing maternal mortality is about valuing women. It also requires a long-term commitment. It is tempting to find a quick fix, but the experience from other countries tell us that high-quality evidence-based interventions are the ones which eventually save time, money and efforts. This SBA development plan was thus produced based on the findings from the Assessment of Skilled Birth Attendance in Lao PDR and using the known evidence and good practices from other countries.

The work to produce this SBA development Plan has given UNFPA, MOH and the many national and external development partners an opportunity to further strengthen our commitment and partnership with each other, as well as rallying around one critical task that will ultimately benefit all women, men and children in Lao PDR. Let us keep this momentum in the difficult task of implementing this SBA development plan in order to improve maternal and child health and to achieve MDGs 4 and 5.



Mieko Yabuta
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Acronyms & Glossary of Terms

BemONC	**Basic emergency Obstetric and Newborn Care**. Consists of nine (9) signal functions: Parenteral administration of antibiotics, oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction –ventouse delivery; plus, stabilization of woman for referral, pre-referral care and referral; and resuscitation of the newborn with pre-referral care and referral of newborn with complication.
BeON-LSS	**Basic emergency Obstetric and Newborn - Life Saving Skills**. Includes basic first-aid (pre-referral care and referral) for postpartum haemorrhage, including giving an oxytocic drug IM; infection, including giving one dose of antibiotic IM; eclamptic fit, including giving magnesium sulphate or Diazepam IM; and resuscitation of newborn -including assisting with initiation of breathing, thermo-protection, correct cutting and ligature of the umbilical cord and recognition of newborn infection and giving a initial dose of IM antibiotic.
CEmONC	**Comprehensive emergency Obstetric and Newborn Care**. Consists of BemONC (as above), plus caesarean section and blood transfusion and for newborn, management of severe complications.
CHT	**College of Health Sciences Technologies**
CMw	**Community Midwife** Registered by MOH, DOP, until Midwifery or Nursing and Midwifery Council or similar, is established. Requires, as minimum, academic study at Diploma level is recognized as mid-level provider, able to work at HC and District Hospital Level B.
Competencies	Set of knowledge, skills, attitudes and experience, to carry out a task to proficiency in any situation
DOP	Department of Organization and Personnel, MOH
EmONC	**Emergency Obstetric and Newborn Care** same as BemONC, but includes both basic and comprehensive emergency care
EOC	**Essential Obstetric and Newborn Care** Includes routine care for women and newborns who have no complication in pregnancy, childbirth and neonatal period (childbirth-cycle) PLUS EmONC and management of other medical conditions and ailments that may occur in women and or newborn during the childbirth-cycle, i.e. those not necessarily considered emergencies.
EPI	**Expanded Program of Immunization** (including hepatitis B)
HC	Health Centre
IMCI	Integrated Management of Child Infections
JICA	Japan International Cooperation Agency

MMR	Maternal Mortality Ratio
MOH	Ministry of Health
PSoN	**Provincial School of Nursing**
RM	**Registered (professional) Midwife**. Registered by MOH, DOP, until Midwifery or Nursing and Midwifery Council or similar, is established. Requires academic study to minimum of Higher Diploma level. Is recognized as high-level provider, able to work at all levels of the health system.
SBA*(ce)*	**Skilled Birth Attendance**. Skilled care for pregnancy, childbirth and newborn care.
SBA*tt*	**Skilled Birth Attendant**. A midwife or a nurse, physician or medical assistant with midwifery skills, including as minimum, core competencies to provide BEmONC Some SBA*tts* can do more than minimum – can provide minimum and CEmONC.
TBA	Traditional Birth Attendants
UNFPA	United Nations Population Fund
WHO	World Health Organization

Skilled Birth Attendance Development Plan 2008 to 2012

PART 1

Introduction

This ambitious plan provides a road-map for leadership to strengthen the human resources for health required for reduction of Maternal Mortality Ratio (MMR) and newborn mortality in Lao PDR by 2015. It is not intended that the Plan should be implemented as a vertical or stand-alone project. Many of the activities mentioned in the Plan are being planned or are in the process of being implemented under a variety of different initiatives being undertaken across the Ministry of Health (MOH). The intention is not to duplicate activities, but rather have these all identified in one pragmatic programmatic action plan, so that any gaps can be identified and addressed. It is also proposed this initial road map is reviewed and updated regularly and integrated into the 2011 –2015 Health Plan.

Like many countries with similar economic challenges, Lao PDR's high MMR and newborn mortality is mainly due to poverty, poor infrastructure and weak health system, with those living in remote areas with no roads having almost twice the MMR than urban areas (Census 2005). In an attempt to address this situation, the Ministry of Health (MOH) have, with assistance of their external development partners, developed an integrated package of health services for the 1st level of the health system. This package of interventions is based around the needs of mothers, newborns and children and includes Expanded Program of Immunization (EPI) and nutrition. It is also intended to link with the referral services offered by the network of hospitals at district, provincial and central levels.

The Integrated Package of Maternal, Newborn Child Health (MNCH) services has been developed and is currently being implemented. However, it is well understood that one of the main factors to contribute to the successful implementation of this package is to have a properly trained, deployed, supervised and managed workforce with the requisite competencies for the services identified in the integrated package. It is clear from the recent SBA National Assessment (MOH, UNFPA 2008) that the current skills set of healthcare providers at the health centres (HC) are deficient for skilled care at birth. Moreover, the skills of providers in referral facilities offering basic and comprehensive emergency obstetric and newborn care (EmONC) also need strengthening.

In a recent joint statement by UN Agencies and The World Bank, these agencies pledged to jointly intensify support to countries to achieve the Millennium Development Goal 5 *To Improve Maternal Health*. Globally, MDG 5 is showing the least progress among the goals. This is not surprising given that maternal mortality has root causes in gender inequality, low access to education (especially for girls), early marriage, adolescent pregnancy, low access to sexual and reproductive health (including for adolescents) and other social determinants. They do acknowledge, however, that maternal mortality can be effectively reduced by addressing the above mentioned determinants and by ensuring universal access to: (a) family planning, (b) skilled attendance at birth, for which care during pregnancy as

well as labour and birth and after birth for care of mothers and newborns is essential, and (c) basic and comprehensive emergency obstetric care.

The steps needed to achieve the above while appearing simple, are quite complex and require multiple but parallel actions by multiple partners including the community. This plan helps to identify the steps needed to ensure health care providers are properly trained, recruited, deployed and supervised and have the necessary support including essential drugs and supply systems so they can function properly. Without such a plan, it is hard to see, given the many challenges facing the health system, how best to increase the health sector capacity to deliver the needed services to save the lives of mothers and newborns.

Overall Objective and Goals

The general objective of the SBA Plan is to further develop the health sector's capacity to deliver culturally appropriate and accessible health services for pregnancy, childbirth and postnatal care of mothers and babies. This will be achieved by ensuring adequate human resources are produced, recruited, retained, supervised and provided with the necessary enabling environment (including referral system) to contribute to maternal and newborn mortality and morbidity reduction in Lao PDR in line with the existing National Health and Development Plans and documents**.** There are five critical goals to be achieved and these are to:

1. Establish a skilled workforce with the capability to reduce maternal and newborn mortality and morbidity (i.e. adequate numbers of competent Skilled Birth Attendants), including developing midwife cadres (RM and CMw);
2. Strengthen system to produce the skilled SBA workforce;
3. Strengthen system to manage (i.e. deploy, retain and supervise) the skilled SBA workforce;
4. Strengthen the working environment so skilled attendants can function properly and provide "skilled care"; and
5. Strengthen links between the health sector and community, including referral system for obstetric and neonatal emergencies.

Background and Rationale

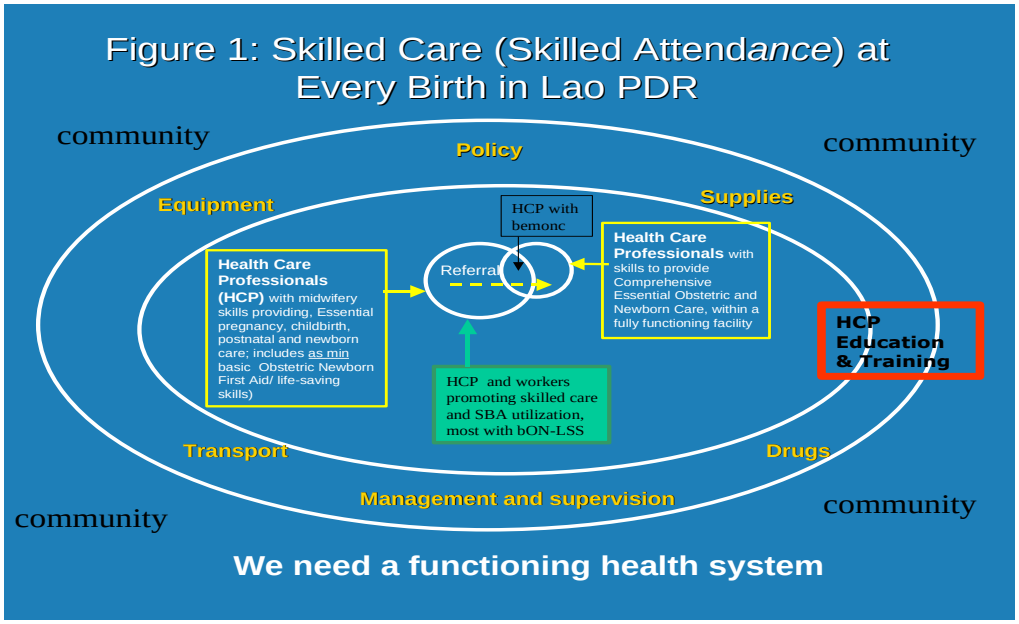
In 2007, as part of its efforts to reduce the very high maternal and newborn mortality and the presumed high levels of morbidity, the Ministry of Health (MOH) of Lao PDR, with assistance from external development partners, launched an initiative to increase the capacity of the health sector to deliver high quality, culturally appropriate, accessible, quality "skilled care" in pregnancy childbirth and for mothers and newborn in the postnatal period since it is

now well documented that skilled care saves lives (WHR 05[1]).
Reducing maternal mortality is more than just meeting the Millennium Development Goals; it is also about valuing women. Skilled care therefore has to be a top priority for all Lao men and women and not just the MOH. Without skilled care, not only is development and poverty reduction almost impossible, but it is also a human tragedy when society fails to care for its women. The same is true for the care of newborns that need protection and have a right to life.

Skilled care *(*also known as skilled attendance or SBAce) denotes care by a skilled attendant (SBA*tt*), a skilled pair of hands assisting pregnancy, childbirth and during the postnatal period in an enabling environment, supported by a functional referral system for emergency obstetric and neonatal care (EmONC) (PMNH, 2007)[2]. Skilled care is part of the universal package of basic health care that all countries are expected to provide and in Lao PDR, is the core component of the Integrated Package of Maternal, Newborn and Child Health.

The SBA Initiative in Lao PDR

The SBA initiative in Lao PDR was launched through a national workshop at Talath on 4-6 July 2007. At this workshop it was agreed there was a need for specific, intensive, unified action, to address the human resource issues for maternal and newborn health.
Human resources however do not operate in a vacuum and therefore there is need to also consider the wider policy, production (Education & Training system) and the operational environment needed for the trained provider to function properly (see Figure 1). The first activity of the SBA Initiative was to launch a national Skilled Birth Attendance Assessment to consider in detail the situation in a selected number of districts and provinces by establishing a national profile/benchmark.



[1] World Health Report 2005: Make Every Mother & Child Count. Geneva, World Health Organization, 2005 (available on WHO web-site)
[2] Partnership of Mother Newborn and Child Health web site

The findings of the SBA Assessment, conducted under the leadership of a specialist SBA committee that reported to a technical working group on Maternal and Child Health, was presented for wide dissemination in June 2008. The results and recommendations of the SBA Assessment (MOH, 2008) are the basis for and have guided the development of the Skilled Birth Attendance (SBA*ce)* Development Plan.

Under the leadership of Dr. Eksavang Vongvichith, MOH Vice Minister and concurrent Director of the Department of Organization and Personnel (DOP), a Collaborating Committee was established under Ministerial Decree 670 (with amendment 907), to produce a Skilled Birth Attendance (SBA*ce*) Plan (see Annex 1 for members of the Collaborating Team).

To reflect the complexity involved in developing such a plan and in particular, the need for cross-departmental collaboration and ownership of this plan, the Collaborating Committee was accountable to a high level Responsible Committee. The Responsible Committee, made up of heads of various relevant departments, was responsible for the approval of the final plan and submission to higher level for MOH acceptance and adoption.
The United Nations Population Fund (UNFPA) provided specific technical assistance for the development of this plan, in collaboration with other partners, specifically, the World Health Organization (WHO) and the Japan International Cooperation Agency (JICA).

Lessons from around the world constantly demonstrate that the key for ensuring equitable access to skilled care for all pregnant women and their newborn is to have a properly skilled workforce with the competencies to provide essential midwifery care, including life saving skills. (See Annex 2) Such providers must be supported by quality EOC referral facilities. Moreover, the he providers must be culturally acceptable, operate where needed at a cost women can afford.

In most countries, women, especially those living in poverty, are rarely able or willing to travel many miles for such care, except in exceptional circumstances such as very isolated villages. Neither do they have the social capital to pay for such care or the status to demand their rights to such care. Women in Lao PDR are no exception. Therefore, these skilled healthcare providers need to be deployed as close as is realistic to where women live. Also, their services, including the services for referral care when needed, must be made available at no cost at the point of service delivery. This has major implications for financing health care but mechanisms need to be found within the resources available to make this a reality.

The Future Workforce for Saving Lives of Mothers & Newborns in Lao PDR

They must have essential midwifery competencies and be built on existing human capital (meaning from both within the current workforce and also the many trained nurses who are currently unemployed in Lao PDR) because:

- The future SBA*ce* workforce must be easily identifiable so that:

1. the wider community is able to distinguish who is a Skilled Birth Attendant (SBA*tt*), so they can seek SBA*ce* when needed
2. to make it easier to deploy *SBAtts* where needed, to priority areas first
3. to monitor, both coverage of SBA*tts* (in terms of deployment) and performance
4. to make it easier to regulate the SBA*tt* – so there is common foundation and expectation of what they can and should.

