National Action Plan for Maternal Health

2020-2030

Ministry of Health & Family Welfare
Government of the People's Republic of Bangladesh

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Contents

Preface

Bangladesh's achievement in the health sector, particularly in the area of maternal, newborn and child health, over the last two decades is recognized internationally. There has been progressive increase in utilization of critical maternal health services. Maternal health is a top priority of the Government of Bangladesh and its Development Partners (DPs). Ministry of Health and Family Welfare developed the National Strategy for Maternal Health 2019-2030, which provide the strategic directions and guiding principles for maternal health programming and implementation in Bangladesh.

The development of National Action Plan for Maternal Health 2020-30 is an important step to operationalize the national strategy for maternal health and represent a great achievement. This national action plan, developed through extensive stakeholder consultation, is a time bound document to ensure the strategy implementation. The overall goal of Action Plan for Maternal Health is to support the implementation of priority interventions that provides timely, equitable, accessible, high quality, evidence-based, respectful maternal health care in an efficient and effective manner. The action plan will greatly contribute towards implementing national priorities and global commitment for better health of mothers and save their lives.

I thank the joint effort of the organizations and individuals who made great contributions toward the development of this action plan.

I firmly believe that "National Action Plan for Maternal Health 2020-30" to be useful for the policy makers, project planners, managers, service providers, professional associations, development partners, international organizations and all relevant stakeholders in the maternal health area. I sincerely hope that these action plan will be implemented in phases and will contribute in achieving the maternal health goals & targets in Bangladesh

Prof. Dr. Abul Kalam Azad
Director General
Directorate General of Health Services

Foreword

The National Action Plan for Maternal Health 2020-2030 is an important milestone in the government's effort to improve maternal health, reduce preventable maternal death and to achieve the Sustainable Development Goal by 2030. The action plan provides guidance to implement prioritized evidence based high impact interventions to accelerate momentum for maternal health and monitor progress. It provides an opportunity to engage key stakeholders for priority programme planning, effort to scale-up of equitable and sustained actions for maternal health and mobilize resources through ensuring commitment of government & development partners.

This action plan was developed in five thematic areas along with crosscutting issues and in alignment with seven strategic directions outlined in the maternal health strategy. The thematic areas are 1) Preconception & Antenatal Care; 2) Comprehensive Emergency Obstetric & Newborn care, Basic Emergency Obstetric & Newborn care, Normal delivery, Midwifery care 3) Postpartum Care and Postpartum Family Planning; 4) Antepartum Hemorrhage, Post Partum Hemorrhage, Eclampsia & Preeclampsia; 5) Maternal & Perinatal Death surveillance and Response, Maternal morbidities, Response to Gender Based Violence.

It needs to mention that this National Action Plan for Maternal Health is the result of praiseworthy and valuable contribution of all stakeholders from the Ministry of Health & Family Welfare, UN agencies, USAID, Professional Associations, Academia, Donor agencies, International & National NGOs.

Ministry of Health & Family Welfare is committed to ensure the implementation of the National Action Plan for Maternal Health 2020-30, that will contribute in reduction of preventable maternal death and improve wellbeing. I look forward for successful implementation of the National Action Plan for Maternal Health with the support and coordination of all relevant stakeholders.

Dr. Mohammed Sharif
Director, (MCH-Services) &
Line Director- MCRAH
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Acknowledgement

The members of the Core Committee gratefully acknowledge the contributions of many individuals to preparation of this action plan.

Special thanks to the members of the Technical Sub Committees, experts from Health Economic Unit of MOHFW, Directorate General of Health Services, Directorate General of Family Planning, Directorate General of Nursing & Midwifery, Obstetric and Gynaecological Society of Bangladesh, Perinatal Society of Bangladesh, Bangladesh Midwifery Society, UN Agencies, The World Bank, USAID, ICDDRB, International and National NGOs, Donor Agencies, who participated in a series of meetings, stakeholder workshops and contributed in developing this important document for maternal health in Bangladesh. Their keen interest in and support to maternal health is evident throughout.

We acknowledge and thank UNICEF, WHO, UNFPA, USAID and Save the Children for their technical and financial support throughout the process.

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Acronym

ANC Antenatal Care
BCC Behavior Change Communication
BDHS Bangladesh Demographic and Health Survey
BHFS Bangladesh Health Facility Survey
BEmONC Basic Emergency Obstetric and Newborn Care
BHFS Bangladesh Health Facility Survey
BMDC Bangladesh Medical and Dental Council
BMMS Bangladesh Maternal Mortality Survey
BNMC Bangladesh Nursing and Midwifery Council
CBE Clinical Breast Examination
CBHC Community Based Health Care
CC Community Clinics
CEmONC Comprehensive Emergency Obstetric and Newborn Care
CES Coverage Evaluation Survey
CG Community Group
CHCP Community Health Care Provider
CIN Cervical Intraepithelial Neoplasia
CPR Contraceptive Prevalence Rate
CSBA Community-based Skilled Birth Attendant
CS Civil Surgeon
CSG Community Support Group
DDFP Deputy Director Family Planning
DEPB District Evidence-based Planning and Budgeting
DGDA Directorate General of Drug Administration
DGFP Directorate General of Family Planning
DGHS Directorate General of Health Services
DH District Hospitals
DGNM Directorate General of Nursing & Midwifery
DM Diabetes Mellitus
DPs Development Partners
DSF Demand Side Financing
ECP Emergency Contraceptive Pill
ECBSS Effective Coverage of Basic Social Services
EPPM Ending Preventable Maternal Mortality
FP Family Planning
FWAs Family Welfare Assistants
FWV Family Welfare Visitor
GoB Government of Bangladesh

GBV Gender Based Violence
HA Health Assistant
HCF Health Care Facility
HMIS Health Management Information System
HNPSP Health Nutrition and Population Sector Programme
HPNSDP Health Nutrition and Population Sector Development Programme
HIV Human Immunodeficiency Virus
HR Human Resources
HSS Health System Strengthening
HTR Hard to Reach
ICT Information and Communication Technologies
ICDDRB International Centre of Diarrhoeal Disease Research Bangladesh
IEC Information Education & Communication
IFA Iron Folic Acid
IUD Intra Uterine Device
LBW Low Birth Weight
LGD Local Government Division
LD-HSM Line Director-Hospital Service Management
LD-MIS Line Director-Management Information System
LD-CBHC Line Director-Community Based Health Care
LD-BHE Line Director- Bureau of Health Education
LD-IEM Line Director- Information Education Management
MCWC Mother and Child Welfare Centers
MIS Management Information System
MMR Maternal Mortality Ratio
MNCAH Maternal Neonatal, Child and Adolescent Health
MNCH Maternal, Neonatal and Child Health
MNCHFP Maternal, Neonatal and Child Health, and Family Planning
MNH Maternal and Neonatal Health
MOF Ministry of Finance
MOHFW Ministry of Health and Family Welfare
MOLGRDC Ministry of Local Government Rural Development and Cooperative
MPDSR Maternal and Perinatal Death Surveillance and Response
NGO Non-Governmental Organization
NMR Neonatal Mortality Rate
NNS National Nutrition Service
NVD Normal Vaginal delivery
OGSB Obstetrical and Gynaecological Society of Bangladesh
OF Obstetric Fistula
OCP Oral Contraceptive Pill
PNC Postnatal Care
PMTCT Prevention of Maternal to Child Transmission of HIV

PPH	Post Partum Hemorrhage
PRSP	Poverty Reduction Strategy Paper
RMNCAH	Reproductive, Maternal, Newborn Child and Adolescent Health
PPFP	Post Partum Family Planning
QI	Quality Improvement
SACMO	Sub-Assistant Community Medical Officer
SBCC	Social & Behavioural Change Communication
SOP	Standard Operating Procedure
SSK	Shasthyo Shurokhsha Karmasuchi (Health Protection Scheme)
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UHC	Upazila Health Complexes
UH&FWC	Union Health and Family Welfare Center
UHFPO	Upazilla Health & Family Planning Officer
UFPO	Upazilla Family Planning Officer
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic Acid
WFHI	Women Friendly Hospital Initiative
WHO	World Health Organization

Introduction

Bangladesh has made significant progress in improving reproductive and maternal health outcomes over the past decades. The maternal mortality ratio (MMR) deceased from 322 maternal death per 100,000 live births in 2001 to 194 per 100,000 live births in 2010[1] and there is further reduction of MMR to 176 per 100,000 live births in 2015 as per UN estimate[2]. While these improvements are impressive, the reduction rate in maternal mortality is far less than the desired level of achieving the ambitious Sustainable Development Goal (SDG) target of MMR, 70/100,000 live births by 2030. This is likely to be due to stagnant modern contraceptive prevalence rates, limited quality of care and capacity to deal with the main causes of maternal death, and high caesarean section rates. There is not much change in the major causes of maternal mortality over the last decade; major causes of maternal mortality are hemorrhage (31%) and Eclampsia (24%)[3].

Achieving the desired mortality level needs accelerated efforts by the government and development partners for rapid scale-up of high impact and cost-effective priority interventions and achieving the effective coverage. Access to quality reproductive maternal, newborn, adolescent health care services remains a challenge across all level of care and including equity among population subgroups. Evidence also suggests that increased coverage and quality of preconception, antenatal, intrapartum, and postnatal interventions by 2025 could avert 71% of neonatal deaths, 33% of stillbirths and 54% of maternal deaths per year[4].

Substantial increase was achieved in skilled attendance at deliveries, 4+ ANC and PNC coverage between 2014 and 2017 BDHS surveys[5]. However, there is gap between contact and content of ANC. The contact is defined as the percentage of pregnant women with four or more antenatal care visits. The content of ANC is an essential component of service quality and defined as proportion of pregnant women who sought ANC and receive all basic component of ANC including weight & blood pressure measured, urine & blood tests and information on signs of possible pregnancy complications. BDHS 2017 data shows a huge gap between contact and content in the antenatal period. 47% of women received four or more ANC visits, whereas only 18% of the women received all ANC content or quality compoements[5]. There is also gap in coverage of this essential services among different geographic location[6]. The findings from a study reveal that the coverage of antenatal care service remains critically low in Netrokona, a low performing district in Bangladesh. The findings also highlight that even when women attend ANC contacts, substantial gaps in content remain during these contacts. Therefore, women are not fully benefiting from these services[7].

There is increasing evidence to support that increased coverage of recommended contacts alone is insufficient to reduce maternal and neonatal mortality and morbidity [4,8,9 ,12,13]Quality of care is being internationally recognized as a critical aspect of the unfinished maternal and newborn health agenda[8,10] Recently, the World Health Organization has proposed standards of care and measures for assessing quality of maternal and newborn health care.

There is need to include elements of quality of care for regular monitoring through routine health management information systems, household and facility surveys in order to identify the real gaps in effective coverage. Periodic program assessments can include a measure for content analysis of ANC and PNC visits in a given sample of mothers and newborns and explore reasons of omitting certain interventions. Further research is also required to identify more sensitive indicators on quality of care and including these in future household surveys.

There is link between continuum of care and quality of care. International study highlights that having four antenatal care visits and receiving better quality of antenatal care affected women's subsequent use of skilled birth attendant. The odds of having skilled birth attendant increases by 30 to 50% for women who received blood pressure measurement, urine sample taken, and blood sample taken as part of antenatal services[11]. The current maternal, newborn and child health coverage indicators for pregnancy, labour and postnatal period focus merely on contacts with the health system with no information on quality and process of care. Focusing on merely contacts with health system rather than on content of care is a critical gap in assessing the true effectiveness of maternal and child health interventions. Such gaps between globally recommended coverage indicators measuring contacts and actual content indicate ineffective care resulting in lack of accelerated progress towards maternal and newborn survival. To move towards elimination of preventable causes of maternal and newborn deaths, increased coverage of recommended contacts should be accompanied by increased focus on content of services[8,10,12]

In order to end preventable maternal deaths, accurate information on how many women died, where they died and how they died is essential, but is currently inadequate. It is essential to count every maternal and newborn death for understanding immediate and underlying causes of these deaths and developing evidence-informed, context-specific programme interventions to avert future deaths. As utilization of health care services increases, many of the deaths are occurring at health facilities. The outcome of care in health facilities reflects the evidence-based practices used and the overall quality of services provided. Poor-quality services and care reduce the effectiveness of interventions and increase the risks for hospital acquired infections, life-long disability and death from avoidable complications and preventable causes.