- Skilled Birth Attendants (SBA*tts*), by the nature of the job, the specialist competency they must possess, and the level of responsibility they have for mothers and newborns should be seen and acknowledged as minimum, a Mid-level provider.
- It is important to make a SBA*tt* more easily identifiable, especially at the community level and to give status to the health workers providing this important role of SBA*ce*, as well as build a workforce in line with regional and international norms. It is also important for long-term sustainability and capacity development. Priority needs to be given to build midwife cadres (RM and CMw).

Who are the cadres who will have SBA*ce* competencies?

- Midwives; 2 types; 1) Registered Higher Diploma-high level (RM) [direct entry and post-basic nursing i.e. as an additional qualification after nursing], as well a current Nurse-midwives and midwives with midwifery skills update and 2) Diploma-mid level Community Midwife (CMw)[direct entry and post-basic after first training as Aux. Nurse, Assistant Nurse or PHCW] [See Annexes 3 & 4]
- OBGYN specialists
- Physicians (those currently in practice working in maternity areas- to have additional short clinical skills-based training)
- Medical Assistants (those currently in practice working in maternity areas - to have additional short clinical skills-based training)

Who are the cadres who will have basic obstetric & newborn Life-saving skills in future?

- All

What about TBAs?

- Those able (with accomplishment of upper secondary schooling or grade 12) – to be encouraged and supported to train as CMw Direct Entry (2 yrs). Those with schooling grade 8 and interested to be CMw will have special formal education courses within the programme, so they can exit with equivalence to upper secondary schools in order to meet entry requirement.
- Those not able to train as CMws – give supervision and support (link to) SBA*tt*, Plus: give training in health education, basic neonatal and child care, breastfeeding, advocacy for family planning, recognition of complications, making a referral and making birth and emergency preparedness plan that including access to SBA and Register as "Maternal and Child Community Health worker/volunteer" and give regular health education updates (see annex 12).

Achieving the Skilled Workforce for Skilled Birth Attendance[3]

Identifying the true human resources gap to achieve skilled birth attendance is difficult due to the current lack or robust data. However, as shown in Annex 8.1, some predications can be made based on the number of facilities, the proposed workload indicator (see Annex 8) and new staffing levels (see Annex 9). Using these figures it is possible to make a rough estimate of what is needed and potential cost for creating the number of Skilled Birth Attendants to achieve SBAce (see Table 1 below). Such costing however will need refining based on a number of variables, such as where training is undertaken and final agreements on staffing norms.

Developing the necessary competencies for skilled care during labour and birth takes time, especially where caseloads are low and thereby restricting opportunities for hands –on-practice, therefore it will be necessary to keep training cohorts small. Consequently achieving the numbers of skilled birth attendants will take time. Therefore, given the results of the SBA National Assessment, which showed the lack of skills in many current staff, immediate interim measures are also required to increase some of the basic MNCH skills of current staff while implementing the training to become an accredited SBAtt (see Annex 5).

Table 1.Training Needs to create sufficient Skilled Birth Attendants

Category of Staff with potential to be SBA	**Current numbers in the system (***based on DOP data Nov 2008)*	**Train needs to be competent SBA**	**Length of Training** *(all training based on competency achieved so some time lines flexible)*	**Number need to be trained or newly produced** [4]*(for 100% coverage of estimated births)*	**Estimated cost US$ to train up** **Unit Cost**[5]	**Total Cost US$**	**Remarks**
Existing staff: OBGYNs	69 (*data by Medical University)*	CEmONC	Short Internship (3 months)	40	500	20,000	Some 20 plus already had training in EOC
MDs	1169	• SBA IP (see annex 5) • BEmONC	2-3 months Short Internship	200	500	100,000	1 per Hospital facility as back up
MA	1546	• SBA IP • BEmONC	2-3 months	200	500	100,000	1 per facility as back up
Midwives	Not known	• 5 core MNCH modules	2-3 months Short Internship	N/A	N/A	N/A	Known to be less than 100 in total
Nurse-midwives	178	• SBA IP[6], • plus 5 core MNCH modules[7]	2-3 months	100	500	50,000	Must be working in maternity areas and have met the

[3] Based on proposed National Staffing Norms for SBA (annex 9) and HR gap as identified in Figure 8.1 Annex 8
[4] Numbers trained up to 2012 based on availability of training places
[5] Unit costs are based on costs at 2008 rates. Cost for internships are minimal based on providing accommodation and small DSA only
[6] Training to be undertaken at neatest Provincial Training Centre

							required SBA competency criteria
Technical Nurse	738	Post- basic RM High level Midwife (see annex 3)	2 years	120 (up to 2012)	2,000	240,000	Some may need 4-6 month bridging course
Aux Nurse	3,946	Community Midwife Training (see annex 3)	1 year	240 (up to 2012)	2,000	480,000	Many will need 4 –6 month bridging course prior to training
PHCW	246	Community Midwife Training (see annex 3)	1 year	246	2,000	492,000	Priority to female workers
Nurse Tutor – to become specialist Midwifery Tutor to train SBAs	20 *(6 CHT and 2 per Provincial school of Nursing (PSoN)*	• Clinical update[8] • TOTs (for MNCH clinical updates • Specialist Midwifery Pedagogy	2 months 25 days total 6-8 weeks	20	800 3,600 (per ToT)	1,600 18,000 260,000	
New Staff: OBGYNs	→		**4 years**	**10**	**10,750**	**107,500**	**Already planned**
Direct entry RM (high level midwife	→		**3 years**	**100** (up to 2012)	**6,000**	**600,000**	
Direct entry Community Midwife	→		**2 years**	**160**	**4,000**	**640,000**	

Estimated Long-term Training Costs up to 2012[9]: US$ 3,109,100 to create adequate numbers of Skilled Birth Attendants

[7] This is still under debate. It may be possible to test SBA competency and decide on training needed on an individual basis, can take some modules from year 3 of RM curriculum as needed to reach competency, those with very low scores will have to do same as Technical Nurse – years 2 and 3

[8] Ideally to be undertaken in one of the Central Hospital VTE (travel and small DSA required)

[9] Does not include training as interim measures as outlined in Annex 5

PART 2

Achieving the Specific Goals

Goal ❶ **Establish a skilled workforce to reduce maternal and newborn mortality and morbidity**

Strategic Objective 1.1*

As an immediate priority and an interim measure while waiting for the production of properly trained and competent Skilled Birth Attendants (SBA*tts*), ensure that all facilities (health centres and district hospitals B) where births take place and where there is no physician/high level provider has as minimum: 1 provider with basic obstetric and newborn life-saving skills[10] (the ideal is 2 just in case one is not on duty or busy) and then, to incrementally upgrade staff in basic essential (or first level) Maternal and Newborn and Child Care Service package[11] as core for the Integrated Maternal Newborn and Child Health package (see Annex 5 for numbers needed to be trained).

Strategic Objective 1. 2*

Develop midwife cadres (i.e. RM and CMw) from existing staff and also those already trained as nurses but currently unemployed, as well as new recruits in the service including trained TBAs with requisite education background (see Annex 3) so that MOH can:

- manage workforce better (know how many trained midwives there are, where are they, how many leave the service, how many more are needed, where are the gaps);

** Based on Lao SBA Assessment*

[10] Basic emergency obstetric and newborn life-saving skills (BeON-LSS) training includes basic first-aid (pre-referral care) for postpartum haemorrhage, including giving an oxytocic drug IM; infection, giving one dose of antibiotic IM; eclamptic fit, including giving magnesium sulphate or Diazepam IM; resuscitation of newborn -including assisting with initiation of breathing, thermo-protection, correct cutting and ligature of the umbilical cord and recognition of newborn infection and giving a initial dose of antibiotic IM.

[11] Consisting of a series of short clinical "skills-based" trainings for provision of 1st level Maternal, Newborn and Child health care in HC or hospital (see Annex 5), of which BeON-LSS is a compulsory foundation module. Other modules, such as antenatal/ postnatal care, family planning, essential newborn care to be taken in sequence to be decided by district Health Supervision Team (see Annex 10), in collaboration with District Health Officer. Moreover, modularisation of this package allows for additional modules such as, IMCI and community IMCI, nutrition and EPI including hepatitis B, as examples, to be added as required for implementation of the Integrated Maternal-Newborn and Child Health Service package, – the full list MNCH Package is still under discussion at time of writing this plan.

- deploy staff according to need; and
- ensure SBA competency is maintained (regulate practitioners).

To achieve this, there is need to strengthen the Regulations for Midwifery Practice within the Nurse and Midwife Law. However, as an initial measure, develop a guideline for Midwifery Scope of Practice to describe who can (has the right to) practice midwifery (ensure includes recruitment from all ethnic groups to guarantee equity), define what they can do and what they have to do to maintain competence (i.e., fitness-for-practice, have the essential core competencies stated in Annex 2), as well as grounds for removal of the licence. All of these should be included in the guidelines of Scope of Practice of Midwife. The guideline must be drafted so all those who practice midwifery must comply with the Scope of Midwifery Practice regardless of where they work (e.g. government or private practice).

Strategic Objective 1.3*:

Ensure there is a team of staff in all referral facilities (those designated to provide referral level services) that can provide the full package of comprehensive emergency obstetric and newborn (CEmONC) services as defined in MNCH package (see annex 14) and can supervise and train other staff in basic emergency obstetric and newborn care (BEmONC) and BeON-LSS competencies.

Strategic Objective 1. 4*:

Make sure that all future health care providers exit pre-service programmes with the basic obstetric and newborn life-saving skills (BeON-LSS) and other core skills for delivery of the 1st level MNCH Service Package (as core for Integrated Package of MNCH), including SBA*ce* competencies where agreed and that high -level providers exit pre-service programme with all above- plus BemONC skills.

Goal ❷ ☙ Strengthening the production of SBA*tts*

Strategic Objective 2.1:

Develop and implement standards for production (education and training of workforce based on the Provisional Standards of Education and Training for Midwifery/SBA in Annex 6) to ensure high quality staff as well as a mechanism to ensure the standards are complied with (for example through accreditation of the training curricula, training sites and establishing an education quality assurance programme for regular and periodic re-evaluation and improvements).

Strategic Objective 2.2:
Ensure adequate numbers of trainers in schoolsand clinical training sites with the capacity to teach SBAce competencies, midwifery and, BeON-LSS, (based on education standard) and as a long-term action for sustainability, develop a specific continuing professional development programme for SBA teachers especially midwife teachers.

As an interim measure there will be need for a number of Trained Midwife Teachers who can offer technical assistance for at least first year of midwifery training. Plus, to assist with the increased workloads for providing Clinical Skills updates it is advised that at least 1 new temporary Nurse Teacher is employed in each PSoN for 2009.

Strategic Objective 2.3:

Make a detailed national pre-service and long term upgrading education plan for 2009-2010 and calculate estimated numbers of midwives needed for 2011 and beyond (as minimum five to ten years) with budget requirements (see Annex 7, Provisional Production Numbers of new Midwives – all types).

Goal ❸ ☙ Strengthening the SBA workforce management

Strategic Objective 3.1:

Ensure appropriate staffing standards are agreed for recruitment into service and for deployment to ensure correct mix of skills, including creating posts where required depending on Workload Indicator (see Annex 9, provisional proposed Staffing Standards and Workload Indicator].

Strategic Objective 3.2:

Establish mechanism to ensure compliance with new Standards for Clinical Practice and the new Midwifery Scope Practice, making sure that compliance with this Scope of Practice is integrated into the regular supervision system. This includes developing and implementing a supportive supervision mechanism, including indicators to track workload increases (see Annex 9, proposed new Workload Indicator for SBA*tts* and Annex 10, proposed SBA*tts* Supervision System).

Strategic Objective 3.3:

Ensure pay and conditions (grade) reflect level of SBA*tts* responsibility and are attractive to motivate staff. Ensure too that SBA*tts* are able to obtain decent living wage and adequate incentives as permitted under general human resources policy.

Strategic Objective 3.4:

Develop and implement a specific SBA Supportive Supervision system, to include tracking workload indicator and also for identifying future needs, learning on the job, maintain standards of practice (and maintaining fitness-to-practice).

Goal ❹ ☙ Strengthen the working environment for SBA*tt*s

Strategic Objective 4.1:

Develop and disseminate evidence-based standards for clinical midwifery practice areas and a mechanism for regular and periodic auditing of clinical practice; as part of quality assurance and improvements (see Annex 11, Provisional List of Midwifery Practice Standards).

Strategic Objective 4.2:

Ensure all facilities have essential equipment and essential drugs, including mechanism to prevent drug stock-outs and responding to missing equipment plus logistic training for key staff at all levels.

Goal ❺ ☙ Strengthen links between health sector and the community including referral system

Strategic Objective 5.1:

Promote birth & emergency preparedness planning using media, radio, community awareness and peer education techniques.

Strategic Objective 5.2:

Develop participatory approach with the community in making, implementing, regularly monitoring & periodically evaluating the district plan; for increasing access to SBA*ce.* This includes close collaboration with the Women's Union and community leaders.

Strategic Objective 5.3:

Provide TBAs with support mechanism by linking TBAs to Skilled Birth Attendants and empowering them either through:

- Entering into the community midwifery programme to become Community Midwife (government employee or private practitioner), or
- Being trained and registered as Maternal and Child Community

Health Volunteer, (see Annex 12, Proposed modules for training TBAs to become MCH Community Health Volunteers).

Costing the Plan

Until some of the provisional activities have been completed it is not possible to give robust cost estimates; for example until decisions are made regarding salary grades and incentive packages as well as agreements on staffing norms.

Based on some initial provisional estimates the total cost of implementing the Plan will be in the region of 4.4 US$ million. Some of the costs will be from MoH own budget, however it is anticipated that substantive resource mobilization will be required to implement the plan in total.