Maternal health is a top priority of the Government of Bangladesh and its Development Partners (DPs). Ministry of Health and Family Welfare developed the National Strategy for Maternal Health 2019-2030, which provide the strategic directions and guiding principles for maternal health programming and implementation in Bangladesh. The broad objective of the Bangladesh National Strategy for Maternal Health (BNSMH) 2019-2030 is to guide the Ministry of Health and Family Welfare (MOHFW) in addressing the existing gaps and inequities in the delivery of quality maternal health services as well as the social and development factors that impact on maternal health.

MOHFW initiate developing this National Action Plan for Maternal Health to accelerate the efforts in reducing preventable maternal death by operationalizing the strategies and laying out a costed action plan that can be implemented through their operational plans.

In this scenario, UNICEF, UNFPA, WHO, USAID and Save the Children supported the MOHFW in developing and finalizing the action plan through conducting wide stakeholder's consultation and participation. During the process, gap analysis was conducted to recommend appropriate actions aligning with Maternal health strategies, to address the gaps. It is expected that the action plan will be incorporated into the respective operation plans for implementation. This action plan identifies some key priority actions that require urgent attention by the MOHFW and to accelerate implementation immediately.

The overall goal of Action plan for Maternal Health is to support the implementation of priority interventions that provides timely, equitable, accessible, high quality, evidence-based, respectful care in an efficient and effective manner.

Rationale:

To ensure health and well-being for every woman, child and adolescent, we must build on what has worked in the past and use what we have learned to overcome existing and emerging challenges. Addressing preventable maternal deaths requires clear consensus on actions and broad coordination of partners working in different areas. Bangladesh National Strategy for Maternal Health 2019-2030 provide strategic directions and identified key coverage and impact targets to be achieved by 2030. Now the maternal health strategy is to be translated into action plan for implementation through ensuring commitment and engagement of the government, development partners and all relevant stakeholders. The action plan provides guidance to implement prioritized evidence based high impact interventions to accelerate momentum for maternal health and monitor progress. The administrative and clinical leaders in maternal health identify gaps, issues of priorities and improvement opportunities in maternal health and health care delivery system in order to improve the maternal care experience and overall health care system performance.

It provides an opportunity to engage key stakeholders including programme peoples, professionals, academia, NGO/private sectors, civil society in participatory discussions, stimulate national dialogue for priority programme planning, accelerated effort to scale-up of equitable and sustained actions for maternal health and mobilize resources through ensuring commitment of government & development partners and to achieve sustainable development goals.

This action Plan will respond to the global agenda of ending preventable maternal deaths, and is consistent with the global and national goals and approaches in maternal health under the overarching commitment of achieving sustainable goal 3

This action plan is for ten years in consistent with the National Maternal Health Strategy. However, it needs periodic review considering the changes occurring in key social and economic dimensions such as urbanization, women's education, employment and status, income growth that are rapidly modifying reproductive and maternal health care- seeking behaviors with important implications for the planning of health services, the availability of new evidences and also lessons learned from implementation of the action plan.

Development Process of National Action Plan for Maternal Health

- Formation of National Core Committee and five Technical Sub-Committees in December 2019 for development of an action plan based on Bangladesh National Strategy for Maternal Health 2019-2030.
- Under the guidance of National Core Committee, five Technical Subcommittees were assigned to work in five following thematic areas;

    i. Preconception, Antenatal care, Maternal Nutrition
    ii. Normal delivery, Basic Emergency Obstetric & Newborn Care (BEmONC), Comprehensive Emergency Obstetric & Newborn Care (CEmONC), Midwifery care
    iii. Postnatal care, Postpartum Family planning

iv. Antepartum Hemorrhage (APH), Post partum Haemorrhage (PPH), Preeclampsia, Eclampsia
v. Maternal, Perinatal Death Surveillance & Response (MPDSR), Maternal Morbidity, Gender Based Violence Response

- Series of meetings held with maternal health key stakeholders including programme peoples from DGHS, DGFP, Health Economics Unit of MoHFW, OGSB, Development Partners, WHO, UNICEF, UNFPA, USAID, Save the Children, The World Bank, Jhpiego, ICDDRB, Academia, NGOs. All partners were engaged under the leadership of Line Director- MNCAH, in participatory discussion and agreed on the outline of the action plan and process of development
- An international consultant reviewed the primary and secondary data, strategy documents, reports, publications, SOPs, guidelines, WHO recommendations, relevant action plans from a variety of sources. Information related to the local and global maternal health situation was also obtained from the publications of national and international organizations and from web searches.
- Reference documents were collected and shared with the Technical Groups.
- First draft (1) was prepared as per agreed outline and shared with the five Technical Groups.
- The five Technical Groups worked on the draft (1) in respective thematic areas, identified key issues, gaps and proposed priority actions to address the gaps. Key actions, activities are aligned with the seven strategic directions from the Bangladesh National Strategy for Maternal Health. All inputs and feedbacks were incorporated in the draft (2)
- A national workshop was held on 5-6 February 2020 to share the draft (2), validate the gap analysis, consensus on the priority maternal health interventions and review of the action plan with wider stakeholders
- All comments, feedbacks were incorporated from the national workshop and action plan revised (draft 3)
- The revised action plan (draft 3) was shared again with the Technical Groups for review validation and finalization. All comments incorporated and final draft (draft 4) prepared.
- The final draft (4) Action plan is then submitted to the National Core Committee for review and endorsement
- GOB, UNICEF, WHO, UNFPA, USAID, Save the Children, The World Bank, OGSB, ICDDRB, Jhpiego and other partners provided valuable inputs in development of the action plan

Gap Analysis

Gap analysis was done on the five thematic areas of maternal health interventions in line with seven key strategic directions identified in the Bangladesh Maternal Health Strategy through a series of consultative meetings and workshop. A national consultation workshop organized by Directorate General of Health Services (DGHS) was held to validate the findings. The gap analysis is incorporated in the six thematic areas of action plans.

Priority activity

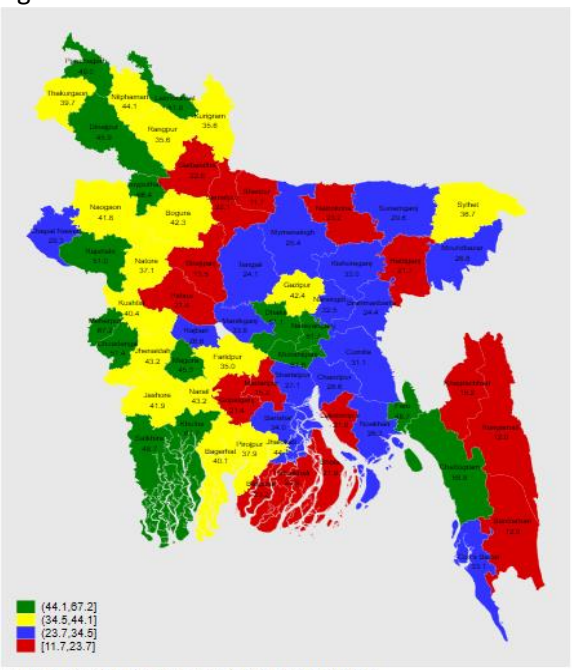
During the stakeholder's consultation for developing the action plan, a consensus was made that each thematic group will identify few priority actions that require to be implemented on a priority basis preferably within this sector program. These priority activities are selected based on the gap analysis,

reviewing of recent survey data, global evidences on key maternal health interventions etc. Evidence suggests that increased coverage and quality of preconception, antenatal, intrapartum, and postnatal interventions by 2025 could avert 71% of neonatal deaths, 33% of stillbirths and 54% of maternal deaths per year[4]. It is important to note that most of this activity implementation is ongoing, however the coverage and quality is not adequate to accelerate the reduction of preventable maternal & neonatal death.

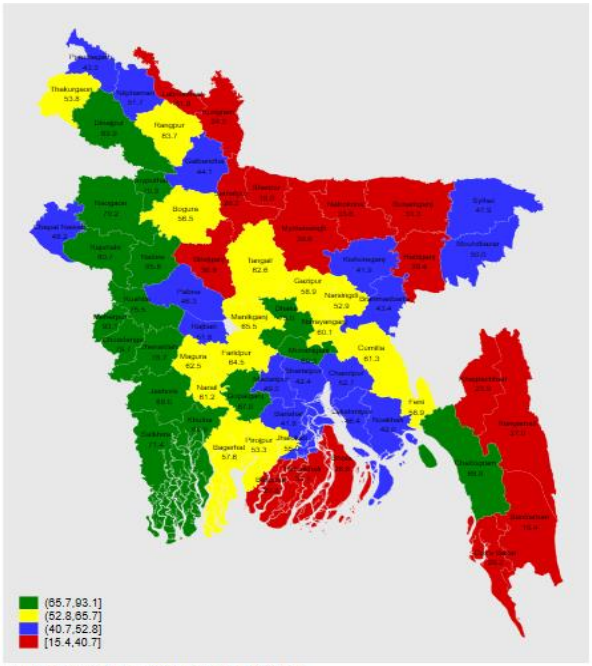
Facility readiness for providing quality MNH care especially the emergency obstetric care is an important barrier and is evident in the Bangladesh Health Facility Survey report 2017. Care seeking behavior of women is an impediment to increase the coverage of key maternal health interventions as 40.3% women still believe that antenatal care is not necessary and 33.2% women felt it is not necessary to deliver at a health facility (ECBSS 2018)

The Bangladesh Multiple Indicator Cluster Survey (MICS) in 2019 identifies 16 lowest performing districts for 4+ ANC coverage and Institutional deliveries as shown in Figure 1. Among the 16 districts, 11 districts are common for both lowest 4+ ANC coverage and institutional deliveries. This finding is consistent with the International study which highlighted that having four antenatal care visits and receiving better quality of antenatal care impacts on women's subsequent use of skilled birth attendant. Despite continued investment in some of these districts, Maternal, Newborn Health (MNH) indicators have remained relatively poor. This could, in part, be explained by inadequate resources to adequately address these problems, inappropriate allocation of the available resources, or lack of implementation of the most effective interventions, inadequate leadership etc. Systematic priority setting by using performance data and resource allocation could contribute to alleviating these limitations.

Figure:1



NOTE: Four or more Antenatal care (ANC) by District, Bangladesh 2019



NOTE: Institutional delivery by District, Bangladesh 2019

Many actions/activities are identified in five thematic areas align with seven strategic directions of National Maternal Health strategy and describe in details in the Action Plan Section.
Among these the following activities are identified as key priorities by the five thematic groups for immediate implementation within the next two years (2022) during this ongoing 4th sector programme (HPNSDP);

1. Accelerate action to ensure early pregnancy registration of all pregnant women with mobile number (e-Tracking). Each Upazilla should have 100% pregnancy registration
2. Provision of 4+ quality ANC services with key components to all pregnant women prioritizing the low performing districts. Quality of antenatal care should be given more focus. Improve facility readiness for ANC services at Community Clinics, Union Health & Family Welfare Center and Upazilla Health Complexes
3. Prepare and implement facility readiness at district hospitals for 24/7 comprehensive emergency obstetric & newborn care services (CEmONC) and increase readiness by 60% from baseline (BHFS 2017)
4. Increase facility readiness at 50% UHCs from baseline (BHFS 2017) for basic emergency obstetric & newborn care services (BEmONC) including universal practice of prereferral stabilization of All obstetric complications
5. Prepare plan to equip selected strategically located UH&FWC for 24/7 normal delivery services (Special attention to underserved unions, peri-urban areas, char, haor, tea gardens and other hard to reach areas)
6. Increase notification, review and response of each maternal & perinatal death. Expansion of MPDSR to all 64 districts
7. Develop a common reporting platform for MNH performance tracking including urban and private sector
8. Develop Regulatory Framework for standardized service delivery & quality improvement (including MNH care) at private and NGO facilities
9. Demand generation and awareness creation through organizing nationwide special maternal health campaign including service week for safe motherhood
10. Review existing social protection schemes for the poor and disadvantaged population and develop an equity focused strategy based on lessons learnt from different safety net approaches
11. Prioritize and resource allocation for implementation of interventions related to maternal morbidities especially obstetric fistulas as per national action plans

Action plans by thematic area

Thematic Area: Preconception & ANC

Strategy 1: Service delivery along the continuum of care								
Preconception & ANC	**Key issues**	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas)**
				20-22	**23-26**	**27-30**		
Preconception	Adolescent nutrition (Anemia, stunting, obesity, worm infestation) Adolescent Sexual & reproductive health Family Planning	lack of awareness and services	Implement school adolescent health and nutrition services (IFA supplement, Vit D, physical exercise, deworming)	x	x	x	NNS/IPHN, NCDC, School Health DGHS, LD-MCRAH, DGFP	# school implemented
			Implement roll out national iron plus initiative including weekly IFA at health facility	x	x	x	LD-MCRAH, LD-NNS	# Health facilities distribute weekly IFA
			Organize family counselling at health care facilities on health and nutrition education	x	x	x	LD- CBHC, LD-MNCAH, LD-MCRAH, LD-NNS	# HCF conduct family counselling
			Accelerate action on couple registration immediately after marriage	x	x	x	LD-MCRAH-FSD LD- CBHC, LD-MNCAH,	# Couple registration
			Management of menstrual health and hygiene at all level of health facilities	x	x	x	LD-MCRAH-FSD LD- CBHC, LD-MNCAH,	# menstrual health managed at health facilities
	Pre pregnancy care	Child marriage, adolescent pregnancy	Conduct family planning counselling (Pre-conception and ANC) and provide services (OCP, Condoms, ECP) at health facilities (CC, UHFWC, UHC)	x	x	x	LD-MCRAH, DGFP LD- CBHC	# couple receive FP counselling & service
		Prevention of maternal and foetal complication	Conduct screening of high-risk pregnancy (DM, Hypertension, other medical disorder, Rh factor, rubella, thyroid disorder, HIV/AIDs, STIs and congenital anomalies) and referral	x	x	x	LD- CBHC, LD-MNCAH, LD-MCRAH, LD, Hospitals	# screening # referral for high risk pregnancy

Ante Natal Care	ANC care providing at all levels as per SOP	Low coverage of 4 quality ANC The gap between contact and component of ANC is huge	Increase coverage of 4+ ANC visits with all quality components of health and nutrition services as per national ANC and Maternal Nutrition guidelines (BP checkup, Weight measurement, Urine test, Hemoglobin checkup, counselling) at all facility	x	x	x	LD-MNCAH, LD-MCRAH, LD-CBHC, LD-NNS, LD-IEC, LD, L&HEP, CS, DDFP, UHFPO, UFPO, MO-MCH	Percentage of quality 4 ANC visits
			Improve facility readiness for quality ANC services as per SOP at CC, UHFWC, UHC, DH	x	x	x	LD-Hospitals, LD-MNCAH, LD-MCRAH, LD-CBHC, CS, DDFP, UHFPO,UFPO, MO-MCH	Percentage of facility readiness to provide quality ANC services
		Lack of dedicated space	Identify dedicated space with privacy for ANC at all service delivery points	x	x		LD-MNCAH, LD-MCRAH, LD-CBHC, LD-Hospitals, CS, DDFP, UHFPO, UFPO, MO-MCH	# facilities with space & privacy for ANC services
		High risk pregnancy	Identification, management and referral of maternal complications during pregnancy including pre-referral management of severe preeclampsia, eclampsia and follow up.	x	x	x	CS,DDFP,UHFPO, UFPO, MO MCH-FP	# pregnant women with complication referred # of women with pre-referral management
		Intervention for prevention of stillbirth, birth defect and newborn survival	Provision of syphilis and STI screening, detection and treatment at health facility as per guideline	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH, LD-Hospitals,	Syphilis & STI Screening system establish # cases identified and treated # pregnant women receive folic acid supplementation
			Provision of Folic acid supplementation during pregnancy to prevent stillbirth, birth defect, low birth weight and newborn survival	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH, LD-Hospitals, LD-NNS	
			Detection and management of hypertension, diabetes mellitus during pregnancy as per SOP	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH, LD-Hospitals,	

			Detection and management of fetal growth restriction as per SOP	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH	
			Provision of antenatal corticosteroid for threatened preterm birth (at UHC and DH) as per SOP	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH, LD-Hospitals,	
		Inadequate Follow up	Conduct follow up and reminder for subsequent ANC visits through IPC and using technology (mobile base messaging)	x	x	x	LD-MCRAH, LD-CBHC,LD-MNCAH, LD-IEC, LD-L&HEP, LD-NNS	# registered pregnant women received 4 ANC
		Inadequate BCC materials, job-aid	Provision of SBCC and job aid materials in ANC/PNC room (posters on 4+ANC visit, maternal danger signs, birth planning, hypertension & preeclampsia/eclampsia & PPH identification and management algorithm)	x	x	x	LD-MNCAH, LD-MCRAH, LD-CBHC, LD-IEC, LD-L&HEP, CS, DDFP, UHFPO,UFPO	# facilities with SBCC materials & job aids
			Harmonization of ANC/PNC card, registers and reporting format (among DGHS, DGFP, NGO, Private sector) and use of harmonized ANC/PNC card, registers and reporting format at all public and private facilities	x	x		LD-MNCAH, LD-MCRAH, LD-MIS, LD-HIS and eH, LD- CBHC	harmonized ANC/PNC cards, registers, reporting format available at all service delivery points
			Develop a comprehensive antenatal care communication package (printed, audio-visual, multi-dialect and interactive) for every pregnant woman, adolescents, parents, in-laws and husbands explaining the dos and don'ts of pregnancy and labor, possible harmful effects of unnecessary C-Section & importance of necessary C-Section)	x	x		LD-MNCAH, LD-MCRAH, LD-Hospitals, LD-IEC, LD-L&HEP,	ANC Communication package available
		Lack of adequate counselling	Provision of appropriate counselling (nutrition, PPFP, birth preparedness & maternal danger signs) for pregnant women as per national guideline & SOPs	x	x	x	LD-IEC, LD-L&HEP, LD-NNS CS, DDFP, UHFPO, UFPO, MO, MCH-FP	# Pregnant women receive counselling # monitoring visits
			Conduct courtyard meeting including birth preparedness session, Mother's assembly at community	x	x	x	LD-IEC, LD-L&HEP, LD-NNS CS, DDFP, UHFPO,	# courtyard meeting held # mother's assembly held

							UFPO, MO, MCH-FP	
	Pregnancy with HIV	Non availability of PMTCT service	Integration of PMTCT into national ANC guideline and SOP	x			LD-MNCAH, LD-MCRAH, LD-TB Leprosy and HIV-AIDS	PMTCT integrated into ANC guideline &SOP
			Integration of PMTCT with ANC services as per national PMTCT guideline		x	x	LD-MNCAH, LD-MCRAH, LD-TB Leprosy and HIV-AIDS	# facilities offer PMTCT services

Thematic Area: CEmONC/ BEmONC/Normal Delivery/ Midwifery care

Key Strategy 1: Service delivery along the continuum of care								
Midwifery care/ Normal Delivery/ BEmONC/ CEmONC	**Key issues**	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas)**
				20-22	**23-26**	**27-30**		
Comprehensive Emergency Obstetric &Newborn Care	Facility readiness plan for CEmONC Blood transfusion	Availability of CEmONC for 24/7 remain a challenge for decades Blood transfusion facilities are not commonly available	Prepare and implement facility readiness plan for all district hospitals (DHs) as per SOP for ensuring 24/7 CEmONC services; - Deployment of a minimum numbers of pair (3 Pairs) of obstetricians & anesthesiologists (Trained MOs), pediatrician, - Availability of blood transfusion services through provision of equipment, screening reagents, blood bag and deployment of laboratory technicians - Supply of drugs, logistics and equipment	x	x		LD-MNCAH, LD-HSM, LD-HRD	# DH providing CEmONC services # CEmOC facilities with standard number of HR
			Review of existing CEmONC services at UHCs, performances, necessity and time distance to other CEmONC facilities and identify required number & location of facilities	x			LD-MNCAH LD-CBHC,	Assessment done
			Prepare and implement a comprehensive facility readiness plan as per SOP for ensuring CEmONC service at selected UHCs (based on the findings of above activity)	x	x		LD-MNCAH, LD-CBHC, UHFPO	# Upazilla providing CEmONC services

		only 4% (BHFS 2017)	Explore innovation for ensuring 24/7 blood transfusion services (Public private partnership) at CEmONC facilities		x	x	LD-MNCAH LD-HSM, LD-MCRAH	# innovation to ensure blood transfusion services
			Review and include criteria for minimum requirements of facility readiness for CEmONC services at private facilities (linked with registration)		x	x	DGHS, LD-MNCAH, LD-HSM	Criteria for facility readiness for CEmONC services implemented at private sector
		High rate of C-section 33% and highest in private sector (84%) -BDHS 2017	Introduce Robson classification to monitor and rationalize C-sections performed in CEmONC facilities in public and private sectors	x	x	x	LD-MNCAH LD-HSM, LD-MCRAH,	# facility introduced Robson classification
			Conduct periodic monitoring of All facilities (both private and public) providing caesarean deliveries including Robson classification analysis to rationalize caesarean section.	x	x	x	LD-MNCAH LD-HSM, LD-MCRAH,	# monitoring visit to public & private facilities
Basic Emergency Obstetric &Newborn Care	Facility readiness for BEmONC	Only one - tenth facilities that offer NVD services performed all seven signal functions of (BEmONC) in the last 3 months (BHFS 2017)	Prepare and implement facility readiness plan at all UHCs as per SOP for ensuring 24/7 BEmONC service including normal vaginal deliveries (in phases) - Deployment of skilled doctors, nurses, midwives - Provision of drugs, logistics and equipment - Conduct regular monitoring of signal functions	x	x	x	DGHS, LD-CBHC, LD-MNCAH	# Upazilla providing BEmONC services
			Make functional referral system demonstrating strong linkages within public system including free transportation and technical support between all BEmONC & CEmONC facilities.	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH UHFPO	Functional referral linkage among EmONC facilities # of referral
			Provision of quality PAC services at facility level with appropriate technology (in BEmONC facilities)	x	x	x	LD-MNCAH, LD-CBHC, UHFPO,	# BEmONC facilities provide PAC services
	Normal delivery	Labor room protocol	Implement and monitor labor room protocol in all public and private facilities providing MNH care	x	x		LD-MNCAH LD-HSM, LD-MCRAH	# facilities implemented labour room protocol
		Institution delivery 50% Sylhet has low	Mapping and assessment of each Upazilla including Union level facilities for provision of NVD and provide support to strategically located facilities including HTR areas, urban (based on comparing expected number of annual births for each upazilla & actual number of deliveries as in DHIS2) to achieve the target of institutional deliveries	x			LD-MNCAH LD-CBHC, LD-MCRAH, UHFPO,	Mapping & assessment of upazilla for NVD done

		institutional deliveries 38%	Set Targets for facility delivery considering facility capacity, availability of skilled HR and distribution of facilities at each upazilla (aligning with national targets for maternal health) and monitor the performance periodically	x			LD-MNCAH LD-MCRAH, CS, DDFP, UHFPO,UFPO	# District has target # Upazilla has target # UH&FWC for MMH service coverage
			Assessment of midwifery led care services and expansion		x	x	LD-MNCAH LD-MCRAH DGNM	Assessment done # upazilla expanded with midwifery led care
			Assign Midwives/EOC trained nurses to labour ward Develop a separate duty roster for labour ward & maternity care unit with skilled providers (at UHC and DH)	x	x	x	LD MNCAH, DGNM, Hospital Director, UHFPO, Nursing superintendent, Nursing supervisor	# of facilities having separate roster for (midwives /EOC trained nurses) maternity unit
			Prepare and implement a comprehensive facility readiness plan for 24/7 NVD facility at selected strategically located union level facilities (MCWCs/UHFWCs) for conducting quality normal deliveries	x	x		LD-MCRAH, UFPO, MO-MCHFP	# UHFWC conducting quality normal deliveries # UH&FWC with upgraded infrastructure
			Upgrade Infrastructure to increase available beds for labor and birth at a minimum of 500 of UH&FWC in strategic location for 24/7 Normal Vaginal Delivery		x	x		
			Identification and monitoring of the complicated and high risk pregnancies and labor (not appropriate for delivery at union/upazilla level health facilities). Refer to proper CEmONC facilities and monitor referral outcome	x	x	x	LD-MCRAH, LD-CBHC LD-MNCAH	# of referral of complicated cases
			Promote institutional vaginal deliveries (both public & private facility) by - Presence of professional midwives in all facilities that perform normal deliveries, adhere to the SRH and labor ward protocol - Analgesic use in facilities to reduce labor pain - All women give informed consent for C-Section	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH	# deliveries at public & private facilities
			Review and develop standard informed consent form for C-section for universal use.	x	x		LD-MNCAH LD-HSM, LD-MCRAH	standard informed consent form for C-section developed & used