As identified in Part 1 an estimated US$ 3.1 million is needed just for training of Skilled Birth Attendants up to 2012, but funding beyond 2012 will also be required.

Moreover additional funds are also required for:

- Technical Assistance to MoH, 1 International and 1 National Coordinator
- Monitoring and evaluation of the Plan
- Upgrading clinical facilities.

PART 3

Implementation of the Plan

Attempts have been made to discuss and share ideas with as many stakeholders as possible during the development of the plan. However, once approved by Ministerial Steering Committee, there will be a need for wide spread discussion and sharing of the plan with all stakeholders at the national, provincial and district levels.

Also, there is need for a collaborative meeting for resource mobilization among members of the donor community, where it will be important to reach agreements on who will take lead and who will provide technical assistance for each of the activities. At this meeting it will be possible to amend and agree the final Implementation Schedule as stated in Annex 13, Draft Implementation Schedule).

The complexity of the SBA Plan requires a strong and steady leadership from MOH and a high-level of coordination across all departments within the ministry and with donors. To ensure that all components of the plan are implemented in a timely and effective manner and according to the agreed implementation schedule, the Ministry would be best served if it considers appointing a dedicated high-level focal point. This Focal Point will coordinate all the necessary inputs from donors, actors and all MOH activities. Consequently, the Focal point needs to have authority to work across departments and to be able to liase directly with all partners to ensure effective coordination of the work plans. There may be a need for a National Consultant to work inside MOH to help assist in the coordination of all activities.

Responsibility for implementation of the SBA Development Plan should be undertaken within existing structures; basically this is through the Technical Sector-wide Working group which should have the SBA Plan as a standing agenda item. Overall responsibility for operational issues will be through the Technical Working Group for Human Resources (TWG-HRH) in collaboration with Technical Working Group for MNCH. The focal point and SBA international and National coordinators should be x-

officio members of TWG-HRH and be invited to report to TWG-MNCH on a regular basis or when issues related to Human Resources are being discussed.
For successful implementation there is need for additional staff in the Education and Training Department. Capacity within DOP would need to be strengthened as the plan will require an increased workload in this department.
Critically, it is likely that MOH will also require substantial technical assistance for implementing all components of this plan. In particular, it is likely there will be a need for assistance from at least one, but maybe more than one, international midwifery expert/s. One should be experienced at the policy level and strategic planning. Other midwifery expert with an education and training background are needed to assist with the implementation of the various curricula and training programmes. Therefore consideration should be given to recruiting at least 1 full time international technical officer to work with MOH, (possibly through one or both of the UN agencies involved in the development of this plan, on cost sharing basis). If funding permits, then the possibility of getting a Midwife UNV, or similar, in each provincial training school will be an advantage.

Moreover, given the large number of training courses envisaged and the need to update the existing teachers in training schools on midwifery and prepare clinical supervisors and preceptors (mentors), training schools will need to be strengthened in terms of additional staff. Consideration should therefore be given to employing, on temporary basis for at least 12 to 24 months, additional staff in each of the training schools. These additional staffs (minimum of 2 to 3 in each school) should include 1 person to assist with additional administration and logistic workload and a minimum of one, but ideally two, nurses to release those teachers to be involved in clinical up-skilling and or in the new midwifery programmes. There will also be need for additional permanent teaching posts, as the new midwifery programmes come on-line.

A preliminary "Implementation Schedule" has been developed (see Annex 13) to assist MOH with the development of their annual work plans. In the implementation, attention will be given to implementing more than 1 activity at the same time. For example combining training on birth and emergency birth preparedness under goal 5 will be included in the ANC /PNC training 1.1.6. Orientation meetings will cover as many activities for each goal as is practical. This implementation schedule gives proposed time frames for activities and highlights actions to be taken in priority order. This schedule can also assist with MOH discussions and agreements for annual plans with donors, as well as can be used for resource mobilization.

Finally, to assist with community advocacy to promote health-seeking behaviours for skilled attendance, consideration should be given to developing a specific logo (emblem) that could be on all materials produced under this plan. Such a logo could also be used as a badge (symbol) for identification of the new midwife cadres, so that the community can

easily identify and seek out care from this new cadre.

A detailed SBA Development Action Plan is outlined below, complete with strategic objectives and proposed activities, milestones, levels of responsibility given for achievement of each goal. This action plan should be seen as a road-map and needs to be adapted to take note of ongoing and new activities from all parts of the MOH. Estimations for the amount of budget required for each activity is also provided. These estimates are based on MOH and UN data for training conducted July 2008 and should be seen as indicative only, until actual costing can be made. In the implementation, consideration should be given to maximising resources, both financial and human by linking activities or conducting activities in parallel where this is possible. It will not be possible to implement this plan however, without additional resources being made available to MOH. Therefore it will be important to maximise concerted efforts for identifying sources and mobilizing additional resources. Where this is not forthcoming MOH will need to make some hard choices on prioritisation

Monitoring and Evaluation of the SBA Development Plan

Milestones are provided for each activity and these can be used to monitor the Plan.

Process indicators to measure implementation include:

- Annual numbers of SBA produced
- Numbers of existing staff completed the full package of MNCH skills updates
- Numbers of facilities meeting basic standards and able to delivery MNCH services
- Annual proportion of all expected births by trained healthcare provider by District
- Number of BEmONC facilities functioning correctly within last 3 months by population
- Caesarean Section Rate
- Number of Training Institutions Accredited for Midwifery Programmes by type of programme.

In view of the ongoing general activities related to Human Resources, over and above those related to SBA, it is proposed that the SBA Plan is reviewed with stakeholders in detail annually, with a detailed external qualitative evaluation taking place in mid 2012.

Detailed Skilled Birth Attendance (SBA*ce*) Development Action Plan

Goal #1: Establish a skilled workforce with capability to reduce maternal and newborn mortality and morbidity					
Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder[5]
1.1. By 2010 all facilities have at least 1, preferably 2 staffed with basic emergency obstetric and newborn life-saving skills (BeON-LSS) and from 2009 staff incrementally upgraded in core essential maternal and neonatal care modules** **As core for Integrated MNCH Service Package [See Annex 4 numbers needed to be trained in clinical short courses]	1.1.1. Develop BeON-LSS Training Manual	1. National SBA Clinical Curriculum Dev Committee 2. DOP to Approve Curriculum	Draft Completed by end Nov 2007	1,000	WHO, UNFPA
	1.1.2 Train national BeON-LSS Trainers (from central level and Province)	CHC with assistance from CHT and University OBGYN dept	Nov 2008 minimum 20 Provincial trainers trained	7,000	WHO, UNFPA
	1.1.3 Develop And Implement National BeON-LSS Training Plan	1. DOP approve training and develop plan 2. National SBA Supervision Committee Approval and monitoring of Training Sites 3. Approved SBA Training Centres – for delivery of training	1. Dec 2009 min 800 HC & Hosp B trained 2. Dec 2010, minimum 1 HCP in every HC & Hosp B Trained	146,250	WHO UNFPA ADB, LUX DEV
	1.1.4 Develop Training Needs Assessment Tool for 1st Level MNH Service Package	UHS, CHT, MNCH in collaboration with Curative Department	Tool ready for piloting 2008	No additional funds required	UNFPA, WHO
	1.1.5 Implement Training Needs Assessment Tool for 1st Level MNH Service Package	MNCH in collaboration with Curative Department	Introduced in all provinces by mid 2009	1,000	UNFPA

[5] Included to date, only those areas current included in annual work plans of WHO and UNFPA, other donors contributions yet to be included

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
1.1 Continued	1.1.6 Develop National Short Clinical Updating Training Plan for remaining 1st level Maternal-Newborn care modules (minimum 3 modules in addition to BeOn-LSS), including TOTs for each module. **Note:** other modules for the Integrated package for MNCH - such as, IMCI, EPI and Nutrition will also be required, but are already available in country. MNCH TWG responsible for updating these if needed	1. Training package design - National SBA Short Clinical Update Training Development Team under leadership of UHS and CHT 2. DOP approve training and develop plan 3. National SBA Superv. Committee approval and monitoring of Training Sites 4. Approved training centres - for delivery of training modules	1.Schedule for training approved by DOP Dec 2008	1,000	1. UNFPA (MODULE DEVELOPMENT AND TOT FOR ANC/PNC AND FAMILY PLANNING) 2. WHO FOR ESSENTIAL NEWBORN CARE PLUS OTHER AGENCIES - TO BE AGREED
	1.1.7 Implement National Short Clinical Updating Training Programme for 1st level Maternal-Newborn care (minimum 4 modules including BeON-LSS, ANC/PNC, Ess NBC, FP), including TOTs for each module	UHS and CHT with DOP, MCHC and Health and Hygiene Dept	By end of 2009 minimum of 1 HC worker in each HC trained in 3 modules plus BeON-LSS	410,000	Lux-Dev to be confirmed for VTE Province Other provinces to be agreed
	1.1.8 Develop Short SBA training package for MDs & MAs	University and OBGYN Society to draft and Implement with MCHC and DOP to Approve	first batch of trainees trained by May 2009	1,000	UNFPA
	1.1.9 Implement Short SBA training package for MDs & MAs	University and OBGYN Society to Implement with MCHC and DOP	1st Training by Mar 20009	220,000	To be Agreed
	1.1.10. Develop and maintain SBAtt database, including recording completion of clinical skills training	DOP, MCHC	System running & key staff trained by Jan 2009	1,000	To be Agreed

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
1.2. Develop Midwife Cadres (RM and CMw) who have all SBA ompetencies, including skills for all BemONC functions, from existing staff and new Direct entry students [See Annex 3: Proposed New Midwifery Cadre and Annex 6 for annual production numbers]	1.2.1 MOH to approve new cadres and agree with Finance Dept and other relevant Ministries, pay and allowances and TOR (to be conducted with activity in 3.2)	DOP	MOH APPROVAL SEPT 2008	Regular budget	To Be Agreed
	1.2.2 Approve Midwifery Education & Training Standards plus Accreditation process of Midwifery Training Schools	DOP	PRESENTED FOR APPROVAL BY NOV 2008	3,500	UNFPA
	1.2.3 Develop curriculum for new Direct Entry 3+11 Midwifery Education Diploma to become RM, in line with national standards (both MoE and DOP Standards of Education)	National Midwifery curriculum development group, under leadership of CHT and University	NATIONAL WORKSHOP TO DISCUSS DRAFT NOV 2008	10,000	WHO, UNFPA
	1.2.4 Develop curriculum for new post-basic Midwifery Education Programmes at Diploma level to become (RM) as an alternate career pathway for trained Professional Nurses; 3 year nurse-midwives; Technical Nurses	National Midwifery curriculum development group, under leadership of CHT and University	AS ABOVE IN 1.2.3	Included in above 1.2.3	WHO, UNFPA
	1.2.5 Develop curriculum for new 2-year Community Midwifery Education Programmes at Advanced Certificate level (CMw) as direct entry, with option for Assistant Nurses, Aux Nurses and PHCWs to enter part 2 (after first 6 months).	National Midwifery curriculum development group, under leadership of CHT and University	IN 1.2.3	Included with 1.2.3	WHO, UNFPA

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
1.2 Continued	1.2.6 Develop guidelines for Scope of Midwifery Practice, including SBA competencies (in long term need to revised Nursing and Midwifery Regulations to strengthen midwifery practice)	DOP and Curative Dept	Draft available for comment Jan 2009	20,000	JICA
	1.2.7 Develop long-term plan for entry into midwife teacher preparation programme (*for future teachers*)	- CHT and University - DOP approval programme	Draft available May 2009	10,000	WHO, UNFPA [TBC]
1.3 Ensure a <u>team</u> of staff in all referral facilities (those designated to provide referral level services), can provide comprehensive emergency obstetric and newborn (CEmONC) services and can supervise and train other staff in basic emergency obstetric and newborn care (BEmONC) competencies and BeON-LSS.	1.3.1 Review and if need be revise National b &c EmONC manuals; make sure newborn and follow-up SBA supervision added	Ob Society with MCHC training in collaboration with Curative Department and Paed Soc	Dec2008 National workshop	1,000	UNFPA,WHO
	1.3.2 Reprint Manual(s), if needed	MCHC	Manual ready for training	400	UNFPA
	1.3.3 Develop National basic & comprehensive EmONC training plan, including develop Training Needs Assessment tool and refresher Training for Trainers, if needed	MCHC for developing and monitoring training in collaboration with Curative Department and DOP	Training plan developed by Feb 2009	No additional funds required	WHO and UNFPA can assist with technical support
	1.3.4 Implement National basic & comprehensive EmONC training plan in all Provinces	MCHC, DOP with Curative	1st batch by Jan 2009	320,000	WHO,UNFPA, plus others to be agreed
	1.3.5 Training Provincial EMONC Supervision Team, to ensure regular supervision, including identification of training needs	National SBA Supervisory Committee	1st Training by Feb 2009	10,000	UNFPA, WHO

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
1.4 From 2009 all future health care providers will exit pre-service programmes with, <u>as minimum,</u> basic emergency obstetric and newborn life-saving skills (BeON-LSS) and core competencies for 1st level MNH services (for *all MD graduates this will be SBA core competencies and full BemONC skills)*	1.4.1 Orientation of national and provincial teachers and heads of Training schools, university, to disseminate core content for all programmes that lead to recognition as SBA*tt*, in line with best evidence and applicable for Lao context	National SBA Development Plan Collaborating team	National workshop April 2009	10,000	WHO UNFPA [TBC]
	1.4.2 Printing, translation (English and Lao) and dissemination of Education and Training guidelines (1.2.2) for SBA*tts*, including standards and all the different curricula for Midwifery programmes.	DOP, CHT, MCHC and Curative Department	Key Texts available by April 2009	5,000	UNFPA

Goal # 2: Strengthen the system to produce the skilled workforce					
Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
2.1 Develop and implemnt *standards* for production (education and Training) of SBA workforce to ensure high quality staff, and develop and implement a mechanism to ensure *standards* complied with2 [See Annex 5] **[2***Accreditation of training, training sites and curricula and develop and implement a Education Quality Assurance system for regular and periodic re-evaluation and improvements*	2.1.1. Develop and adopt National Education Standards for Midwifery Programmes[12]; including standards for approval of clinical training sites	National SBA Supervision Committee	Standards printed by Jan 2009	2,000	WHO, UNFPA
	2.1.2 Establish Accreditation Process whereby training centres can be approved and Re-Approved for offering Midwifery Education (pre-service and post-basic programmes); including, development and piloting of tools for Accreditation/ Re-Accreditation	National SBA Supervision Committee	Accreditation Tool Piloted May 2009	20,000[13]	To be agreed
	2.1.3 Upgrade Training centres to meet standards and, implement Accreditation process to designate centres for Midwifery Education[14].	DOP	Plan for all centres identifying gaps, ready for agreement by Dec 2008	80,000[15]	To be Agreed *[WHO and UNFPA can contribute to this activity]*

[12] To include: 1) standards for curriculum –minimum hours theory and practice, outline content, student case load, student: teacher ratio; 2) standards for the training institution – midwife teachers, 3) Standards for clinical experience and places for practicum training– minimum number of normal & uncomplicated births per year, number of clinical preceptors (mentors) to students etc.