	Home delivery	Utilization of CSBAs	Assessment of CSBA program and develop future plan Deploy existing CSBA in hard to reach areas (public and private)	x			LD-MNCAH LD-MCRAH, DDFP, CS, UHFPO, UFPO	# delivery conducted by CSBA
	National referral guideline	Lack of clearly defined and functioning referral system	Develop and implement National Referral Guideline for MNH	x			LD-MNCAH LD-MCRAH	National referral guideline developed
			Collaborate/partnership with private sector for ambulance/ Local transport services supported by hot-line or call centers for emergency referral in between health facilities (at union, upazilla, district level)	x	x	x	LD-MNCAH, LD-CBSC LD-MCRAH CS, UHFPO	# Collaboration/partnership established
	Urban	MNH Service	Coordinate with MoLGRD to update the urban health & urban nutrition strategy focusing on quality MNH and nutrition service delivery for urban population	x			MoLGRD, MO-LGI, LD-MNCAH, LD-MCRAH, LD-NNS	Urban health strategy revised & updated

Thematic Area: Post Natal Care (PNC), Post Partum Family Planning (PPFP)

Key Strategy 1: Service delivery along the continuum of care								
PNC, PPFP	**Key issues**	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas**
				20-22	**23-26**	**27-30**		
Post Natal Care	Low uptake of PNC (52% women & children receive PNC within 2 days BDHS 2017)	Quality component of PNC is not defined for mother Facility readiness Inadequate capacity of service	Develop standard components of PNC package (eg. BP, temperature, anaemia, PV bleeding, hygiene, nutrition, Iron Folic Acid supplementation) in alignment with SOP (for quality) (DLI Indicator – weight, nutrition, counselling, BP)	x			LD-MNCAH, LD-MCRAH, LD-NNS	Standard component of PNC developed
			Provide all component (quality) of PNC services including comprehensive counselling on PNC, nutrition & PPFP before discharge from health facilities at all level	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH, LD-NNS,CS, DDFP, Director, Hospital, UHFPO	# of women received all component of PNC at health facilities before discharge
			Conduct follow up of all registered pregnant women for 4 PNCs through community group, CSG, phone messaging (use of ICT)	x	x	x	LD-MNCAH, LD-CBHC LD-MCRAH	# registered pregnant women received 4 PNCs

		providers at all level Follow up for PNC visits	Harmonize PNC visit schedule in SOP and reporting in DHIS2/Routine MIS	x			LD-MNCAH, LD-MCRAH, LD-HIS & eH, LD-MIS,	PNC visit schedule harmonized in DHIS2/MIS
			Immediate identification of postpartum complications, start primary management as per protocols and referral to appropriate facilities	x	x	x	Consultant OBGYN, CS, DDFP, UHFPO, UFPO, RMO, MO-MCHFP	# post partum complications receive primary management before referral to higher facilities
			Conduct PNC follow up service (using ICT, phone messaging) for special cases such as pre eclampsia, eclampsia, gestational diabetes mellitus, heart disease, jaundice, anaemia in appropriate place.	x	x	x	CS, DDFP, UHFPO, UFPO, Consultant OBGYN, MO-CC, MO-MCHFP	# of PNC visits with special cases (PPH, Eclampsia etc.) at facilities
			Develop an innovative approach to deliver PNC care for increasing quality PNC coverage (especially women who deliver at home & follow up visits for women who deliver at hospitals)	x			LD-MNCAH, DGHS, DPs	Innovative approach developed
			Provision of Post Abortion care, post MRM/MR service including family planning services at all level as per guideline	x	x	x	DGFP, LD-HSM, LD-CBHC, CS, DDFP,UHFPO,UFPO	# No of PAFP services by FP types.
	Home delivery (7% of mother and baby received PNC within 2 days those deliver at home	50% deliveries occur at home and has no access to quality PNC Inadequate Promotion of maternal health related behavior	Institutionalize system set up for delivery notification (e tracking, mobile phone, notification slip) to health authority and to ensure counselling, referral and follow up for timely PNC visit through community volunteer	x	x	x	CS,DDFP,UHFPO,UFPO,RMO, MO-MCH-FP	# women received PNC who delivered at home
			Integrate key messages on routine PNC &PPFP into existing guideline of community groups and CSG	x	x	x	LD-CBHC, LD-MNCAH, LD-MCRAH	# community groups active & promote PNC, PPFP
			Provision of post natal care at home/satellite clinic to all women by trained providers (CSBAs, FWVs), irrespective of place of delivery, in case families fail to seek care from the facilities	x	x	x	LD-MCRAH, LD-MNCAH, LD-CBHC, CS, UHFPO, DD-FP, UFPO, MO-MCH	# women received PNC who delivered at home
	Post partum depressio n	Lack of assessment of post	Screen and assess postpartum depression and provide counselling and services including referral as needed at all level of health facilities	x	x	x	LD-MNCAH, LD-CBHC, LD-MCRAH, LD-HSM	# postpartum women screened & assessed

		partum depression						
PPFP	High unmet need for FP during post partum period 44%	Lack of trained service providers in DGHS facilities for PPFP service Only one quarter of health facilities provide long acting reversible, permanent FP methods	Include Plan & allocation of resources in relevant operation plans (CBHC, MNCAH, HSM, DGNM, CCSDP, FSDP) for capacity building of DGHS, DGFP, DGNM & private sector doctors, nurses, midwives on PPFP counselling & services and conduct training	x	x	x	LD-HSM, LD-MNCAH, LD-MCRAH, LD-CCSDP, DGNM, LD-FSDP	fund allocation in respective OPs # service providers trained
			Examine bottlenecks of Model Clinic and revitalized by addressing system issues and establishing them as skill lab for pre-service training. Setting up of model clinics made mandatory in all medical colleges (new and old, public and private).	x	x	x	DGFP, LD-HSM, LD-MCRAH	Assessment of bottlenecks done # MCH has model clinic
			Incorporate PPFP into medical, nursing, midwifery, paramedics pre-service and in-service curriculum and clinical training	x	x	x	Director -CME, DGNM	PPFP incorporated in preservice curriculum
			Promote PPFP and family planning service to all Private Medical Colleges, Private Hospitals, Private Clinics, hospitals managed by other ministries/local government institutes NGO and clinics				DGFP, LD-MCRAH LD-MNCAH,LD-HSM	# health facilities providing PPFP
			Implement all activities indicated in the Bangladesh National Action Plan for Postpartum, Post-MR and Post-Abortion Care Family Planning	x	x	x	DGFP, DGHS	Bangladesh National Action Plan for PPFP implemented
	Only 22% of all facilities are ready, according to WHO criteria, to provide quality FP services	Institutional readiness	Provision of PPFP kit/methods in the labour room and Operation theater for ensuring PPFP services immediately after delivery by doctors, midwives and nurses at DGHS facilities	x	x	x	DGFP, Hospital Director/Superintendent, UHFPO, Consultant OBGYN	PPFP kit/methods are available at DH, UHC
			Conduct counselling during ANC, delivery, PNC, post abortion care, newborn care, EPI, to increase uptake & reduce discontinuation of contraceptive use	x	x	x	Hospital Director/Superintendent, DDFP, UHFPO, Consultant OBGYN, MO-Clinic, UHFPO, UFPO	# women receive counselling
			Inclusion of Postpartum family planning service data in DHIS 2 reporting system of DGHS and make it interoperable with DGFP MIS	x			Director MIS, DGHS and LD-MIS, DGFP	Inter operability of DGHS & DGFP MIS establish

Thematic Area: APH, PPH, Preeclampsia

Key Strategy 1: Service delivery along the continuum of care								
APH, PPH, Preeclampsia, Eclampsia	**Key issues**	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas)**
				20-22	**23-26**	**27-30**		
PPH, Eclampsia	Hemorrhage & Eclampsia account for 55% maternal deaths (BMMS 2016)	SOP and PPH and eclampsia action plan are not implemented The risk of dying from these causes remain unchanged between 2010 &2016 BMMS	Implement PPH- Eclampsia action plan including provision of first line resuscitation (PPH, Eclampsia) at first point of contact as per the SOP at UH&FWC, UHC, MCWC, DH, MCH	x			LD - MNCAH, LD-HSM LD - MCRAH	# of facilities implemented PPH and Eclampsia action plan
			Follow active management of third stage of labour as per SOP for all deliveries both at public and private facilities	x	x	x	LD - MNCAH, LD – MCRAH, LD-HSM, LD-CBHC	# birth with Active management of third stage
			Establish supportive supervision, coaching & mentoring system for doctor, nurses, midwives, FWVs and CSBAs both at public and private facilities	x	x	x	LD - MNCAH, LD -MCRAH	# monitoring visits # feedback provided
	Facility readiness: Facilities are not ready to provide emergency case management	The facilities not interested to take the emergency case to keep the case fatality rate minimum Lack of emergency readiness & skill of staffs No coordination between the emergency room and the labour/gynae	Develop an emergency room protocol and emergency response team (RMO, MA, Midwife, Nurse) with specific TOR for management of maternal health complications at different level of facilities and provide orientation of the team (UHC, DH)	x	x		LD - MNCAH, LD - MCRAH LD- HSM, LD-CBHC	# of facilities having functional emergency response team.
			Provision of PPH bundle (Teamwork, Facility Readiness, networking, communication leadership, data monitoring, respectful maternity care) Eclampsia kit at the emergency room	x	x	x	LD - MNCAH, LD -MCRAH, LD-HSM, LD-CBHC	PPH bundle, Eclampsia kit available at emergency room
			Improve technical supervision of doctors, nurses, midwives and FWVs by OSGYN consultant/MO-MCH/OGSB	x	x	x	LD- MNCAH, LD- HSM, LD-CBHC, Consultant OBGYN, MO-MCH,	# Supervisory visit # feedback given
			Establish system to review the complicated cases (near miss cases) and proper documentation of complicated cases and its referral		x	x	Director Hospital, CS, DDFP, UHFPO,	# facilities review near miss

		ward for handling the emergency cases					Consultant OBGYN, MO Clinic	
			Periodic assessments of near miss cases and death from eclampsia, PPH to minimize the system gaps		x	x	LD MNCAH, LD-HSM, LD-MCRAH HIS & e-HMC MIS-DGFP	# of near miss cases reviewed # of facilities taken action based on the review
	About 47% deliveries are conducted at home	Low rate of misoprostol Distribution at home and facility Poor domiciliary visit by HA and FWA	Revise the current distribution policy of misoprostol in both DGHS & DGFP and develop a comprehensive, coordinated distribution policy. Ensure the 4th ANC at 32 weeks and distribute misoprostol. So that misoprostol can be administered timely who opt for home delivery if necessary	×			LD MNCAH, LD CBHC LD MCRAH, CS, DDFP, UHFPO, UFPO	Misoprostol distribution policy revised# misoprostol distributed during ANC visits
			Ensure quality ANC/PNC including antenatal counselling on danger signs of pregnancy and emergency preparedness	x	x	x	CS, DDFP, UHFPO, UFPO, Public Health Nurse	All pregnant women have birth planning & emergency preparedness plan
		Information on initial stabilization & referral at facility level are not available	Modify the existing labour room register, incorporate number of PPH and eclampsia cases reaching the facility, information on the first contact point, pre referral treatment information and number of cases receiving initial resuscitation at the respective facility	x			LD MNCAH, LD MCRAH LD-MIS, LD-HIS&eH	# of facility provided segregated data on PPH & Eclampsia

Thematic Area: MPDSR, Maternal morbidity, response to Gender Based Violence (GBV)

Key Strategy 1: Service delivery along the continuum of care						
MPDSR, Maternal	**Key issues**	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**	**Responsibility Lead/Co-Lead)**	**Indicators (output level as**

morbidity, response to GBV				20-22	23-26	27-30		per thematic areas)
Maternal & Perinatal Death Surveillance & Response (MPDSR)	MPDSR implementation gap	Guideline not updated	Review and update MPDSR guideline and forms including inclusion of stillbirth	x		x	LD-MNCAH, LD-MCRAH, LD-MIS, LD-HIS & eH	MPDSR guideline updated
		Under reporting of maternal & newborn death	Conduct advocacy meeting at different level to create an enabling environment for improving timely death notification and reporting	x	x	x	LD-MNCAH, LD-MCRAH, LD-CBHC	# Advocacy events held
			Organize monitoring of maternal and perinatal death review at district and upazila level public, private, NGO, urban health facilities and integrate the process with Quality Improvement initiatives	x	x	x	CS, DDFP, UHFPO, UFPO, Director hospital, LGIs	# monitoring visit # action taken
		Low coverage	Expansion of MPDSR to 16 new districts, including urban and private sector facilities and strengthen in existing 48 districts	x	x		LD-MNCAH, LD-MCRAH, LD-HSM, Director, Hospital & Clinics	# district implementing MPDSR
		Lack of coordination for death notification and registration	Collaboration/coordination with CRVS to harmonize maternal, perinatal death notification and registration	x			LD-MNCAH, LD-MCRAH CRVS	# meeting held # action taken
		Delay in identifying cause of death at community	Cause assignment (maternal, newborn death & stillbirth) from verbal autopsy analysis to be done at district, upazila level and facility death review to be done at public, private & NGO facilities.	x	x	x	Director Hospital, CS, DDFP, UHFPO, UFPO, LGI	# cause analysis done
		Data quality	Improve record keeping, data collection and reporting on maternal, perinatal death at all facilities and during verbal autopsy at community	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, Director Hospital, CS, DDFP, UHFPO, UFPO	# death details information available at health facilities # of data quality assessments/audit

		Poor Competence in conducting facility death review	Mandatory facility death review by nurses, midwives, FWVs & private providers in consultation with doctors at health facilities	x	x	x	Director Hospital, CS, DDFP, MO-Clinic Nursing superintendent	Nurse/midwife are involved in death review
		Server issues delay non entry of data	Introduce separate database for MPDSR linked to DHIS2 & DGFP - MIS	x	x		DGHS, DGFP, Director MIS	Separate database for MPDSR linked to DHIS2 establish
		Lack of response by level	Develop and implement MPDSR action plan at local levels (upazila, districts)	x	x	x	CS, UHFPO DDFP, MO-MCHFP	# district/upazilla action plan implemented
		Lack of social action and follow up after MPDSR	Conduct community social autopsy and implementation of recommendations from social autopsy and follow up	x	x	x	UHFPO, UFPO, LGIs	# Social autopsy held # recommendations implemented
		Documentation and report	Prepare & publish annual report at district and national level based on MPDSR findings	x	x	x	LD-MNCAH LD-HSM LD-MCRAH	# Annual report prepared
		No confidential inquiry on maternal death	Introduce confidential inquiry on a sample of selected maternal death by an independent higher committee and standardized clinical audit to MCHs, DHs, UHCs		x	x	DGHS, LD-MNCAH,	# health facilities introduced Clinical audit
Maternal Morbidity	Obstetric Fistula, 3rd and 4th degree perineal tear, Genitourinary prolapse	Under reporting	Distribution & orientation of 04 questions checklist, fistula pocket handbook for the field level health care providers of DGHS, DGFP, Private sector, NGOs to identify, report and refer fistula patients.	x	x	x	LD-MNCAH, LD-CBHCP, LD-MCRAH, LD-HSM	# of 04 questions checklist and fistula pocket handbook distributed
			Printing and distribution of fistula, cervical & breast cancer prevention and screening related SBCC materials	x	x	x	LD-MNCAH, LD-MCRAH, LD-L&HEP, LD-IEM	# SBCC materials printed & distributed
		Lack of Community Awareness	Observation of End to Obstetric Fistula day and Cervical and Breast cancer prevention countrywide – at national, district and upazila level	x	x	x	LD-MNCAH, LD-MCRAH, DPs	End to Obstetric Fistula day observed nationwide
	Identification of		Provision of local level counselling session for the family of the fistula survivors	x	x	x	UHFPO, UFPO	# family of the fistula survivors

	obstetric fistula							receive counselling
	Referral & diagnosis	Lack of functional referral system, proper diagnosis and management	Improve functional referral system for fistula cases from the community to the specialized referral facility where fistula surgeries are conducted	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM,	# fistula cases referred to higher facility
			Conduct mapping of fistula repair facilities (public, private, NGO) and ensure routine reporting to DHIS2 indicators	x	x	x	LD MNCAH, LD-HSM,LD-MIS	Mapping done # of HF reporting fistula to DHIS2
			Establish and make functional fistula repair centers at least one in each division with deployment of fistula surgeons. Increase number of fistula repairs in the designated centers		x	x	DGHS, LD-HSM, Director, Hospital& Clinic	# Functional fistula treatment site
			Provision of early bladder catheterization in case of prolonged and obstructed labour at all level health facilities, counselling and referral	x	x	x	LD-MNCAH, LD-HSM, LD-CBHC, LD-MCRAH	early bladder catheterization in prolonged and obstructed labour at health facility established
			Develop a roadmap for developing a pool of wide range of skilled professionals such as fistula surgeon with required expertise on pelvic surgery, urologist, physiotherapist in the country by 2030	x			LD-MNCAH, OGSB	Roadmap developed
		Documentation and report	Documentation and preparation of annual report based on Fistula, cervical & breast cancer	x	x	x	LD-MNCAH LD-HSM, LD-MCRAH	# Annual report prepared
	Cervical & Breast cancer	National HPV vaccination program not implemented for primary prevention Lack of capacity in early detection and diagnosis of cervical & breast cancer	Introduce National routine HPV vaccine programme under EPI for girls in school & community (9-13 Years)	x	x	x	LD-MNCAH	Percentage coverage for HPV vaccination in the target population
			Establish screening by VIA, diagnosis by colposcopy and treatment (thermos coagulation) of CIN 2 & 3 at all DHs (implementation of the 'see and treat' approach).	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, LD-CBHC, LD-L&HEP, LD-IEM, BSMMU, OGSB, NICRH	Percentage of DHs implementing colposcopy and treatment of cervical pre-cancer
			Conduct screening by Clinical Breast Examination (CBE) (complementary with VIA in a single package) for breast	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, LD-CBHC,	Percentage of UHCs

		(secondary prevention)	cancer in all UHCs and mammography in all Medical College Hospitals				LD-L&HEP, LD-IEM, BSMMU, OGSB, NICRH	implementing CBE
		Lack of histopathology and diagnostic services (tertiary prevention	Establish a functional referral network for all patients with CIN 3 and above to undergo histopathology at the medical college hospital	x	x	x	LD-MNCAH, LD-HSM LD-MCRAH, LD-L&HEP, LD-IEM	# MCH provide histopathology services for cancer diagnosis
		Inadequate treatment services	Establish adequate treatment services (surgery, radiotherapy and chemotherapy) in at least one medical college hospital/public hospital in each division	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM	# MCH provide treatment
GBV Response		Improper and non-responsive and lack of respectful care	Review of Woman Friendly Hospital Initiative, OCC and GBV interventions amid overlapping of interventions and recommend a harmonized model to address GBV/WFHI	x	x		LD-MNCAH, LD-MCRAH, LD-HSM, LD-CBHC	Review done & harmonized model recommended
			Use of updated protocol on Health Sector Response to GBV and Web-based Clinical Management of Rape by health care providers at all level of hospitals phase-wise (public and private)	x	x	x	LD-MNCAH, LD-MCRAH, Director-Hospital & Clinic, PM-GNSPU	# of public and private hospitals using protocol on health sector response to GBV
			Incorporate gender equity including response to GBV into all training modules/curriculum for health service providers	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM PM-GNSPU	# training module incorporate gender equity
		Lack of Reporting, record keeping and use of different form	Print & distribution of registers, medico-legal examination forms, consent forms, referral slips at public and private hospital	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM,PM-GNSPU	# public and private hospitals where reporting forms, registers are available
		Poor monitoring of health sector response to GBV services	Assign one focal person for GBV at all facilities	x	x		PM-GNSPU, LD-MNCAH, LD-MCRAH, LD-HSM,	# of public and private facilities assigned one GBV focal person
			Identify indicators to measure health response to GBV and develop a system of monthly GBV service reporting and monitoring at facility (public and private hospitals) &	x	x	x	Director-MIS, LD-MNCAH, LD-MCRAH, PM-	DHIS2 incorporated GBV reporting # of hospitals

			community and Inclusion of GBV reporting in DHIS2 and Routine MIS				GNSPU, LD-HSM,	providing monthly report # of monitoring visit
		Lack of functional referral system for GBV services	Establish structured referral system from community to higher level facility for better management of GBV	x	x	x	PM-GNSPU, LD-MNCAH, LD-MCRAH, LD-HSM, LD CBHC	# of GBV survivors referred from CC,UH&FWC to higher health facilities

Thematic areas: Crosscutting Issues

Key Strategy 2: Health System Strengthening

Key Issues	Gaps/Challenges	Key Action/Activities	Timeframe			Responsibility Lead/Co-Lead)	Indicators (output level as per thematic areas)
			20-22	23-26	27-30		
Leadership & Governance	No coordination meeting at national, divisional, district, upazila level to review MNH program implementation comprehensively	Form a high-level Maternal Newborn Health Steering Committee comprising of members from MOHFW, DGHS, DGFP, DGNM, Professional bodies, UN, development partners, NGOs and private sectors for overseeing the implementation of National Action Plan for Maternal Health and conduct meeting biannually	x	x	x	MOHFW DGHS, LD-MNCAH	Committee formed and gazette published # meeting held # action taken
		Form Maternal Newborn Health (MNH) Core Committee (including all relevant line directors) at directorate level and organize quarterly performance review meeting to review MNH performance data (This committee will replace all existing committees of maternal health such as MPDSR, EmONC, PPH, Fistula, DSF, cervical cancer etc.)	x	x	x	LD-MNCAH LD-MCRAH	Committee formed and gazette published # meeting held # action taken
		Form Maternal & Newborn Health Committee at divisional (including all relevant stakeholders) level and organize quarterly MNH performance review meeting	x	x	x	LD-MNCAH LD-MCRAH, Divisional Directors, Prof. Of OBGYN of MCH	Committee formed and gazette published # meeting held # action taken
		Form Maternal & Newborn Health Committee at districts, upazilla & conduct monthly MNH performance review meeting and discuss progress of all components of maternal and newborn health (Include Representative of service providers as member)	x	x	x	LD-MNCAH LD-MCRAH, CS, DDFP, UHFPO	Committee formed and gazette published

		(This committee will replace all existing committees of maternal health such as MPDSR, EmOC, PPH, Fistula, DSF, cervical cancer etc.)					# district # upazilla MNH meeting held # action taken
		Organize National Fistula Task Force (NFTF) meeting biannually	x	x	x	LD-MNCAH, Director-Hospital & Clinic	# of NFTF meeting
Training	Inadequate capacity Capacity development on ANC, PNC, PPFP, postpartum depression, counselling	Capacity development of managers on leadership, management, procurement, program planning, supervision and monitoring	x	x	x	LD-MNCAH, LD-MCRAH	# managers trained
		Develop a comprehensive (Health & Nutrition) national ANC, PNC training module (competency based) and implement capacity development plan for selected health & family planning service providers (all levels of care)	x	x	x	LD-NNS, LD-MNCAH, LD-MCRAH, LD-CBHC, CS, DDFP, UHFPO, UFPO	# service providers trained on ANC, PNC SOP, Guideline
		Conduct capacity building of service providers (UHC, DH, MCWC, MCH) on postpartum depression assessment and counselling	x	x	x	LD-MNCAH, LD-CBHC LD-MCRAH,	# of service providers received training
		Orient community health workers and provide Job aids and SBCC materials to ensure 4+ANC, PNC and PPFP counseling and referrals	x	x	x	LD-MNCAH, LD-CBHC LD-MCRAH LD-HEPLS, LD-IEC, LD-L&HEP, LD-NNS	#Community Health worker received orientation and job aids, SBCC materials
		Build capacity on improve communication skill of health care providers at all level including respectful care and incorporate SBCC in training curricula	x	x	x	LD-MNCAH LD-MCRAH	# Health care providers trained
		Train district quality improvement/assurance team on ANC, PNC & PPFP to ensure on job training and supportive supervision	x	x	x	LD-MNCAH, LD-CBHC, LD-MCRAH, LD-NNS	# district QI team trained to provide on job training & mentoring
		Engage and sensitize religious scholars and leaders to address the religious and cultural taboos regarding long acting and permanent contraceptive method uses during postpartum period	x	x	x	LD-MNCAH, LD-CBHC, LD-MCRAH, CS,DDFP, UHFPO,UFPO	# religious scholars and leaders sensitized
	EmONC training and follow up	Conduct EmONC training (1 year) for the doctors of DGHS and DGFP (DGFP- 15-20 per year) (DGHS- 20 per year). Organize post-training follow-up and ensure continuous monitoring	x	x	x	LD-MNCAH LD-MCRAH	# doctor trained on EmONC/Year