[13] For Short Term TA Regional/ International advisor for 2 months plus 2 national meetings

[14] Based on gaps identified in assessment and checklist for accreditation (developed under 2.1.2) plus TOT for short courses will be part of this training package

[15] Based US$ 10,000 per training school for reequipping with models etc for midwifery and midwifery kits for students to do out of facility /home-based care and home births. Additional funds may be needed for upgrading residential accommodation for midwifery students

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
2.2.Ensure adequate numbers of trainers to meet education standard, with capacity to teach SBA competencies, Midwifery and for 1st level MNH services and Develop a long-term Professional Development Programme for teachers of midwifery [for 2009 there is likely to be need to employ at least 1 temporary teachers in each PSoN] Note: there is need for additional technical assistance for PSoN and CHT from International	2.2.1 Develop Training manual for Up-skilling Teachers ready for new Midwifery Programmes[16] – based on Adult learning Approach/ Participatory education methodologies.[17]	CHT and University – develop and implement DOP - Approve programme	20 trainers selected (central and Provinces) to Vietnam March 2009	10,000[18]	WHO UNFPA plus others – yet to be agreed
	2.2.2 Implement Training manual for Preparation for Teachers of new Midwifery Programmes[19] – based on Adult learning Approach/ Participatory education methodologies.[20]	CHT UHS with DOP	In country ToT May 2009	300,000[21]	WHO and UNFPA To be agreed Lux Dev[22]
	2.2.3 Develop additional Teaching and learning materials, including translation of key texts into local language and establish e-centre for midwifery, newborn and child health education	CHT and University – develop	Key Text identified by April 2009 Printed by Aug 2009	10,000	To be agreed *[WHO and UNFPA ADB can contribute to]*

[16] Consider including visit for 3 weeks to Vietnam for clinical practice and to see how they train the Village midwife, midwives from ethnic communities – this will require additional funds

[17] Estimates do not include cost for full time International Midwifery Trainer(s) to work with DoP or training schools, or cost of additional temporary staff for 2009-2010 to assist with additional workload and for new permanent Midwifery Teachers in Training schools for new Midwifery Programmes, these costs must be added

[18] TA for 1 month from Regional/International Midwifery Education Expert plus 1 national meeting to review draft manual

[19] Consider including visit for 3 weeks to Viet Nam for clinical practice and to see how they train the Village midwife, midwives from ethnic communities – will require additional funds

[20] Estimates do not include cost for full time International Midwifery Trainer(s) to work with DoP or cost of additional temporary staff for 2009-2010 to assist with additional workload and for new permanent Midwifery Teachers in Training schools for new Midwifery Programmes, these costs must be added

[21] Based on National consultant for 3 months, 1 month TA from Regional Midwifery Expert and small fee for teachers to attended national training in CHT and VTE PSoN

[22] Will hire 1 Regional Midwife teacher expert to be based in VTE PSoN but can assist with national upgrading of midwife teachers

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
(2.2 Continued) Midwifery trainers – possible as VSO	2.2.4 Develop long-term Professional Development (CPD) Programme -for teachers of SBA competencies (midwives, nurses and Medical educators); including out of country training to Master level midwifery for all midwifery teachers[23]	CHT and University – with DOP	Link to 2.2.1 and 2.2.2 and 1.4.1	3,000[24]	*WHO and UNFPA can provide technical assistance for this*
	2.2.5 Phased implementation of long-term Professional Development Programme (CPD) for teachers of SBA competencies; including out of country training to Master level midwifery[25]	DoP with assistance from CHT and University	Plan developed and presented at National workshop April 2009 (1.4.1)	10,000[26]	To be agreed
2.3 Make detailed National Pre-service Training Plan– with budget [See Annex 6 for projected production numbers]	2.3.1 Identify numbers midwives and other cadres (for SBA*ce*) needed to be trained (pre-service) for all trainings in 2008-9, with estimates for next 5 years, to be updated annually	DOP MCHC and Curative Departments in collaboration with CHT and UHS	5 year Training Plan completed by Dec 2008	No additional Funds required[27]	WHO
	2.3.2.Develop Training Plan for All Trainings, including need to recruit and train more trainers/ teachers, in Training Schools; including those needed as temporary measure during 2008-9 while current teachers being upgraded and to cover teachers doing In-service clinical upgrading (1.1.7)	DOP in collaboration with Curative Department and MCHC	Midwifery Training Plan to Ministerial committee for approval, Dec 2008 1st batch students commence Sept 2009	No extra budget required	To be agreed

[23] Costs for implementation, including out of country training for Master level midwifery is not included in estimated budget – consider funding through WHO Fellowship scheme
[24] For national workshop on Midwifery Education and Training with CHT and University
[25] Costs for implementation, including out of country training for Master level midwifery not included in estimated budget – consider funding through WHO Fellowship scheme
[26] To establish Fund for CPD activities based on 2,000 per year for 5 years
[27] Regular Budget refers to assumption that there are no additional costs for this activities over and above current budget for MOH, or that the activity can be assimilated into current activities -with no additional costs to MoH

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
2.3 Continued	2.3.3. Implement Midwifery Training Plan for All Trainings, including need to recruit and train more midwife trainers/ teachers, in Training Schools; including those needed as temporary measure during 2008-9 while others being upgraded	DOP CHT and UHS and Provincial Training Schools	3-year RM programme commenced CHT Sept 2009 and CMWs in PSoN [28]	603,000 per year[29] 2,412,000 (to 2012)	To be agreed
	2.3.4 Negotiate with all Training Centres and agree MoU for trainings (including short course trainings)	DOP with Curative Department and MCHC	Plan approved by October 2008	Regular Budget	

[28] Introduced in PSoN from Sept 2009 as they meet Midwifery Education Standard
[29] Based on estimate of US$2,000 per student per year (total cost)

Goal # 3: Strengthening SBA workforce management					
Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
3.1 Ensure appropriate staffing standards are set, to ensure proper recruitment and for deployment –for correct skill mix; including create new posts where required [*See Annex 7, Proposed Staffing Norms*]	3.1.1 Central level orientation and establish National SBA staffing levels for types of facility, including national and sub-nation workload index (Agree optimal Midwife to Birth Ratio – National Average proposed - 55 births per 1 midwife per year)	DoP with Planning and Budgeting, MCHC, Curative and dept of statistics	Staffing standards for approval Dec 2008	1,000	WHO to be agreed
	3.1.2 National Workshop to ensure all Provincial Officers and District Officers are aware of new SBA staffing needs and gather data annually on staffing shortages /needs	DOP with Planning and Budgeting	Workshop help Jan 2009 in line with 3.3.3	10 to 20,000	To be agreed
	3.1.3 Develop guideline for SBA staffing	DoP	Guideline ready by March 2009	2,000	To be agreed
	3.1.4 Selection of staff and deployment based on agreed new staffing norms	DOP with Provincial and District level	Minimum 80% all HC have staffing according to new standard by Dec 2011	Regular Budget	

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
3.2 Establish mechanism to ensure SBA compliance with Midwifery Clinical Standards and Midwifery Practice Regulation (Guideline for *Midwifery Scope of Practice*).	3.2.1 Establish system for reporting all births that take place outside the facility and this is integrated into routine HIMS (Health Information Management Syst)	MCHC and HMIS	Reporting form available by Jan 2009	5,000[30]	To be agreed
	3.2.2 Establish mechanism whereby District Office can check eligibility of Midwives practicing (as Govt/private or independent practitioners in the community i.e. that they do hold a proper qualification and are on SBAtt database)	DOP	System agreed by July 2009	Regular Budget	
	3.2.3 Integrate periodic check for main-taining SBA*tt* competence (fitness for practice) into the regular supervision system	DOP with National SBA Supervision Committee	SBA*tt* Supervision tool Piloted in selected Districts by Jan 2009[31]	Regular Budget	
3.3. Ensure pay & condi -tions (grade) for new midwife cadre to reflect level of SBA responsibility and ensure they are attractive to motivate staff, including, ensure SBA*tt*s are able to obtain decent living wage and adequate incentives as	3.3.1 Develop policy for incentive package for SBA staff working in rural/remote areas and hold national workshop to get agreement	DOP & Budget and Planning	Feb 2009	5000	To be agreed
	3.3.2 Establish pay/salary grade for new cadres (RM and CMw) and obtain necessary approval	1.DOP draft new pay scales 2. Approval -Ministerial Steering Committee & PACSA	Pay scales agreed and incorporated into HR budget by March 2009	5,000[32]	WHO to be agreed

[30] for additional short term technical assistance
[31] Prioritise districts for piloting Integrated Package of MNH
[32] To cover costs of central level meeting and workshop

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
(3.3. Continued) **Permitted under general HR Policy.**	3.3.3 Develop detailed job descriptions that show levels of accountability and responsibility and CMws are expected to do out-of-facility births (home births) where women family cannot be persuaded to come to HC or hospital	DOP with MCHC and Curative Departments	Written Job descriptions approved by Oct 2009	5,000[33]	To be agreed
	3.3.4. Dissemination and information to Provinces on new cadres, including pay grades. *integrate with other activities	DOP /Planning and Budgeting	April 2009	1,000[34]	To be agreed
3.4 Develop & implement a SBA specific supportive supervision mecha-nism; to include indicators to track workload increases *[See Annex 9 SBA Super-vision system & Annex 8 Proposed SBA Workload Indicator. This Committee may be linked into Regulatory mechanism for all HCP once this is established]*	3.4.1 Establish National SBA*tt* Supervision Committee[35], with sub-committee at Province level *(to include defining tasks to strengthen existing Supervision Team at District level, and to incorporate SBA supervision into existing routine monitoring and supervision system)*	DOP in collaboration with all Departments concerns *(Link also with work done in Task force on MNCH Integrated package and HS strengthening)*	Central Committee established by Dec 2008	1,000[36]	WHO - To be agreed
	3.4..2 Development of supervision system	National SBA Supervision Committee	Draft ready for approval Jan 2009	Regular Budget	WHO, UNFPA
	3.4.3 Orientation training of Provincial and District Supervisors on new SBA*tt* supervision system	DOP with National SBA Supervision Committee	1st Orientation workshop by March 2009	10,000	To be agreed

[33] To cover cost of national consensus workshop, to finalise and agree new job descriptions – to ensure inputs from Provincial and District level
[34] To cover costs of translation and printing and dissemination of new SBA staffing guidelines etc
[35] This committee maybe ultimately be subsumed into HCP Regulatory system once this is established
[36] To cover cost of meetings national and provincial and printing of guidelines)

Goal # 4: Strengthen the working environment for SBA*tt*s					
Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
4.1 Develop and disseminate *standards of Midwifery Practice* for clinical practice areas and a mechanism for regular and periodic auditing of *standards,* for quality assurance and improvements. [See Annex 10 Provisional List of draft Standards of Midwifery Practice	4.1.1 Develop and Approve National Standards of Midwifery Practice, including basic life saving standard	National SBA Supervision Committee *(To be established under Goal 3)*	Standards agreed by Dec 2008	3,000[37]	WHO, UNFPA [to be confirmed]
	4.1.2 Print National Standards of Midwifery Practice	DOP AND curative	Jan 2009	1,000	To be confirmed
	4.1.3. Develop regular periodic Clinical Audit Tool; that includes health system requirements for proper provider performance	National SBA Supervision Committee, TWG for MNCH and MNCH, with assistance from OBGYN Soc & Paediatric society	Pilot of audit tool March 2009	1,000	WHO, UNFPA [to be confirmed]
	4.1.4 Dissemination workshop for all Provinces to familiarise them with *National Standards of Midwifery Practice*	MNCH	National Workshop Jan 2009	10,000	To be agreed
4.2 Ensure all facilities have essential equipment and essential drugs, including mechanism to prevent drug stock-out and transportation and communication systems for referral.	4.2.1. Revise list of essential drugs and medicines to be in line with clinical standards and national protocols	Curative Dept, Food and Drugs Dept	Dec 2008	Regular budget	WHO and UNFPA

[37] To cover cost of national meeting to present and approve standards

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
4.2 Continued	4.2.2 Revise essential equipment list to be in line with clinical standards and national protocols	Curative and Equipment Division			
	4.2.3 Revise budgets to ensure adequate financing for essential drugs and equipment	Budget & Planning	Budget presented by Dec 2008	Regular budget	WHO, UNFPA
	4.2.4 Revise mechanism for reporting and responding to lack of essential equipment	Curative Dept and MESC	New guidelines developed by Dec 2008		WHO, UNFPA
	4.2.5 Revise mechanism for reporting and responding to drug stock outs of essential drugs	Curative Dept and MESC	New guideline available for discussion Jan 2009	No additional funds needed	WHO
	4.2.6 ToT (3-day) for Logistic Training	Curative Dept and MESC	Jan 2009	3,500	To be agreed
	4.2.7 Implement 3-day logistic training in Provinces and District level	Curative Dept and MESC	1,000 persons trained nation-wide by end of 2009	10,000	To be agreed