		Conduct 6 months EmONC training for FWVs/Nurses (DGFP-30-40 per year) (DGNM- 30 per year). Organize post-training follow-up and ensure continuous monitoring	x	x	x	LD-MNCAH LD-MCRAH, DGNM	# FWVs/Nurses trained on EmONC/Year
	Midwifery training	Conduct midwifery training for FWVs in line with ICM standards	x	x	x	LD-MCRAH,	# FWV trained
	Life saving skill training Continuous professional development training Emergency drill	Organize LSS (Life saving skill) training to doctors, nurses, midwives, FWVs (Including private and NGO sector Providers), conduct post-training follow-up and ensure continuous monitoring	x	x		LD- MNCAH, LD MCRAH, LD-HSM, LD-CBHC	# service providers trained # of Upazila received post training follow up monitoring
		All MNCH professional providers participate in annual continuous professional development to include: NVD, assisted vaginal delivery, external cephalic version, vaginal breech delivery and practice for vaginal birth after previous C-section (VBAC) and complication management drill (APH/PPH, Eclampsia, HBB)	x	x	x	LD-MNCAH LD-HSM, LD-MCRAH,	# of providers participate in annual professional development
		Organize periodic emergency drill at the emergency room to ensure functioning of emergency response team & internal referral linkage	x	x	x	Director Hospital, CS, DDFP, UHFPO, UFPO	# facilities organize emergency drill
		Develop a training plan for service providers for periodic upgrading their knowledges and skills on MNH SOPs, protocols and guidelines	x	x	x	LD-MNCAH LD-MCRAH, LD-NNS	Training plan available
		Orientation of all relevant health care providers and administrators of both public & private hospitals on the use of Robson classification to monitor and rationalize C-sections performed in their respective facilities.	x	x		LD-MNCAH LD-HSM, LD-MCRAH,	# heath care providers receive orientation
	MPDSR	Capacity building of urban, district, upazilla and union level health & family planning officials/health service providers/ MPDSR focal person / statisticians on timely maternal & perinatal death notification, monitoring, causal analysis and reporting	x	x		LD-MNCAH, LD-MCRAH, DGNM	# Health Care Providers trained
	Maternal nutrition	Strengthen capacity of CHCPs at community clinics to ensure that they become first line community-based service providers of promotional, preventive and first line curative nutritional care	x	x	x	LD- CBHC, LD-NNS, LD-MNCAH, LD-MCRAH, Director IPHN	# CC provide first line nutritional care
		Conduct training of health service providers on promotional, preventive and curative nutritional care including urban areas	x	x	x	LD- CBHCP, LD-MNCAH, LD-MCRAH, Director IPHN, LD-NNS	# service provider trained

	Maternal morbidity (fistula)	Develop capacity of all level health workers (govt. and NGOs including volunteers) on screening, diagnosing and reporting of obstetric fistula, perineal tear, and genitourinary prolapse	x	x	x	LD-MNCAH, LD-CBHC, LD-MCRAH, LD-HSM,	# health worker trained
		Improve and retain surgical capacity of the Urogynecologists through organizing short refresher training/orientation by the national fistula trainers	x	x	x	LD-MNCAH, OGSB	# training # participants trained
	Capacity building on response to GBV	Conduct capacity building of the health care providers on health sector response to gender based violence (GBV) at public and private hospitals	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, PM-GNSPU	# of health care providers trained
		Conduct orientation and awareness of the health care providers and frontline field workers of CC and UH&FWC on identification of GBV, basic psycho-social support and referral	x	x	x	LD-MNCAH, LD-MCRAH, PM-GNSPU, LD-CBHC	# of health care providers from CC, UH&FWC oriented
	Gap in functioning of management committee	Include MNH agenda in the Management Committees meeting at different tiers of health facilities including CC, UHFWC, UHC, DH, MCH	x	x	x	LD-MNCAH, LD-MCRAH, CS,DDFP,UHFPO,UFPO	# meeting held # action taken
	Lack of local level planning for improving MNH situation & implementation	Consolidate learning from evidence based MNCH Planning experience and use planning toolkits for development of district & upazilla MNH plan (District Evidence-based Planning and Budgeting)	x	x		LD-MNCAH LD-MCRAH	# districts using planning toolkits
		Devolution of financial authority at district and upazilla to implement local MNH action plan	x	x		LD-MNCAH LD-MCRAH	# decentralize financial and administrative authority delegated
	Lack of regulation for private sector	Develop Regulatory Framework for standardized service delivery & quality improvement (including MNH care) at private and NGO facilities consistent with the national MH SOPs	x	x		DGHS, LD-HSM	Regulatory system developed
		Establish a mechanism/forum to coordinate and engage the private sectors with the national programs	x	x		LD-HSM LD-MNCAH, LD-MCRAH,	Coordination forum established
	Licensing & accreditation	Review and strengthen system for licensing and certification for service providers/medical/nursing teaching institutions		x	x	MOHFW, BMDC, BMNC	licensing and certification system reviewed & strengthen
		Establish a body/ council to develop and implement accreditation standards and processes for MNH services in public and private health facilities		x	x	MOHFW, DGHS, DGFP, LD-HSM	Accreditation standards and process developed

	Engagement of local elected bodies for MNH issues	Engage Local elected bodies, Union Parishad, Health and Family Planning Standing Committee at different level to strengthen their role in multisector mobilization around MNH issues through engaging NGOs, professional bodies, UN agencies	x	x	x	DGHS, DGFP, CS, DDFP, UHFPO, UFPO, LGIs, PM-GNSPU	# advocacy event held
	Gap in uninterrupted supplies of logistics, lifesaving drugs, test kits in health facilities	Develop coordinated procurement system between DGHS, DGFP to strengthen logistics, drugs, supplies and requisition system for availability of all commodities	x	x	x	HEU, LD-MNCAH, LD-HSM, LD-MCRAH, CS, DDFP, UFFPO, UFPO	Coordinated procurement system developed # health facilities has requisition system for all commodities
		Functionalize fully automated logistic (eLMIS) system at all service delivery points to improve supply change management	x	x	x	LD-MNCAH, LD-MCRAH	Fully automated logistic management system in place
		Prepare procurement plan, timely procure and distribution of equipment, drugs & logistics at all service delivery points for ANC, PNC, delivery services (as per SOPs) CC/UHFWC/UHC/MCWC/DH: BP machine, Stethoscope, Adult weighing machine, Height meter/Measuring tape, Spot light, urine albumin examination facility (Lab /kit), urine sugar, blood sugar &hemoglobin test facility (lab/kit), Blood grouping facility, ANC/PNC card / doppler/USG	x	x	x	LD-MNCAH, LD-MCRAH, LD-CBHCP, LD-Hospitals, CS, DDFP, UHFPO, UFPO	# facilities with supplies & logistics as per SOP # facilities perform routine lab test as per SOP
		Plan, procure and supply of FP commodities, job aid, register, leaflet at the health facilities (especially at UHC, DH)	x	x	x	DGFP, LD-MCRAH LD-MNCAH, LD-HSM, LD-CBHC	# UHC, DH has supply of FP commodities
	MgSO4 available in 14% facilities offering delivery care (BHFS 2017)	Prepare plan, procure & supply logistics and drugs including life saving drugs at all service points including MgSO4, misoprostol, oxytocin	x	x	x	LD - MNCAH, LD - MCRAH, LD-HSM, LD-CBHC	# of facilities having all drugs and supplies as per SOP
		Procure and supply of survivor kits in public and private hospitals which includes logistics for medico-legal examination, Emergency contraceptives, Post-Exposure prophylaxis, etc. (for response to GBV)	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, LD-ASP, PM-GNSPU,	# of public & private hospitals are equipped with survivor kit
	Low pregnancy registration	Accelerate action to ensure pregnancy registration of all pregnant women with mobile number (e tracking) and unique ID	x	x	x	LD-MCRAH LD- CBHC, LD-MNCAH, LD-HIS & eH, LD-MIS	# pregnant women registered

	Patient safety, client satisfaction	Establish patient safety, client satisfaction, public grievances redressal mechanism (through all round quality assurance)	x	x	x	DGHS, DGFP, DGNM, LD-MNCAH, LD-MCRAH, LD-CBHC, LD-HSM	Patient safely, client satisfaction, public grievances redressal mechanism establish
		Institutionalize logging client views through suggestion boxes, direct texting of concerns, client satisfaction surveys and devise mechanism to make health manager accountable on those concerns	x	x	x	MOHFW, DGHS, DGFP, LD-MNCAH LD-MCRAH	# Client satisfaction survey Logging client view institutionalized
	Costing of action plan	Develop costing of the action plan for maternal health and integration into the operation plan	x			LD-MNCAH LD-MCRAH, DPs	Action Plan costing done
	The capacity of health facilities to conduct basic diagnostic tests is still very limited (BHF survey) Lack of basic lab test at upazilla	Improve capacity of health facilities to conduct basic diagnostic tests through deployment of lab technician and supply of necessary equipment, supplies and logistics in district and upazila level	x	x	x	LD-MNCAH, LD-HSM,LD-MCRAH	# DH conduct basic diagnostic test # MCWC conduct basic diagnostic test # UHC conduct basic diagnostic test
		Establish safe blood transfusion facilities/Blood bank at all district hospitals (24/7) and selected upazilla health complexes	x	x		LD-MNCAH, LD-HSM,LD-MCRAH	# DH with safe blood transfusion facilities
	Infrastructure development	Upgrade, renovate, develop infrastructure to provide quality MNH services (dedicated space with privacy for ANC, facility readiness as per SOP, labour ward, eclampsia room)	x	x	x	LD MNC&AH, LD MC&RAH HED, LD-HSM	# of Upazila and union level facilities upgraded
	Telemedicine	Provision of telemedicine service for maternal health follow up services and in case of emergency situation	x	x	x	LD-MNCAH, LD-MCRAH, LD-HIS & eH,	Telemedicine service implemented
Human Resources	Lack of skilled human resources Retention of skills of MNH	Coordinate the utilization of human resources available at both DGHS and DGFP for efficient MNH service provision (Task sharing among DGFP and DGHS service providers)	x	x	x	LD-MNCAH, LD-MCRAH,CS,DDFP,UHFPO,UFPO	# HR sharing events
		Establish Case load-based (NVD, ANC, PNC etc) HR deployment at all level (right sizing of HR)	x	x	x	MOHFW, DGHS, DGFP, DGNM	# case load-based deployment done
		Develop skill lab at district hospitals for skill development of service providers		x	x	DGHS, LD-HSM LD-MNCAH	# districts with skill lab

	service providers Chronic HR gaps in the rural & HTR areas Caseload not considered for HR deployment	Develop and implement guideline for contractual appointment of doctors for district and upazila level (gynecologist/ anesthetist/medical officer)	x			LD-MNCAH LD-MCRAH	Guideline developed
		Recruitment, deployment & retention of midwives at upazila health complexes (8 midwifes/upazilla) in phases. Prioritize deployment into the upazillas with high number of deliveries in coordination with DGHS	x	x	x	MOHFW, DGNM, DGHS	#Midwife recruited #Midwife deployed
	Incentive for Retention of HR in HTR areas	Develop innovative incentives to fill vacancies in hard to reach areas and ensure retention		x	x	DGHS, DGFP, DGNM, LD-MNCAH LD-MCRAH	Innovative incentive mechanism developed
		Implement performance awards for service providers for encouragement including international attendance of workshops, seminars, training for best performers	x	x	x	DGHS, DGFP, DGNM, LD-MNCAH, LD-MCRAH	#Person/institution receive performance award
	Inadequate supervision, monitoring and feedback Non alignment to protocol /SOP	Conduct regular monitoring at district /upazilla/union level for provision of quality maternal health service delivery (ANC, PNC, Delivery, PPFP complication management) including compliance to SOP using a uniform tool and provide feedback (at least one qualitative visit 6 monthly with uniform tools)	x	x	x	LD-MNCAH LD-MCRAH, CS, DDFP, UHFPO, MO-MCH&FP Consultant (FPCS/QIT), District Public Health Nurse	# Monitoring visits with uniform tools # feedback given
	Non availability of SOPs, protocol at the facilities Lack of awareness on SOPs	Periodic review and update of protocols, SOPs, guidelines, implementation package		x	x	LD-MNCAH LD-MCRAH	# protocol, SOP reviewed
		Print, distribution of approved maternal health SOPs, protocols, guidelines (ANC, PNC, PPFP etc.) at all service delivery points and academic institutions and monitor implementation & adherence to ANC SOPs at all level of facilities	x	x		LD-MNCAH LD-MCRAH, CS, DDFP, UHFPO	# facilities with SOP, protocols, guideline
		Develop e-guideline/eSOP/eProtocols (printed, e-book, apps, digital learning platform) and video contents to sensitize and build capacity of service providers on maternal health	x	x	x	LD-MNCAH LD-MCRAH LD-MIS	# eSOP, e-Guideline available
Health Information System	Quality of data There is no agreed core	Create a system for data sharing, integration of information platforms between DGFP and DGHS through establishing effective linkage between two MIS:	x	x		LD-MNCAH, LD-MCRAH, LD-MIS LD-HIS & eH	# routine data sharing platform established

	set of maternal health indicators Lack of data validation system Inadequate use of MH data for planning and monitoring at all level Data sharing	a) Support printing of recording registers (in alignment with DGFP registers) b) Capacity development of MIS staff at both HQ and in all facilities for collection of information according to supplied format (DHIS2), ensure monthly completeness and timeliness of reporting, individual tracking and gradual shifting to e-recording and reporting c) Facilitate harmonized reporting: systematic record keeping, analysis of data and reports at local level, sharing between DGHS and DGFP field managers					
		Identify core set of maternal health (Including PPFP, fistula) indicators, and incorporate them into routine MIS/DHIS2	x			LD-MNCAH, LD-MCRAH, LD-MIS	# core indicators identified
		Set target for maternal health indicators (output levels/Input level) in alignment with Maternal Health Strategy and other national targets	x			DGHS, DGFP, LD-MNCAH, LD-MCRAH,	# analysis of indicators
		Conduct capacity development of managers, staffs, statisticians for data entry, reporting and analysis, feedback for planning, monitoring and performance review	x	x		LD-MNCAH LD-MCRAH LD-CHCP	# Managers trained
		Develop a system for data validation and data quality improvement	x	x		LD-MNCAH LD-MCRAH, LD-MIS, LD-HIS & eH	Data validation, quality improvement system in place
		Establish mechanism for mandatory reporting on MNH services (including PPFP, fistula, maternal, newborn death, stillbirth notification, GBV) from private and NGO sector at national, district, upazilla level	x	x	x	LD-HSM, CS, UHFPO	# Private facilities/ NGO submit reports
Financing		Incorporate action plans into the respective operation plans and next HNPSP to be fully implemented and financed	x	x	x	HEU, LD-MNCAH, LD-CBHC, LD-MCRAH, LD-MIS, LD-HSM	Incorporation of action plan into OPs
Essential medical products and technology		Promote Technology transfer through international collaboration and interinstitutional partnerships	x	x	x	LD-MNCAH, LD-MCRAH	# technology transfer
Key Strategy 3: Reducing Inequities							

Key Issues	Gaps/Challenges	Key Action/Activities	Timeframe			Responsibility Lead/Co-Lead)	Indicators (output level as per thematic areas)
			20-22	23-26	27-30		
Inequities in use of maternal health service by the lowest quintile	Out of pocket cost high (64%) followed by government spending (26%)	Review existing social protection schemes for the poor population and develop an equity focused strategy based on lesson learnt from different safety net approaches	x			LD-MNCAH, LD-MCRAH,	Equity focused strategy developed
		Review and update the current DSF program and Scale up/expansion of DSF program. The following suggestions are proposed; - Introduce same costing for normal delivery and C-Section - Identify low performing upazilas for expansion of DSF program - Strengthen the technical capacity of DSF cell at local and national level - Include incentives for complication management (PPH, Eclampsia) - provider payment should be delinked to avoid incentives to inappropriate practice (eg. To inappropriate C-section) - Faster cash transfer to client (instant cash to mother) - Include Incentive for postpartum Family Planning for facility care - Include transportation cost for pregnant women up to post-natal period - Include major maternal morbidity (fistula)	x	x		LD-MNCAH, LD-MCRAH LD-CBHC	DSF program reviewed & updated # upazilla DSF expanded
		Coordinate with MoSW, MoWCA to provide financial support/free medicine through social protection scheme, Hospital social welfare services for poor patient	x	x	x	MOHFW, DGHS, LD-MNCAH, LD-HSM, LD-CBHC	# poor women supported by Social Welfare Department
	Safety net for maternal morbidity	Building awareness among the different stakeholders in the district and sub-district level including the local government to ensure rehabilitation and reintegration support for the fistula survivors in the society and in the family	x	x	x	CS, DDFP, UHFPO, UFPO	# fistula survivors rehabilitated and reintegrated in the society
Geographic inequity	Gap in availability of service in	Design and implement need-based service delivery at the hard to reach areas (public private partnership/NGOs)	x	x	x	LD-MNCAH, LD-MCRAH	Service delivery developed in hard to reach areas

	urban poor & hard to reach areas (Char, haor, tea garden)	Design and test feasible financial care scheme especially for urban poor, chars, teagarden and other hard to reach areas (Leaving no one behind)		x	x	MOHFW, DGHS, DGFP	# feasible financial care scheme
		Implement different strategies for CSBAs (private and public) in hard to reach areas for MNH services	x	x		LD-MNCAH LD-MCRAH	Strategy to use CSBAs for hard to reach area
		Coordination with local government, NGOs, private facilities for MNH service delivery in urban areas & prepare health work force plan including capacity building for urban areas	x	x	x	Local government, LD-MNCAH LD-MCRAH,	maternal care services in urban area available
	Public health expenditure Only 5.6% of the total govt budget in health in financial year 2011-12(MOF 2012)	Review the current public health expenditure for MNH services and advocacy for increase MNH specific allocation	x			MOHFW, DGHS, DGFP,	# Current public expenditure in MNH reviewed and report available
Key Strategy 4: Improving the Quality of Care							
Key Issues	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas)**
			20-22	**23-26**	**27-30**		
Quality of care	Efforts to ensure quality of acre are sporadic Lack of regulatory and quality improvement systems and mechanism for both government and private sector	Operationalize strategic framework and action plan for quality improvement (QI) in RMNCH for both public and private sector health facilities - Orientation of facility staff on QI strategic framework & make it functional - Involving professional society in QI committee - Conduct capacity building of facility-based QI teams and supervisory system	x	x	x	LD-MNCAH, LD-HSM, LD-CBHC, LD-MCRAH, CS, UHFPO,	# Health facilities implemented RMNCH quality improvement system # report prepared
		Designate human resources for quality improvement at national, district and upazilla level	x			LD-MNCAH, LD-HSM, LD-MCRAH	Designated HR for national, district, upazilla level available
		Monitor quality indicators from routine MIS/ DHIS2 and prepare annual report, share with service providers and in coordination meetings	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH,	quality indicators incorporated into routine MIS/DHIS2 #report prepared

	Quality of care is recognized as a critical gap in maternal health	Conduct supportive supervision, coaching & mentoring for quality of MNH clinical care, documentation and record keeping	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH, DGNM,	Coaching & mentoring system established # of clinical mentoring visits
		Consolidate and document successful initiatives, learning experience/evidence from current implementation of MNH quality improvement initiative and scale up successful approaches across the country		x	x	LD-MNCAH, LD-HSM, LD-MCRAH	# documentation done # new district expansion
	Lack of harmonization of MNH services with QI initiatives	Coordination among the Quality Improvement Secretariat and all relevant Line Directors (implementing MNH services) to implement the QI initiatives, including strengthening of QI structures at divisional, district and health facility levels				LD-MNCAH, LD-HSM, LD-CBHC LD-MCRAH	# meeting held
Maternal morbidity MPDSR Health facility response to GBV	No monitoring indicators for maternal morbidity, GBV responses	Develop and functionalize a monitoring system to monitor the quality GBV services at the facility	x	x	x	LD-MNCAH, LD-HSM LD-MCRAH, PM-GNSPU	# monitoring visits # action taken
	Lack of utilization of MPDSR data for QI	Integrate and use of MPDSR data for improvement of QOC in facility	x	x	x	Director Hospital, CS, DDFP, UHFPO, UFPO	MPDSR data used for quality improvement
	Deficit in collaborative approach for fistula	Establish strong collaboration among urologists, gynecologists, specialist nurses, anesthetists, physiotherapists, psychotherapists and health advocates in the fistula management in the facilities.	x	x	x	LD-HSM	# of advocacy meeting organized
	Ensure safe surgery	Introduce safe surgery toolkit of WHO to the health facilities where fistula surgical procedures take place	x	x	x	LD-HSM	Safe surgical toolkit introduced by the DGHS
	No centre of excellence for fistula surgery	Establish and designate center for excellence for fistula surgery in Bangladesh	x	x	x	LD-MNCAH	# center of excellence
Key Strategy 5: Community Empowerment and Engagement							
		Key Action/Activities	**Timeframe**				

Key Issues	Gaps/Challenges		20-22	23-26	27-30	Responsibility Lead/Co-Lead)	Indicators (output level as per thematic areas)
Women status, low decision making power on using MNH service utilization	Gap in demand creation low awareness and poor recognition of health risks, Fear of cost lack of information about available services Gap in consistent promotion of healthy reproductive behavior	Collating and reviewing of existing SBCC materials on maternal health & nutrition for consistent information and messages and harmonize gender sensitive messages, tools and approaches	x			LD-MNCAH, LD-MCRAH, LD-IEC, LD, L&HEP, LD-NNS	MH & nutrition messages, tools & approaches harmonized
		Develop and implement comprehensive SBCC strategy for MNH and communication plan to improve awareness, demand creation for MNH services (including ANC, PNC, Normal deliveries, danger signs of pregnancy, PPFP, maternal morbidity, GBV etc.)	x			LD-MNCAH, LD-MCRAH, LD-IEC, LD, L&HEP, LD-NNS	SBCC strategy developed & implemented
		Implement national maternal health & nutrition campaign focusing in priority intervention such as 4+ANC, PNC (1-2 in a year, service week)	x	x	x	MOHFW, DGHS, DGFP LD-MNCAH, LD-MCRAH, LD-CBHC, LD-NNS LD-L&HEP, LD-IEM, DPs	SBCC communication plan implemented
		Observation of Safe Motherhood Day at all level	x	x	x		Safe motherhood day observed
		Develop and launch a national campaign to raise awareness on harmful effects of unnecessary CS and importance of necessary CS. Engage multiple and appropriate channels of communication (print, electronic, social-media) and all sectors of civil society in the campaign.	x	x	x		SBCC materials developed
		Develop context specific SBCC material for special geographical zone		x	x		# ANC, PNC campaign weeks held
		Introduce/Celebrate specific week /days of maternal health campaign when ANC, PNC and PPFP can be provided from service delivery points at CC, UHFWC, UHC, NGO clinics across the country to increase coverage (1-2 in a year, service week)	x	x	x		
		Use of social media for improving communication; Social drama, TV Spot, Songs, public service announcement, Billboard	x	x	x		# Special campaign held in the hard to reach areas
		Develop, print and distribute IEC materials and job aids including appropriate PPFP related posters, brochures and leaflets to reduce myths and misconception	x	x	x		
		Implement communication strategies designed especially for urban slums, hill tracts, char areas and other hard to reach areas.		x	x		

		Conduct qualitative studies (KAP study) to explore the current status of MNH knowledge, awareness, practices. Conduct post campaign survey		x	x	LD-MNCAH, LD-MCRAH,	# survey conducted and disseminated
	Call centers	Establish, strengthen and increase the utilization of call centers for MNH services		x	x	LD-MNCAH, LD-MCRAH, L&HEP, LD-IEC, LD-CBHC	# call centers establish
	Community mobilization for Demand creation for MNH service	Create demand for MNH care and access to health facilities as well as immediate referral through coordinated media strategy and engagement of multiple stakeholders	x	x	x	LD-MNCAH, LD-MCRAH, LD-L&HEP, LD-IEC	# Events/ advocacy meeting held
		Facilitate community group formation and support them in identification of local MNH issues and in development of local action plans in response	x	x	x	LD- CBHCP, UHFPO, UFPO	# community groups activated # meeting held # action taken
		Engage community support system to arrange transport, blood transfusion, money and referral in case of emergency	x	x	x	LD -MNCAH, CBHC, MC&RAH LGI,	# of women received support for obstetric complication
		Organize referral hub, referral networking using mobile phone, hotline (van, autos) to support referral	x	x	x	LD-MNCAH, LD- CBHC, LD-MCRAH, LGI,	# of upazila established referral hub
Lack of awareness of maternal morbidity, maternal & newborn death notification, GBV	Lack of community empowerment and engagement for fistula, maternal & newborn death notification	Implement SBCC activities to increase awareness on GBV, Maternal morbidities, death notifications	x	x	x	CS, DDFP, UHFPO, UFPO	# SBCC activity held
		Engage different local stakeholders including the local government, union parisad / upazila parisad, community support group and community group, NGO workers to increase awareness on fistula, GBV, MPDSR	x	x	x	CS, DDFP, UHFPO, UFPO	# awareness raising event held
		Organize mass campaign on fistula using SBCC poster, leaflet, social network including television, radio, internet (FB, Twitter)		x	x	LD-MNCAH, LD-MCRAH, LD-L&HEP, LD-IEC	# fistula campaign held
Key Strategy 6: Multisector Involvement and Action							
Key Issues	**Gaps/Challenges**	**Key Action/Activities**	**Timeframe**			**Responsibility Lead/Co-Lead)**	**Indicators (output level as per thematic areas)**
			20-22	**23-26**	**27-30**		