Goal # 5: Strengthen the links between health sector and community including referral system					
Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
5.1 Promote Birth & Emergency preparedness Planning, using media, radio, community awareness and peer education techniques.	5.1.1 National launch of SBA plan and orientation Workshop for introduction and orientation of national and provincial staff and stakeholder for SBA strategy and MCH package, including WHO framework for working with Individuals, Families and communities and birth and emergency preparedness planning as part of MNCH Package Launch	Dept of Hygiene with MCHC and CIEH [to be integrated with National advocacy for Integrated MNCH package]	Nov 2008	14 000	WHO and UNFPA
	5.1.2 3-Regional workshops for launch of SBA plan and to build capacity of Health Providers to work in collaborative way with women, their husband and family members to assist families and communities make effective birth and emergency preparedness plans	PHD, DHD PMCH, DMCH LWU Prov and dist	Mar 2009 District workshop[38]	24 000	WHO, UNFPA to be confirm
	5.1.3 District and HC training on birth and emergency preparedness planning and peer education on mother and child health *[to be included in ANC/PNC training* 1.1.6]	Provincial Office	See 1.1.6	No additional funds	WHO UNFPA

[38] Meeting with D CMCH, d, LWU, head of DHD, dMCH plus head of villagers and partners

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
5.1 Continued	5.1.4 National Advocacy campaign to build capacity of families and communities to make effective birth and emergency preparedness plans; including introducing peer-to-peer education for safe motherhood, maternal, newborn and child health.	LWU (Dist Vill) NGOs	Mar 2009	16 000	To be agreed
	5.1.5. Introduce concept of "model family-friendly" national birth and emergency preparedness card, as well as advocacy and training materials, needed for assisting women and families make a personal birth and emergency preparedness plan	Dept of Hygiene and MCHC	Mar 2009 Organize meeting with relate sector + NGOs for designing the card	6 000	WHO, UNFPA to be confirm
5.2 Develop participatory approach to making, implementing, regularly monitoring & periodically evaluating District Plan for increasing access to SBA*ce; to* include close collaboration with Women's Union and community leaders.	5.2.1. Arrange a 2-day meeting to review existing manual and revise "Training Manual of District Facilitators for Participatory Health Planning" to ensure planning needs for achieving skilled attendance is highlighted (*manual already prepared and used by ADB*)	Planning and Budget (ADB) with MCHC and Hygiene and Prevention	Workshop to review manual Dec 2008	4,000	To be agree
	5.2.2. Provincial workshops to introduce "participatory health planning at District and sub-district level" to highlight the need for skilled attendance during pregnancy, birth and postnatal period	Planning and Budget with MCHC		3,000 per Province	To be agreed

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
5.2 Continued	5.2.3. Training of District Facilitators for Participatory Health Planning using revised Training Manual.	MCHC HEC	April 2009	20, 000	ADB to be agree
	5.2.4 Operational research for models of community mobilization for MNCH and skilled birth attendance	NCMC with University and NIOPH	Draft protocol by May 2009	50,000	WHO and UNFPA – to be agreed
5.3 Provide TBAs with support mechanism by linking TBAs to a named Skilled Birth Attendant and empowering them to either: (1) enter Community midwifery programme and become (government employee or private practitioner), *or* (2) Train and register as MCH Community Health Volunteer [See Annex 12]	5.3.1 Develop National Policy on promoting reorient ion of TBA to become MNCH health promoter (see annex 12)	TWG MNCH	May 2009	Regular budget	
	5.3.2. Registration at District Office of all functioning TBAs in District to be reoriented to become Health Promoter for MCH and, establish regular monitoring and supervision of TBA by a skilled birth attendant who can offer on-the-job training and support.	District Officers	Jan 2009	Regular budget	WB and others to be agreed
	5.3.3. Develop Training manual for Training TBAs in health education for maternal, newborn and child health, using non-formal education methodologies and approaches	Dept of Hygiene and MCHC	Jan 2009	1,000	WB and WHO and UNFPA, [to be confirmed]

Specific Objectives	Activities	Responsibility	Milestone (s)	Estimated Budget Needed (US$)	Lead Technical Assistance/ funder
5.3 Continued	5.3.4 Training of TBAs in building capacity of individuals and families for promoting maternal, newborn and child health[39]	Dept of Hygiene and MCHC, HEC	May 2009	20,000	WB others To be agreed
	5.3.5 Regular supervision, arranging monthly meeting for reviewing and future planning (1 month, 3 month, 1 yr)	Dept of Hygiene and MCHC	Start Jun 2009	16, 000	To be agreed

[39] to include working with health sector for improving health service seeking -especially during pregnancy and childbirth and in weeks after birth and specifically for emergencies; including how to use basic health education techniques

ANNEXES

Annex 1

Unofficial Translation from Lao to English by UNFPA

Ministry of Health

Ref: 670/MOH
Date: 21 May 2008

Decree of Minister (MOH)

- According to the Decree of Minister of Health No. 020 / PM dated 19/03/1999 regarding the functioning of Ministry of Health.
- According to the technical cooperation between Ministry of Health and UNFPA
- According to the research and suggestion of the Cabinet of Ministry of Health

The Minister of Health agreed:

Article 1: Appoint the Leading Committee, Responsible Committee and Coordination Team of SBA Development Plan as follows:

A. Leading Committee

1. Assoc. Prof. Dr. Eksavang Vongvichit, Vice Minister of Health
2. Mr. Khamphone Phouthavong, Director of Department of Personnel

B. Responsible Committee

1. Dr. Phouthone Vangkonevilay, Deputy Director of Personnel Department
2. Assoc. Prof. Dr. Chanhphomma Vongsamphanh, Deputy Director of Department of Curative
3. Dr. Somchit Akkhavong, Deputy Director of Department of Hygiene and Prevention
4. Dr. Bounfeng Phommalaysith, Deputy Chief of Cabinet
5. Dr. Somchanh Xaisida, Head of Education and Training Division
6. Dr. Kaisone Chounlamany, Director of MCHC
7. Ms. Sthaphone Insiseingmai, Deputy Chief of Training Division
8. Ms. Phengdy Inthaphanith, Head of Nurse Division, Department of Curative
9. Dr. Chanhem Songnavong, Deputy Director College of Health and Technology
10. Assoc. Prof. Dr. Somboun Phomtavong, Director of Health School
11. Assoc. Prof. Dr. Sing Menorath, Deputy Director of University of Health Sciences
12. A representative of Department of Planning and Budget

This Committee is responsible for planning, facilitating and follow up the SBA Development plan for submission to the higher level.

C. Cooperation Team

1. Ms. Sthaphone Insiseingmai, Deputy of Chief of Training Division
2. Ms. Phengdy Inthaphanith, Director of Nurse Division
3. Dr. Chanhdavone Phosay, Deputy Director Secretariat Bureau
4. Dr. Bouphany Phayouphorn, Deputy Director of Foreign Relations Division

5. Dr.Souliphone Sudachanh, Technical Staff, Division of Personnel
6. Dr. Nounsy Keovanpheng, Technical Staff, Division of Training
7. Mrs. Manyvone , Technical Staff, Nurse Unit,Vientiane Capital
8. Dr. Phouthong Lattanavong , Technical Staff, MCHC
9. Mrs. Sommany Soukphaly, Technical Staff, College of Health Technology
10.Mrs. Sengmany Khammounheuang, Technical Staff, Department of Curative

This Team will coordinate with related parties and develop the SBA plan

Article 2: The Cabinet of Health, Personnel Department, Curative Department, Hygiene and Prevention Department, Planning and Budget Department, MCHC and other related Departments have to implement this decree accordingly.
Article 3: This agreement is effective from the date of its signature.

Vice Minister of Health
Prof. Dr. Eksavang Vongvichit

The above was amended under Decree 907,

Ref: 907/MOH
Date 10 Jul 2008

To include in addition to the above the following members for:

Responsible Committee:

1. Dr. Prasongsith Bouppha, Deputy of Department of planning and budget.
2. Dr. Loun Manivong, Head of Personnel Division, DOP
3. Dr. Chandavone Phoxay, Deputy Director of Secretariat Bureau

For Collaborating Committee:

1. Dr. Somphone Fangmanixay, Deputy of Health System Development Project.
2. Dr.Anon Suedvongsa, Director of NIP (MCH)
3. Dr.Alongkone Phengsavanh, Deputy of Post Graduate University of Health Sciences.
4. Dr.Kotxaythoun Phimmasone, Deputy of Health Services Improvement Project
5. Dr.Souksakhone Southammavong, Technical staff, Midwife MCH
6. Dr.Soulivanh Phonesena, Technical staff, Department of planning and budget

To be effective from date of signature
Signed by Prof. Dr. Eksavang Vongvichit

Annex 2

Core Competencies for all Midwifery Programmes in Lao: *(regardless of length and academic level)*

As minimum, to meet ICM Essential Midwifery Competencies* and to meet minimum criteria required of any Skilled Birth Attendant, as outlined by WHO, ICM and FIGO**, all midwifery programmes (including Direct Entry RM and CMw and short professional upgrading/bridging programmes) must ensure graduates exit with following competencies: *(parenthesis added to highlight SBA core life saving competencies)*

1. Have requisite knowledge and skills from social science, the public health sector and ethics to be able to provide high quality culturally relevant and appropriate care for women, their newborns and families.
2. Have requisite knowledge, skills and experience to be able to provide high quality culturally sensitive health education and family planning services in the community, in order to promote healthy family life, planned pregnancies and positive parenting.
3. Have requisite knowledge, skills and experience to be able to provide high quality antenatal care, to maximise women's health and detect any problems/deviations from the normal, offer appropriate treatments as permitted under national protocols, (*give life saving measures in case of bleeding in pregnancy, severe pre-eclampsia and eclampsia and in case of severe infection)* and refer for specialist assistance if required
4. Have requisite knowledge, skills and experience to be able to provide high quality, culturally sensitive care during labour birth and the first 2 hours after birth, to include give immediate care to newborn, manage emergencies effectively according to national protocols to prevent maternal and neonatal mortality and morbidity.
5. Have requisite knowledge, skills and experience to be able to provide comprehensive, high quality culturally sensitive postnatal care to women. *(Including give life saving measures in case of bleeding, eclampsia and in case of severe infection)*
6. Have requisite knowledge, skills and experience to be able to provide high quality care for newborn infants and young infant. *(Including give life saving measures in case of asphyxia and in case of severe infection.*

In addition to above, for Lao context:

7. Have requisite knowledge, skills and experience to be able to provide high quality IMCI.

***** ICM (International Confederation of Midwives): **Essential Competencies for Basic Midwifery Practice.** ICM, The Hague: 2002 *[http://www.internationalmidwives.org]*

****** WHO. **Making pregnancy safer: the critical role of the skilled attendant, a joint statement by WHO, ICM and FIGO** [http://www.who.int/reproductive-health/publications/2004/skilled_attendant.pdf]

Annex 3

Matrix showing Proposed Midwifery Cadre: with qualifications leading to *Licence to Practice Midwifery* in Lao:

Note: *All Midwife grades to be classified as mid-level providers by virtue of job description /level of responsibility as SBA etc*

Qualification gained after receiving new training	Academic Level	Length of training to be MW	Entry requirements	Qualification(s) on completion of Midwifery programme	Suitable for posting/ deployment to:	Possibilities for Shared learning with:	Upgrade-able?	Interim measures required
Registered Midwife (RM) *Direct Entry*	Diploma	3yrs	• 11 yrs completed schooling and pass aptitude test	1. RM (Registered Midwife)	Any level of Health sector Including Independent private practice	• Some with basic Nursing term 1 • Last few terms Post-basic RM for Prof Nurse and 3 Yr N-MW	Yes in time (when faculty prepared) to Bachelor level – through short bridging programme	No
Registered Midwife (RM) *Post-basic-I* **Post-basic means after initial basic nursing*	Diploma or Higher Diploma	6 to 9 months *(To be agreed)*	• Professional Nurse, or • 3 yr Nurse-Midwife	1. RN (Registered Nurse) plus 2. RM	Any level of Health sector Including private practice	• last terms of RM DE • RM Post-basic II	As above	short BeON-LSS course for nurses working in maternity areas and 1st Level M-N Service package as required
Registered Midwife (RM) *Post-basic -II*	Diploma	1 year to 1.5 yrs: (*To be agreed*)	Technical Nurse *(2.5 years trained)*	1. Technical Nurse plus 2. RM	Any level of Health sector Including as Independent (self-employed)	• last terms of RM DE • RM Post-basic I	As above	As above
Community Midwife (CMw) *Post- Basic*	Advanced certificate	1.5 years	• Assistant Nurse, *or* Auxiliary Nurse, or PHCW Plus: Under 45 yrs age	1. Assistant Nurse / or Aux Nurse/or PHCW, plus 2. CMw (Community Midwife)	Health Centre Hospital A and B Including Independent (self-employed)	• DE CMw	Yes, to Diploma after min 2 years work; plus bridging programme ?1 yr	As above

Qualification gained after receiving new training	Academic Level	Length of training to be MW	Entry requirements	Qualification(s) on completion of Midwifery programme	Suitable for posting/ deployment to:	Possibilities for Shared learning with:	Upgrade-able?	Interim measures required
Community Midwife (CMw) *Direct Entry*	Advanced certificate	2 years	• Min age 21 years • Pass aptitude and entrance test *plus* • Trained TBA with 2 years proven experience, *or* 2 years paid work outside the home	1. CMw	Health Centre Hospital B. Including Independent (self-employed)	• some parts with basic nursing • Share last 18 months with Post-basic CMw	Yes, to Diploma after minimum of 2 years work plus bridging programme ?1 yr	Training on advocacy and assisting families make birth and emergency preparedness plan

Annex 4

Who will be the Skilled Birth Attendants in Lao PDR? Community Midwife, Registered Midwife, Certified as SBA; MA, MD, OBGY

	Current job title (lenght of initial training)	Numbers exsiting in system (to be check by DOP)	Level		Length of new/additional training (full SBA competencies)	Entry requirements for MW training	Will have full skilled birth attant competencies					C-EmONC competency
							Midwife		After new training			
			Current	After training in full SBA competencies			Comminity Mw	Registered Mw	Bachelor Ns/Mw	MA	MD OBGY	
Non-medical	VHV		-	Not	Not applicable							
	TBA (Traditional)		-	Not	Not applicable							
	TBA (trained)	Total unknown	Volunteer	Mw	2 Yrs Direc entry (1)*	At least grade 8schooling + ≥ 21 Y old + > 2Y experience	●					
PHC worker	PHC worker (3Yrs)		Low	Middle	1.5Yrs* (same curr as DE CMW)	< 45 Y old	●					
Nrs/ Mw	Assistant nurse Auxiliary nurse Auxiliary nurse midwife (3months-2Yrs varies)	8,103 +	Low	Middle	1.5Y* (same curr as DE CMW)	< 45 Y old	●	●				
	Technical nurse (2.5Yrs)	1,500 +	Middle	High	1Y (+ 6 months internship)	Working in Mat		●				
	Nurse-midwife (3 Yrs)	500 +	Middle	High	6-9 M	Working in Mat		●				
	Professional nurse (4 Yrs plus)		Middle	High	6-9 M	Working in Mat		●				
			High	High	?				●			
	Midwife (3 Yrs)	80-100 approx	Middle	High	TBA ? 10 days			●				
	New direct entry CMw (1) * 2 Yrs	Not in system	-	Middle	2Y* (same as 1.5 with add 6 months)	≥21 Y old +8Yrs schooling >2Yrs work	●					
	New direct entry RM (2) * 3Yrs	Not in system	-	High	3Y	11Yrs schooling		●				
MA	Medical assistant (3 Yrs)	2,607	Middle	Middle	Short update					●		
Docter	Medical docter (6 Yrs)	1,522	High	High	Short update						●	
	OBGY (post grad)		High	High	Short update						●	●

* As interim period till official grade 11/12, general education will be included to national midwifery curriculum

Annex 5

Numbers of Providers to be trained as immediate as interim measure in Clinical Skills Package for Skilled Birth Attend*ance*:

[To include: (1) 1st Level MNCH Core Service Package *(as core for Integrated MNCH Package, yet to be finalised)* **(2) Short skills update in "Care during Childbirth" for MDs and MAs and (3) BeMOC and CeMOC to be certified SBA*tt*]**

The 1st Level MNCH Core Services -MNH Clinical Skills Updating Training Package: all HCP. To give all health providers, irrespective of professional background or pre-service training, the minimum clinical skills required for basic essential MNCH services at the 1st level of care (HC and Hospital Type-B), with exception of skills for provision of skilled birth (as these skills require more detailed and longer competency-based training and are included in Annex 3 and 4). The MNH clinical updating training package however will include basic emergency obstetric and newborn- life saving skills (BeON-LSS) as proposed for Lao context.

The training is divided into short clinical-based modules that can be taken in any sequence over a period of time. The exception being BeON-LSS module, that is a compulsory foundation module for all providers.

This type of training delivery (in modular format) gives maximum opportunity to combine service delivery with training, as health care providers (HCP) will only need to be absent from workplace for short periods and not in one prolonged block. However, in some areas, because of difficulty in travel, these modules can be taken one following immediately after another (i.e. in one longer period of time).

This type of training, (in modular), also allows for other modules to be added as required, for example additional modules for those areas piloting the Integrated MNCH Package. Providers also often prefer this type of delivery of training, so they are absent from home for shorter periods.

Finally modular training can be most effective in the longer time span, as trainees can concentrate on one set of clinical skills and practice these to mastery level -before they go onto the next skills set (next module).

Core MNH Modules include:

1. BeON-LSS – Compulsory Foundation – 5 days
2. ANC/PNC – 5 days
3. Essential Newborn care (EssNBC)– 5 days
4. Family Planning** – not clear maybe 10 days [to be agreed]
5. IMCI** [training already taking place]

** These trainings already exist and therefore not all HCP will need to take these training; but it is not clear until Training Needs Assessment complete, how many still need training in these.

Each Module will include as integrated content: quality of care and improved provider-client interaction

Numbers to be trained:

- 1 HCP staff in each HC (818)
- 1 or 2 HCP staff per Hospital type B (103)

- **Total HCP to complete total package : 920**

Standard: not more than 20 trainees at one time

Total number of courses required: approximately 45 rotations for each module. SEE TABLE 1

Table 1: Total Numbers to be trained in core MNH modules by Provincial Training Site.

Based on DoP HRH data October 2008

Training centre	Province	To be trained from Hospital type-B	From HC	Estimated No of trainings (based on 20 per cohort)	Costs (US$) for training 1 cohort 20 for 1 x 5 day module[40]
Oudomxay	Phongsali	5	26		
	LN Tha	4	35		
	Oudomxay	5	39		
	Total	**14**	**100**	6	19,500
Luang Prabang	Bokeo	4	30		
	LPB	9	57		
	Total	**13**	**87**	5	16,250
Xienkhuang	Huanpham	5	49		
	Xiengkhang	6	48		
	Total	**11**	**87**	5	16,250
VTE Prov	Xayabouli	6	70		
	VTE	9	44		
	Total	**15**	**114**	6	19,500
CHT	VTE Cap	8	42		
	Bolikhamxay	4	40		
	Total	**12**	**82**	5	16,250
Khamwuan	Khamwuan	7	72		
	Saravan	6	49		
	Total	**13**	**121**	6	19,500
Savannakhet	Savannakhet	11	114		
	Total	**11**	**114**	6	19,500
Champassak	Sekong	3	17		
	CPS	7	60		
	Attapeu	4	26		
	Total	**14**	**103**	6	19,500
Grand Total		**103**	**818**	**45**	**US$ 146,250**

A national clinical skills training team has been established, to design the above training packages under leadership of DOP with assistance from Dr Alongkone (University Medical School) and Dr Bounnack (MCHosp), for newborn skills.

Initially, training will take place only at Central Level and Provincial level where there is a Nurse Training School. Consideration will then be given to offering these training in other Provincial

[40] Based Nov 2008 exchange rate, estimated costs for 1 batch of 20 staff from HC and Hospital type-B would beUS$3,250, to include DSA, average travel costs and Trainer Fee, based on official MoH rates

Hospitals with back up from a Regional EmONC Training Centre, or from one of the Nurse Training schools.

In addition to the above, there is need for 3 additional modules – for selected HCP only:

1. **SBA up-grade Module for existing MDs and MAs** – to be based around partograph and management of various deviations from normal – 3 months internship where they work under supervision of OBGYN trainer doing case studies hands on practice etc Approximately five trainees per trainer at any one time.
2. **2 modules for teams in hospitals 1)BeMONC and 2)CeMONC** these modules will be based on existing training manuals, which are to be reviewed, to ensure they contain skills for management of newborn emergencies and latest WHO advice, adapted for Lao context.

Table 2: Summary Overview of Training For 1st Level Core MNH Service as part of Integrated Package for MNCH (assuming all training to be done in PsoN and there corresponding in Provincial¦ Hospital)

Module	Nov	Dec	Jan	Feb	March	Apri	May	Jun	July	Aug	Sept
MCH	ToT for BeON-LSS	LSS x2 (20 +20)	LSS x2	LSS ANC/ PNC	ToT + EsNBC	EsNBC x2 FP*	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP
Mahosot		LSS x2	LSS x2	LSS ANC/ PNC	ToT + EsNC	EsNBC x2 FP*	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP	EsNBC x2 FP
TOT*		BeON -LSS* (20)	ANC/ PNC* (20)		EsNBC*	FP Up-date*					
Provin-cial											
1. LP		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
2. ODX		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
3. CH		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/P NC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
4. Xk		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/P NC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
5. Km		LSS x2	LSS x2	LSS ANC/P NC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/P NC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
6. SvK		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC/ PNC EsNBC	ANC/P NC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
6. Vte (Provinc e)		LSS x2	LSS x2	LSS ANC/ PNC	ANC/ PNC LSS	ANC /PNC EsNBC	ANC/P NC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP	ANC/ PNC EsNBC FP
Sub Totals		180 180	180 180	180 (LSS) 180 (ANC/ PNC)	140 (LSS) 140 (ANC/ PNC) 40 (EsNBC)	EsNBC (180) ANC/ PNC (140)	EsNBC (180) ANC/ PNC (140) FP (180)	EsNBC (180) ANC/ PNC (140) FP (180)	EsNBC (180) ANC/ PNC (140) FP (180)	EsNBC (180) ANC/ PNC (140) FP (180)	EsNBC (180) ANC/ PNC (140) FP (180)
Acc Total Persons Tr: BeON-LSS		360	720	900	1040	1040	1040	-	-	-	-
FP		-	-	-	-	ToT	180	360	540	720	900
EsNBC		-	-	-	40	240	420	600	780	960	1,140
ANC/PNC		-	-	180	320	460	600	740	880	1,020	1,160

The above Table 2 assumes each of the PsoN/Provincial Training sites will do on average 6 rotations for each module. Central level and CHT are expected to be busy with ToTs and supervising Provincial Training, as well as taking lead for updating Teachers to prepare them for the Medium/long term Midwifery programmes. It is possible they could also do some Training, as outlined in table 1. It is also possible that some Provinces without School of Nursing (SoN) and or a few large District Hospitals could do some of the training in time and with support from the 1st wave Provincial Training Centres. If either of these happens, the above Table 2 would need adjusting to take account of this.

Table 3: For Additional skills training for *selected* health practitioners at referral level:

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
BemONC	Review Current Manuals	…	ToT refresher	x	x	x	x			
CemONC			ToT refresher	x	x	x	x			
SBA for MD & MA			ToT + 20	20	20	20	20	20	20	

Currently there is in excess of 1,614 MDs and a similar number of MAs working in the system (MoH/WHO HR Analysis, 2007). It is not yet clear yet how many of these need to be trained in SBA competencies or BemONC and CemONC. It is vital that only those who are regularly providing SBA services are trained, as if they have no opportunity to practice after training they will soon loose competence.

As can be seen from Table 2 above, most of the persons requiring training in the core 1st level MNCH Service Package can be trained by Sept 2009, if funding can be secured, including for TOTs and Training sites can sustain the number of training rounds to be provided. It is assumed that some slippage will happen, but equally it is possible to show that the numbers to be trained to achieved the goal of 1 person in every HC and in Hospital type-B to be trained in this core MNCH service package is feasible by 2010.

As also demonstrated in Table 1, capacity does exist (in theory) within the present training facilities. However, it may be possible for staff in Provincial Training schools, with assistance from central level, to assist other Provincial or even larger District Hospitals to run some of these trainings. This will increase numbers on accumulative bases and target can be reached much sooner. This however is only possible **after** the Provincial Trainers have undertaken at minimum 2 or 3 rounds and, have become themselves very proficient in such training.

Also, it will essential to ensure other training sites are only used if they meet the criteria to be a designed clinical training site (see Standards for Education and Training – Annex 6) and if trainers have undertaken the requisite ToT.

It is envisaged running more than 1 type of training each month in each Training centre. To ensure staff are not overloaded, careful consideration should be given to selecting teaches and trainers for the various TOTs.

In addition, temporary staff should be employed in each Training centre; ideally 1 administrative assistant and, at least 1 Experienced Nurse to release the nurse teachers who will implement the above trainings (as Trainers) in each centre (total of 8 -14 Nurses and 8 Administrative Assistants). These costs will need to be added to below estimates.

Total Estimated Costs
(Indicative, minus employing temporary staff in PSoN)

1. TOT and finalise the Training Manual; per Module @US$ 7,000 x 3[41]……...…..21,000

2. 1st Level MNCH Core Service package [*1 total package x 20 persons @ US$3,250 (3 modules – BeONC-LSS; ANC/PNC; EssNBC) 45 packages per module = 135 packages Total*]……..……...…438, 750

3. Revision of BemONC & CemONC manual……...…1,000

4. Reprint of BemONC & CemONC manaul ……...……...400

5. BemONC per training (DSA and Travel only) plus refresher ToT for Master Trainers……..…… 40,000

6. CemONC, per team (DSA and Travel) plus refresher ToT for Master Trainers……..……..40,000

7. SBA certification short clinical-based course for MD and MAs5/10 person per course @ 500 per package (DSA & Travel) x 50 packages plus development costs……..……100,000

TOTAL: US$ 621,150

[41] Cost for 1st ToT – BemON-LSS will be more, as it is envisaged bring an international Midwifery Trainer to assist National Trainers introduce Adult Learning Methodology as used in competency-based Midwifery training.

Nationwide Midwives needed - numbers (based on desirable staffing norms, MoH 2009)

No.	Items	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1	Total Projected Population (1)	6,110,600	6,230,200	6,348,800	6,465,800	6,580,800	6,693,300	6,802,000	6,906,200	7,005,200	7,097,900	7,183,500	7,261,600
2	Crude Birth Rate/1000 (1)	30.7	29.9	28.0	28.1	27.2	26.2	25.1	24.0	22.8	21.5	20.1	18.7
3	Total estimated numbers birth in the year (1)	187,595	186,283	177,766	181,689	178,998	175,364	170,730	165,749	159,719	152,605	144,388	135,792
4	Midwives needed for HC - based on staffing norms standard - (2)	904	904	904	904	904	904	904	904	904	904	904	904
5	Midwves needed District and Provincial Hospital -assume gradual upgrade DH (2)	964	964	964	964	964	965	966	967	968	969	970	971
6	Midwives needed in central Hospitals (2)	96	96	96	96	96	96	96	96	96	96	96	96
7	Total midwives needed in clinical areas (2)	1,964	1,964	1,964	1,964	1,964	1,965	1,966	1,967	1,968	1,969	1,970	1,971
8	Midwives needed Depts	27	27	27	27	27	27	27	27	27	27	27	27
9	Midwives produced or completing training (3) -assumes 10% attrition from yr 5*	64	100	160	160	160	160	160	160	160	160	160	160
10	**Total No. needed in clinical areas (gap)**	**1,900**	**1,800**	**1,640**	**1,480**	**1336***	**1013***	**826***	**647***	**503***	**359***	**216***	**73***

References: 1. National Statistic Center, Ministry of Planning and Investment, 20006, *'National Census, 2005'*, Vientiane, Lao PDR.

2. MOH data presented at MOH Retreat for developing five year Health Plan, Jan 2010

3. MOH Training Plan, 2010

Annex 6

Provisional Standards for SBA Education & Training
(Including for new Midwifery Programmes)

Standards for Education (pre-service)

- Maximum of 20 trainees/students per cohort
- Desks 1.5 m between desk
- Must have well stocked Library
- Must have adequate Reading materials
- Must have all essential Teaching and Learning Equipment, including a well equipped skills laboratory for demonstration of birthing techniques and other maternity, obstetric and newborn procedures
- Equipment for washing hand
- Curriculum to be accepted for Ministry of Health and Ministry of Education
- Trainer to be qualified in SBA
- 1 training sited should have 3 to 4 trainers plus trainers /clinical supervisors in hospital
- Must do 20 birth by end of course

Standards for short clinical trainings for Skilled Birth Attendance

- No more than 20 per cohort (course)
- Clinical site must offer MCH services 24 hours a day
- Must comply with Infection Preventions protocols
- Min number of cases - births (125 per month)
- For BemONC and CmONC trainings Regional Hospital, Provincial Hospital with minimum 1800 per year
- Clinical Preceptor /Supervisor must be trained and be availed to work with and supervisor trainees
- Must be 1 Trained Tutor to 4 Trainees
    - (Trained tutor is someone with expertise in subject and has themselves done clinical standardisation for the training course they are going to trainer for) and have received training in clinical training or clinical preceptorship
    - All sites must have at least 1 approved trainer on duty when trainees are working. The approved trainer must be approved as clinical preceptor (they have completed national clinical preceptorship/mentorship[42] training)

[42] The use of terms mentors and preceptors is used interchangeably to mean someone – a clinician working in service delivery, who is experienced / skilled and who can help the trainee in a supportive way, someone who will pass on their skills to trainee, as distinct from a clinical trainer who may well work in training school undertaking demonstrations and may assess trainees – but who may not be an expert in the clinical field, or who may have been once but now not doing actual service delivery as part of their everyday tasks. At present there is no agreed terminology if it should be preceptor or mentor

Curriculum: (pre-service only)

- Must be approved by MoH and Ministry of Education
- Must comply with Ministry of Education rules
- For Direct Entry RM (3 Years) must have minimum of x hours theory and y hours practice (in clinical areas);
- For Community Midwife must have minimum of of x hours theory and y hours practice (in clinical areas); Ratio theory to practice should be 60% in practice/ field area;
- All Midwifery programmes must:
  - Include Theory and practice for home births and births in the community must be included
  - Ensure graduates exit with minimum SBA competencies (see annexe 2)

Annex 7

Estimates for Production of Midwives
(RM DE and RM Upgrade and CMws DE and CMW upgrade)
Assuming PsoN meet Education Standard

	2009				2010				2011				2012		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
CHT															
D.E. RM			(cohort 1)	Yr 1			Yr 2				Yr 3			20	
RM upgrade			(cohort 1)					20			(cohort 2)				
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
LPB															
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
CMw DE			(cohort 1)					20			(cohort 2)				
VTE															
CMw upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
RM upgrade			(cohort 1)					20			(cohort 2)				
KM															
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
CMw DE			(cohort 1)					20			(cohort 2)				
CMPS															
CMw upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
RM upgrade			(cohort 1)					20			(cohort 2)				
OX															
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
CMw DE			(cohort 1)					20			(cohort 2)				
Sav															
RM upgrade			(cohort 1)					20			(cohort 2)				
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
CMw DE			(cohort 1)					20			(cohort 2)				
Xky															
CMw Upgrade			(cohort 1)	20			(cohort 2)	20			(cohort 3)	20			
CMw DE			(cohort 1)					20			(cohort 2)				
Total RM						0				80				20	
Total CMw						140				360				160	
Total										440				180	
Grand Total						**140**				**580**				**760**	

Annex 8

SBA Workload Indicator *(Proposed)*

Using population density, or number of maternity beds or physicians in a facility, may not be helpful in identifying actual workloads for skilled birth attendants, for a number of reasons:

1. It is hoped, especially in the immediate period in Loa PDR, that some staff, as a minimum at least community midwives, will undertake *out-of-facility births*, as well as encouraging women and families to seek hospital care for births.
2. Women often chose to give birth in a relatives home, or another place/facility, not always where they live (currently resident)
3. More than one women can give birth in a 24 hour time frame, so bed occupancy can be more than 100%
4. Women do give birth in paces other than maternity and yet call on maternity staff to assist them

Therefore in order to track workloads, to ensure that staffs are not become overloaded, and therefore result in all the normal outcomes of high workload (low morale, low motivation or even de-motivation, poor quality of care, increase in adverse incidents /accidents with consequent impact on patient/client safety and willingness to seek facility care), ther is need for a workload index to monitor staffing workload and assist with identifying future estimates for staffing numbers, annual production of staff etc.

WHO have undertaken an extensive costing exercise to identify the minimum package of services required for pregnancy, childbirth and care of mothers and newborns after birth, as part of preparation for the `World Health Report 2005' (*Make Every Mother and Child Count, WHO 2005*). Part of this exercise was to identify the total person-hours required to deliver this essential package, in order to establish a annual workload indicator (index) for those working primarily at the first level of care.

The result of this exercise identified that 1 midwife (SBA) could be expected to provide the full package of essential care (as outlined in the WHO guideline *"Essential Care for Pregnancy, Childbirth, Postpartum and Newborn Care",* 2003, with 2nd edition 2006) to approximately 175-200 pregnant women per year. Thus giving a workload indicator (index) of 1:175 – to 1:200.

This figure however assumes that the midwife (SBA) is exclusively engaged in pregnancy and newborn health care services, (i.e. they are not expected to deliver any other health package - other than basic health education promotion etc as part of midwifery competencies – see ICM Essential Midwifery Competencies, Annex 5).

In Laos however midwives (SBAs) except those working in labour room in a large hospital, are expected to delivery other health services i.e. non SBA related services, in addition to SBA services. Therefore the workload index for Laos must be substantially lower than 1:175. A consensus on this figure has still to be reached.

Proposed workload indicators for Laos

1:55 for initial national average, with:

- 1 in 35 for HC,
- 1 in 75 District Hospital
- 1 in 100 Prov Hospital
- 1 in 175 Central Hospital

The above can be revised later once better data on staffing and workloads (total number of birth in and out of facility) become available.

Figure 8.1: **ESTIMATED Midwifery HR 2009**

NO	Province	Current situation								Total NO.SBA needed based on facilities				Facilities Gap			Total NO. SBA needed based on birth			
																	Mws needed if 1 for 55 births			
		Population Lao PDR (data from EPI, base on 2005 census by NSC)	Projected expected Births (data from EPI)	Total Mid level providers available (current stock MoH-DOP March 2008)=A	Total Mid-level MA, nurse, nurse-midwife and midwife available (current stock MoH-DOP March 2008)=B	Total Mid-level MA, nurse, nurse-midwife and midwife available at health facilities (current stock MoH-DOP March 2008)=C	Births per MW/ SBA Ratio A	Births per MW/ SBA Ratio B	Births per MW/ SBA Ratio C	NO. SBA Needed for prov & cen-tral. Hosps	NO. SBA Needed for D. Hosps	NO. SBA Needed for HC	Total facility needed	Total Mid level providers available A	Total Mid-level B	Total Mid-level C	for 40% of all esti-mated births	for 100% of all esti-mated births	Gap for 40% of all estima ted births to C	Gap for 100% of all estima ted births to C
1	Bokeo	157,335	5,208	56	52	36	93	100	145	10	20	30	60	-4	-18	-24	38	95	-2	-59
2	Luangnamtha	160,067	5,522	95	58	32	58	95	173	10	20	33	63	32	-5	-31	40	100	-8	-68
3	Huaphanh	306,771	12,209	114	82	47	107	149	260	10	32	48	90	24	-8	-43	89	222	-42	-175
4	Phongsaly	180,127	5,764	78	58	35	74	99	165	10	28	20	58	20	0	-23	42	105	-7	-70
5	Xiengkhuang	253,920	9,852	90	56	38	109	176	259	10	32	48	90	0	-34	-52	72	179	-34	-141
6	Oudomxay	296,780	11,634	104	83	39	112	140	298	10	28	39	77	27	6	-38	85	212	-46	-173
7	Luang Prabang	438,845	11,798	268	220	126	44	54	94	10	44	53	107	161	113	19	86	215	40	-89
8	Xayabouly	362,315	11,087	189	131	88	59	85	126	10	40	70	120	69	11	-32	81	202	7	-114
9	VTE Pro	452,238	14,517	241	172	118	60	84	123	10	52	44	106	135	66	12	106	264	12	-146
10	VTE Cap	746,322	18,583	159	447	402	117	42	46	100	36	41	177	-18	270	225	135	338	267	64
11	Bolikhamxay	246,916	9,037	128	81	49	71	112	184	10	24	40	47	54	7	-25	66	164	-17	-115
12	Kammouane	362,712	12,659	173	134	73	73	94	173	10	36	72	118	55	16	-45	92	230	-19	-157
13	Savannakhet	882,913	27,723	381	282	168	73	98	165	10	60	105	175	206	107	-7	202	504	-34	-336
14	Saravan	350,839	12,981	140	121	63	93	107	206	10	32	43	85	55	36	-22	94	236	-31	-173
15	Xekong	92,588	3,713	76	66	34	49	56	109	10	16	14	40	36	26	-6	27	68	7	-34
16	Champasack	642,105	18,493	310	238	138	60	78	134	10	40	60	110	200	128	28	134	336	4	-198
17	Attapu	121,095	4,396	85	86	54	52	51	81	10	20	25	55	39	31	-1	32	80	22	-26
	Totals	**6,053,888**	**195,176**	**2,687**	**2,367**	**1,540**	**1,304**	**1,620**	**2,741**	**260**	**560**	**785**	**1,578**	**1,082**	**752**	**-65**	**1,421**	**3,550**	**119**	**-2,010**

Annex 9

Proposed SBA staffing levels

Health Centre	Initially 1 CMw plus 1 BeON-LSS trained staff then 1 CMw + 1 RMs as number of births rise
District Hospital	Initially 3 CMws plus 2 RMs, then 2 CMWs plus 3 RMs (depending on work load indicator – number of births per year)
Provincial Hospital	Initially 10 Midwives RM then depending on workload indicator – number of births per year
Central	RM - 1 for every 175 births per year

Annex 10

SBA Supervision

(*Proposal draft by CC sub-group 6)*

Objective/Purpose:

To periodically check that staff trained in SBA competencies, either during Pre-service or after during In-service/clinical updates, are practicing according to SBA standards and that SBA*tts* are maintaining fitness-to-practice according to the "*Midwifery Scope of Practice".*

Methods

- Self-assessment
- Observation using standardized checklist

Assessment Tools:

- Questionnaire form
- Checklist

SBA Supervision System

Central Level:

National SBA Supervision Committee *(Policy-making level; approval of tools and standard, including revision; training, updating and supporting Provincial SBA Supervisory Committee; final decisions of removal of right to practice)*

Membership: DOP (2); Curative Dept (2), MCHC (2), Hygiene Dept (2) OBGYN Society (1); OBGYN –central Hospital (1); Midwifery Teacher/clinical Trainer (1)

Provincial Level:

Provincial SBA Supervisory Committee: *(Managerial level – to ensure supervision is done/ carried out in accordance with; develop Provincial schedule; review District reports and take necessary action; send reports to National Committee in accordance with national SBA supervision policy, Train District Supervisors/team of)*

Membership: Head of OBGYN in Provincial Hospital, Midwife Trainer (where no school head of maternity in Provincial hospital or one of large District Hospitals); OBGYN clinical trainer; Provincial Health Officer or head of MCH

District Level:

District Supervisors/Supervisor Team: (Operational level- to conduct supervision in hospitals and HC in District. Identify training needs and arrange on the job training where possible, where can not, arrange for clinical update training or report to Provincial level for assistance/need for staff re-training/updating; make regular report to Provincial level; initial investigation of problems /poor performance, claims of poor practice and report to Provincial level for action)

Membership: District MCH officer; mid/high level SBA from District Hospital; Midwife from District Hospital (as interim, until Midwife posted, 1 experiences senior staff nurse with maternity experience and with BeON-LSS)

Annex 11

Provisional List of Midwifery Practice Standards

- **General Midwifery Practice (GMP)**
  - GMP standard 1: Preparation for Healthy Family Life
  - GMP standard 2: Record keeping

- **Care during Pregnancy/Antenatal Care (ANC)**
  - ANC standard 1: Antenatal monitoring and examination
  - ANC standard 2: Management of anaemia in pregnancy
  - ANC standard 3: First-line management of hypertension in pregnancy
  - ANC standard 4: Preparation for labour and delivery
  - ANC standard 5: Prevention of HIV among pregnant women and mother-to-child transmission of HIV

- **Care during Labour and Delivery/Intra-Partum Care (IPC)**
  - IPC standard 1: Care in labour
  - IPC standard 2: Save delivery
    - IPC standard: management of prolong second stage of labour with foetal distress by performing an episiotomy

- **Care after Delivery/Postpartum Care (PPC)**
  - PPC standard 1: Immediate essential care of the newborn (including newborn resuscitation)
  - PPC standard 2: Immediate management within the first two hours following delivery
  - PPC standard 3: Care of mother and baby in the postnatal period

- **Life-Saving Midwifery Practice (LSMP)**
  - LSMP standard 1: Life-saving management of vaginal bleeding in pregnancy
  - LSMP standard 2: Life-saving management of severe pre-eclampsia / eclampsia
  - LSMP standard 3: Life-saving management of prolong labour
  - LSMP standard 4: Life-saving management of retained placenta
  - LSMP standard 5: Life-saving management of primary postpartum haemorrhage
  - LSMP standard 6: Life-saving management of secondary postpartum haemorrhage
  - LSMP standard 7: Life-saving management of puerperal sepsis

Annex 12

Proposed Training Package for TBAs/MCH Community Health Volunteers

There is now sufficient evidence to show that training TBAs to do skilled birth attendance is not possible unless they undergo a full midwifery education programme. Such a programme is possible using non-formal /adult education approaches – but only for those with some education level (with basic literacy and numeracy skills).

However TBAs, both traditional TBAs and the younger Trained TBAs are a important human resource for reducing maternal and newborn mortality and morbidity.

Such community volunteers (TBAs) provide an essential link between the community and the health services. Moreover they often have access to community knowledge, customs and beliefs and, are usually well accepted by the community, primarily because they often live in the place they offer services, so are a neighbour, friend or even relative to the pregnancy women they work with.

Therefore it is propose to maximise this resource in a effective way,

- First, by linking them with the health services to monitor their work and provide supportive supervision from a skilled SBA*tt.*
- Second by providing them with training that will help them over time, in a phase out way, to change their role from attending birth - to being a safe motherhood advocate, community health promoter and for supporting women during birth providing social support to the women, as well as practical assistance to the SBA*tt.*

Training package should:

- Be designed based on non-formal/participatory adult education methodologies
- Include:
  - Health for pregnancy, including why SBA*ce* is important
  - Advocacy Training,
  - Working with Women, Families and communities to make birth and emergency preparedness plans,
  - Nutrition for mothers and newborn and children
  - Basic essential care of newborn at and just after birth, including safe cutting and care of umbilical cord, protection from cold and injury
  - Breastfeeding
  - Basic essential care of postnatal women
  - Birth spacing and promotion of condom use
  - Danger signs for pregnant women, women in labour and postnatal women
  - Danger signs for newborns and children
  - Making effective referrals if danger signs present or if any complication noted
  - HIV and STIs awareness
  - Infection prevention measures
  - Immunization

Annex 13

Implementation Schedule: Phase 2 only (Jan 2010 to Dec 2011) –REALIGED IN LINE WITH MNCH STRATEGY

Note: Source of funding for some activities yet to be agreed with donors; what is included are those activities already in agreed in DP work plans

GOAL 1 Tasks: Up-skilling existing staff for MNCH package	Responsible	Funding/ Donor /TA	2010				2011			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1. Continue training in 3 core MNCH Modules for 1st level HCP	DOP/Prov Schools	UNFPA/Lux/UNICEF /ADB/WB	X	X	X	X	X	X	X	X
1.2. Monitoring 3 Core Modules MNCH	DOP –SBA M and E Comm/MCHC	DPs	X	X	X	X	X	X	X	X
1.3 Review and evaluation of 1st Level MNCH Core Modules	DoP/MCHC	TBA					X			
1.4 Core Training FP 1st level HCP	DoP/Prov Schools/MCHC FP Trainers	UNICEF/			X	X	X	X	X	X
1.5 Review of IUD Training & development of quality assurance tool	MCHC/UNFPA	UNFPA		X						
1.6 IMCI Training in all HC and 1st level facilities (as part of 1st Level MNCH Core Modules	DoP/MCHosp/WHO	UNICEF	X	X	X	X	X	X	X	X
1.7 Community IMCI	DoP/MCHC/WHO/UNICEF	UNICEF/WHO TBC	X	X	X	X	X	X	x	x
1.8 Review of community IMCI	MCH/MCHC	TBA						x		
1.9 Finalize Manual & Printing Manual	DoP/ UNFPA/WHO/UNICEF/ JICA	UNFPA		X						
1.10 Finalization of Short SBA Training MAs, MDs and RNs	UHS/DOP/UNFPA	UNFPA	X							
1.11 ToT Short SBA Update Training	DoP/ DoH/Obs Soc/UHS/UNFPA/UNICEF/WHO	UNFPA			X					
1.12 Audit of clinical sites for SBA Update training	UHS/DOP//MCHC/ DoH/UNFPA	UNFPA		X	X					
1.13 Short SBA Training for MAs MDs RN for District Level HCP	DOP/Obs Soc/DPs	ADB/JICA/ UNFPA/Lux			X	X	X	X	X	X

Tasks: GOAL 1 cont'd	Responsibility	Funding/ Donor /TA	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.14 Completion of Revision of EmONC Training Manual	Obs Society and UHS	UNFPA	X							
1.15 Refresher ToT for master National EmONC training using revised manual	DoP/MCHC/DoHC/ Obs Soc/UHS	UNFPA/WHO/UNICEF/JICA/WB			X					
1.16 Provincial and District Training EmONC teams for all EMONC facilities as facility is upgraded using CHIPU system	DoP/MCHC/DoHC/ Obs Soc/UHS	Dev Partners tbc (based on results of national EmONC NA)				X	X	X	X	X
1.17 Review and evaluation of all curriculum; to ensure MNCH core modules and SBA competencies included where relevant	DOP/UHS	TBA					X			
GOAL 2 **Tasks: Re-introduction of Midwifery**										
2.1 Continued **Upgrade Training Centres**: (Phased approach Based on needs assessment/audit (Tool already have) – to include – New models – Textbooks, Posters and other TEACHNING LEARNING materials – Computer & Printer – Internet access – Community Midwifery bags Skills lab (with fully equipped skills stations for normal births, bemonc, essential newborn care), FP,	DoP	UNFPA/WB/UNICEF/ WHO/Luxembourg		x	x	x	x	x	x	x
2.2 Monitoring and supportive supervision of teachers on 1st batch MtOT for implementation of CMW (Post-basic) curriculum	DoP	UNFPA	x	x	x	x	x	x	x	x
2.3 Out-of-country training on skills labs	DoP	UNFPA/WHO		x						
2.4 Monitoring of CMW Curriculum and revisions based on lessons learnt	DoP	UNFPA		x		x		x		x
2.4 Printing National Education Standards	DoP	UNFPA		x						

Task: GOAL 2 cont'd	Responsibility	Funding/ Donor /TA	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.5 Development of Regulations for Accreditation licensing exam	DoP/National Standing Midwifery Committee	UNFPA		X	X					
2.6 Training National Examiners	DoP/National Standing Midwifery Committee	UNFPA			X					
2.7 1st batch Cohort 1 National Accreditation /licensing examinations 2nd batch Cohort 1 Nation Accreditation /licensing examination	DoP/National Standing Midwifery Committee	UNFPA				X	X			
2.8 2nd batch MtOT	DoP/UHS	UNFPA			x					
2.9 2nd Batch CMW Training	DoP/Provincial schools/UHS	UNFPA/ADB/others tbc				x	x	x	x	x
2.10 2nd Batch National Accreditation /licensing examination	DoP/Provincial schools/UHS	UNFPA /WHO								X
2.11 Review of national production plan for midwives	DoP				x				x	
2.12 English language training of teachers	DoP/Provincial Schools/UHS	UNFPA and other DP tba		x	x	x	x	x	x	x
2.13 Provision of national Uniform for student Midwives	DoP/Provincial Schools/UHS	UNFPA/Luxembourg	x		x				x	
2.14 National Evidence-based Midwifery and conference to contribute to updating of clinical practices	DoP/DoHC/MCHC/ Soc OBGYN society /UHS	UNFPA /other DPs tbc			x				x	
2.15 Advocacy for Midwives day	MoH/UNFPA	UNFPA/WHO/ other DPs		x				x		
2.16 Commence RM for technical Nurses	MoH/UHS							X	X	X
Goal 3: Tasks: Strengthening HRD Systems										
3.1 Continue to advocate integration of SBA HRD plan/needs in national HRD Strategic Plan	DoP/SBA Goal leaders	N/A	x	x	x	x	x	x	x	x

Task: GOAL 3 cont'd	Responsibility	Funding/ Donor /TA	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.2 Orientation of Provincial Offices on Job description for CMW	DoP	UNFPA		x						
3.3 Draft Job description for High level RM	DoP	UNFPA/WHO			X	X				
3.4 Annual planning workshop with Provincial Office	DOP	Development Partners			X				X	
3.5 Agree and disseminate printed information on incentives package for CMW graduates	DOP	WHO/UNFPA			X					
3.6 Integrate SBA database into new HR database when completed (need data input assistance)	DOP	ADB/UNFPA/WHO			x	x	x	x	x	
3.7 Workshop on Staff Appraisal/ Performance and development plans	DOP	ADB/UNFPA/WHO			x					
3.8 Review HRD Training Plan for SBA/MNCH	DOP				X					
Goal 4 **Tasks: Strengthening Service Facilities to Ensure Skilled Birth Attendance**										
4.1.Conduct National EmONC needs assessment – **Agreed Tool – adapt AMDD Tool** – **Train data collectors** – **Test tool** – **Conduct national assessment Analyse results create plan of action** - **Disseminate results**	National EmONC Committee	UNFPA/WHO/UNICEF/WB/Lux017/JICA			X X X X	X				
4.2 Develop Clinical Audit system and tool for auditing clinical standards	DoHC	UNFPA			X					
4.3 Train external auditors	DoHC	UNFPA			X					
4. 4 Orientation key staff on new Clinical audit system and tool (3 Regional workshops)	DoHC	UNFPA				X	X			

Task: GOAL 4 cont'd	Responsibility	Funding/ Donor /TA	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4.5 Phased introduction of Audit of clinical standards for MNH	DoHC	Development partners			X	X	X	X	X	X
4.6 Establish Model Delivery Room	DoH	Development partners				X	X			
4.7 Phased Upgrade Service Facilities: Prioritise Clinical Placement sites Number of tools already available	DoHC/ Budget and Planning	MoH Budget and Planning Development partners					X	X	X	X
Goal 5 Tasks: Advocacy and Demand Creation/community mobilization for Skilled Birth Attendance										
5.1 Pilot WHO IFC Framework and Birth & Emergency Preparedness Planning	PHO/District HO/TF6./MCHC	UNFPA		X	X	X	X	X	X	X
5.2 Translation and Pilot of WHO MNH Counselling Manual	CIEH/MCHC	WHO		X	X					
5.3 Develop Training manual for Community based health workers, including TBA for key MNCH community interventions	CIEH/MNCH	WHO/UNFPA			X					
5.4 Phased Implementation of community based training of health care workers in MNCH	CIEH/MMNCH	WHO/UNFPA/WB/ others			X	X	X	X	X	X
5.5 Integrate Family friendly/client focused care into all training manuals	DoP/UHS/Provincial School		X	X	X	X	X	X	X	X

Annex 14

National Integrated Package MNCH

Suggested Delivery Channels to provide MNCH Care

O: Essential services Δ: Optional services

	Item of services	Community Resources	Outreach Services	Health Centre	District Hospital B	District Hospital A	Central & Provincial Hospital
Care of un-pregnant WRA	Information or counselling	O	O	O	O	O	O
	Condoms and oral contraceptives	O	O	O	O	O	O
	Injectable		Δ	O	O	O	O
	IUD			Δ	Δ	O	O
	Vasectomy, tubal ligation				Δ	O	O
Pregnancy care	4 routine antenatal care visits		Δ	O	O	O	O
	De-worming	O	O	O	O	O	O
	Iron & folate supplementation	O	O	O	O	O	O
	Two doses of TT immunization or at least three in the past		O	O	O	O	O
	Use of insecticide-treated bed nets from prenatal to postnatal	O	O	O	O	O	O
	Monitoring progress of pregnancy and assessment of maternal and fetal well being			O	O	O	O
	Detection of pregnancy problems (e.g. anaemia, hypertensive disorders, bleeding, mal-presentation, multiple pregnancies)			O	O	O	O
	Syphilis testing			O	O	O	O
	STI/HIV risk assessment and counselling			O	O	O	O
	Information and counselling on self care at home, nutrition, sexual activities, breastfeeding, family planning, healthy lifestyle	O	O	O	O	O	O

	Mobilization of delivery in health facility, birth and emergency planning, advice on danger signs and emergency preparedness	O	O	O	O	O	O
	Back up antenatal care if complications				Δ	O	O
	Treatment of abortion complications				Δ	O	O
Child birth care	First level delivery care including partograph, AMTSL[43], injectable antibiotics, oxytocin, magnesium sulphate, neonatal resuscitation			O	O	O	O
	Back up EmONC including above plus vacuum extraction, manual removal of placenta, manual vacuum aspiration				O	O	O
	Back up/comprehensive EmONC including above all functions plus Caesarean Section, blood transfusion					O	O
Newborn care	Immediate newborn care (thermal protection, cord care, assess breathing, initiation of exclusive breastfeeding, infection prevention, eye prophylaxis)	Δ	Δ	O	O	O	O
	Neonatal resuscitation	Δ	Δ	O	O	O	O
	Information and counselling on home care, breastfeeding, hygiene, advice on danger signs, emergency and follow-up	O	O	O	O	O	O
	Immunization according to the national guidelines (BCG, HepB)			Δ	O	O	O
	Special newborn care				Δ	O	O

[43] AMTSL: active management of the third stage of labour

Postnatal care	Information and counselling on home care, breastfeeding, hygiene, advice on danger signs, emergency and follow-up	O	O	O	O	O	O
	Routine postpartum maternal care (up to 6 weeks)		Δ	O	O	O	O
	Postnatal newborn care (within 7 days)	Δ	Δ	O	O	O	O
Child health care	Promotion of breastfeeding and complementary feeding	O	O	O	O	O	O
	Micronutrient supplementation	O	O	O	O	O	O
	Routine immunization of the child		O	O	O	O	O
	TT+2 immunization to women of reproductive age to protect neonatal tetanus		O	O	O	O	O
	Outpatient care of the sick child (IMCI)		Δ	Δ	O	O	O
	Hospital care of the sick child (IMCI)				O	O	O
	Community IMCI	O					
	Use of insecticide-treated bed nets	O	O	O	O	O	O
	De-worming	O	O	O	O	O	O