Multisector Involvement and Action	Involvement of key actors from the multisector is important in achieving the MNH goals and targets	Form an inter-ministerial committee chaired by honorable Minister, MOHFW to serve as a forum for coordinating the activities of all relevant ministries and agencies related to MNH	x	x	x	LD-MNCAH/ LD-MCRAH	Inter ministerial committee formed # meeting held
		Coordinate with development partners, UN organizations, NGOs and private sector for harmonization, effective program implementation, innovation	x	x	x	LD-MNCAH/ LD-MCRAH	# meeting held # action taken
Intersectoral collaboration	Lack of coordination with different stakeholders	Develop and use multisectoral linkage for GBV survivors at all facilities for medico-legal, legal and rehabilitation services	x	x	x	PM-GNSPU, LD-MNCAH, LD-MCRAH, LD-HSM, LD-NNS,MOWCA, MOHA, MOLJPA, MOSW	# GBV survivor supported # of district health system linked with other agencies for medico-legal, legal and rehabilitation services
		Build capacity and engage multisector including the members of the parliament for supporting MNH issues, maternal morbidities.	x	x	x	LD-MNCAH/ LD-MCRAH	# multisectoral member/members of the parliament receive orientation
	Emergency & Humanitarian setting including pandemic	Develop and implement strategy and emergency preparedness & response plan (EPRP) for maternal health and nutrition services in emergency situation such as humanitarian settings, Covid pandemic, natural disaster etc.	x	x	x	LD-MNCAH, LD-MCRAH, LD-HSM, LD-NNS	Strategy and EPRP for MH &Nutrition developed & implemented in case of emergency

Key Strategy 7: Implementation and Impact Evaluation

Key Issues	Gaps/Challenges	Key Action/Activities	Timeframe			Responsibility Lead/Co-Lead)	Indicators (output level as per thematic areas)
			20-22	23-26	27-30		
Implementation and Impact Evaluation	Inadequate monitoring of output indicators and use of data to identify the gap and take appropriate	Develop and implement a monitoring & evaluation framework for MNH service	x			DGHS, DGFP	Monitoring framework developed
		Assign MNCAH coordination officer at district level		x	x	MOHFW, DGHS,	# MNCAH coordination officer at district level
		Monitor the Targets and output indicators identified in the Maternal Health strategy and action plan periodically	x	x	x	LD-MNCAH, LD-HSM, LD-MCRAH	# meeting held # action taken

Monitoring progress	action to address the gaps Lack of use of MNH data at subnational level						
		Include a measure for content analysis of ANC and PNC visits in a given sample of mothers and newborns and explore reasons of omitting certain interventions as part of periodic program assessments		x	x	LD-MNCAH, LD-MIS, LD-MCRAH	Content analysis as part of program assessment
	EmONC assessment	Conduct periodic EmONC assessment for signal functions and sharing at different administrative layers for taking action	x	x	x	LD-HSM LD-CBHC, LD-MNCAH, LD-MCRAH,	EmONC assessment done
	Dashboard	Create a National Maternal Health dashboard	x			LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS, LD-HIS & eH	Maternal health dashboard developed
Strengthening data for evaluation	Lack of evaluation data/ report	Periodic program assessments include a measure for pregnancy registration, death notification, death registration, social autopsy, GBV case referral, WFH	x	x		PM-GNSPU, LD-MNCAH, LD-MCRAH	# program assessment
		Strengthen and utilize routine DHIS-2 data for preparing annual report for MNH including fistula & health response to GBV	x	x	x	PM-GNSPU, LD-MNCAH, LD-MIS	# annual report prepared
		Regular review and capture the best practices (MNH) and share	x	x	x	LD-MNCAH LD-MCRAH	# documentation of best practice and shared
	Operational Research	Conduct operational research to improve cost effectiveness and evaluate innovative approaches in MNH service deliveries		x	x	LD-MNCAH, LD-MCRAH, DPs	# Operation Research
		Develop and implement innovations/approaches to cover urban slum, low performing district, hill tracts and other hard to reach areas		x	x	LD-MCRAH LD-MNCAH, LD-MIS,	# innovations implemented
		Implement Evidence based interventions - Creative use of HR (Task shifting) - Ambulance service - Quality improvement		x	x	LD-MNCAH LD-MCRAH	# Evidence based intervention implemented
		Operation research on MPDSR, Maternal morbidities, Health response to GBV		x	x	PM-GNSPU, LD-MNCAH, LD-MCRAH,	# Operation research conducted
		Demonstration of use of NASG (Anti Shock Garments) in selected districts to improve maternal mortality due to bleeding	x	x		LD -MNCAH, LD-MCRAH,	Operational research conducted on NASG

		Demonstration of use of tranexamic acid in public facilities for prevention of hemorrhage		x		LD-MNCAH LD-MCRAH,	Operational research done on tranexamic acid
		Conduct research on the management of obstetric complications in urban areas including both public and private facilities		x		PMR, MNC&AH, HSM-(Urban),	Operation research conducted on management of obstetric complications

Monitoring & Evaluation framework and responsibility for the Action Plan

	Indicator	Definition	Baseline	Target			Data source	Frequency	Responsibility
				2022	2026	2030			
Impact	MMR	The number of maternal deaths per 100000 live birth	172/100,000 Live births	145/100,000LBs	100/100,000LBs	70/100,000LBs	SVRS/UN Estimates /BMMS	3 years	BDHS, BBS,
Coverage	Contraceptive Prevalence Rate (CPR)	Percentage of women age 15-49 years currently married who are using (or whose partner is using) a (modern or traditional) contraceptive method	62.7% MICS-2019	75%	80%	85%	BDHS/ MICS	3 years	BDHS, BBS
	Total Fertility Rate (TFR)	Total fertility rates (women age 15-49 years) for the three year period preceding the survey	2.1 (BDHS 2017) (2.3 MICS,2019	2.0	1.7	1.5	BDHS/ MICS	3 years	BDHS, BBS
	Antenatal Care from medically trained provider (4 visits)	The percentage of women aged 15-49 with a live birth in a given time period that received antenatal care provided by skilled health personnel (doctors, nurses, or midwives) at least four times during pregnancy.	47% BDHS	50%	80%	100%	BDHS/ MICS	3 years	BDHS, BBS

	Number of 4 ANC visits with quality components	Number of pregnant women who received 4 ANC Visits with all 4 contents (quality component) BP checked, blood test done, urine test done, counselling done	18% (BDHS 2017)	30%	50%	70%	BDHS/ MICS/ UESD	1 year	BDHS, BBS
	Skilled Birth Attendants	Percentage of total births attended by skilled health personnel	52% (59% MICS)	60%	80%	90%	BDHS/ MICS/ UESD	3 years	BDHS, BBS
	Institutional Deliveries	The percentage of women (aged 15–49) who gave birth during the two years preceding the survey and delivered in a health facility	50% (53.4% MICS)	65%	70%	85%	BDHS/ MICS/ UESD	3 years	BDHS, BBS
	Postnatal Care from medically trained provider	Percentage of mothers and babies who received postnatal care within two days of childbirth	52% (65.3% mother 66.7% new born MICS 2019)	60%	80%	100%	BDHS/ MICS/ UESD	3 years	BDHS, BBS
Output	Number of Antenatal Care (4th visits)	Number of pregnant women received ANC (4th visit) from Facilities	652,375 (4 ANC) in 2019 DHIS2				DHIS2, MIS DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Number of women who deliver in the Health facility	Number of women who delivered at health facilities	422,820(Public facilities in 2019) DHIS2 12% of total expected birth	20%	30%	50%	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM LD-MIS
	Facility stillbirth rate (disaggregated by fresh /macerated when possible)	Percentage of total institutional stillbirths among all institutional deliveries	30.5% in 2019, DHIS2 Fresh 61% Macerated 39%	25%	20%	12%	DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS

	Pre-discharge Maternal deaths	Number of women who delivered in the facility and died prior to discharge	*Need to create new indicator in DHIS2				DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Maternal deaths by cause	Number of institutional maternal deaths by cause(ICD-MM)	PPH 17.8% Eclampsia 19.4% (2019 DHIS2)				DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Obstetric case fatality rate (disaggregated by direct/indirect when possible)	Percentage of women who delivered at the facility and experienced obstetric complications (regardless of time of onset) and died from these complications before discharge	.08% (2019 DHIS2)	<1%	<1%	<1%	DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Pre-discharge neonatal mortality rate	Proportion of babies born alive at a facility dies prior to discharge from facility (28 days or less)	*Need to create new indicator in DHIS2				DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Neonatal death by cause	Number of institutional neonatal deaths (28 days or less) by cause (ICD-PM)	Birth asphyxia 35%, LBW 23%, Sepsis 10% (2019 DHIS2)				DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
Experience of care	Pre-discharge counselling for mother and baby (woman-reported)	Proportion of women who received pre-discharge counselling for the mother and the baby in a given period	*Need to create new indicator in DHIS2				DHIS2, Exit interview	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Proportion of women who gave birth in the health facility who had a companion of their choice during	Proportion of women who gave birth in the health facility who had a companion of their choice during labour & childbirth	*Need to create new indicator in DHIS2				DHIS2, Exit interview	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS

	labour & childbirth(woman-reported)								
	Women who experienced physical or verbal abuse in labor or delivery (woman - reported)	Proportion of women who report physical or verbal abuse anytime during labor, childbirth, or postpartum period. (Physical Abuse: slapped, pinched or punched by a health worker or other facility staff; Verbal Abuse: shouted at, screamed at, insulted, scolded or mocked by a health worker or other staff)	*Need to create new indicator in DHIS2				Client questionnaire (sample of women) (e.g. exit interview)	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
Input	Readiness of health facilities to provide normal delivery services	Number of health facilities having 13 essential items for conducting normal deliveries as per WHO Standard	1% (DH & UHC) 2017 BHFS	50%	75%	100%	BHFS	3 Years	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Number of CEmONC health facilities perform all signal functions in last 3 months	Number of CEmONC health facilities perform all signal functions in last 3 months	11% in 2017 BHFS	50%	75%	100%	BHFS, DHIS2	Quarterly	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Number of BEmONC health facilities (UHCs) perform all signal functions in last 3 months	Number of BEmONC health facilities (UHCs) perform all signal functions in last 3 months	25% in 2017 BHFS	50% 0f UHC	75% of UHC	100% of UHC	BHFS, DHIS2	Quarterly	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Maternal and Perinatal death audited and reviewed	Percentage of maternal & perinatal death audited & reviewed with standard audit tool/review form (number of maternal & perinatal death reviewed /total death*100)	16% 2019 DHIS2	50%	80%	100%	DHIS2	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS

	Breastfeeding within one hour (QED)	Percentage of newborns breastfed within one hour of birth	47% MICS 2019	TBD	TBD	TBD	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Immediate postpartum prophylactic uteronic for PPH prevention (AMTSL)	Percentage of women who gave birth in a health facility who are administered immediate postpartum uterotonic to prevent postpartum hemorrhage	*Need to create new indicator in DHIS2	100%	100%	100%	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Birthweight documented	Percentage of newborns with documented birthweight in record or register before discharge	*Need to create new indicator in DHIS2	100%	100%	100%	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Premature babies initiating KMC	Proportion of newborns weighing ≤ 2,000g who are initiated on KMC	NA	TBD	TBD	TBD	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-HSM, LD-MIS
	Early pregnancy registration of all pregnant women	Early pregnancy registration of all pregnant women	10% in 2019 DHIS2/RMNCH scorecard	50 %	80%	100 %	DHIS2, MIS, DGFP	Biannually	LD-HIS and eH LD-MNCAH, LD-MCRAH, LD-MIS

Supervision and monitoring:

For effective program supervision, supervisors/managers are required to visit health facilities at different levels where maternal health services such as ANC, delivery care, PNC, emergency obstetric care, counselling, postpartum family planning are provided. Observation of service provision, availability of logistics, drugs, job aids, registers and providing feedback is part of the supervision. Findings from these visits will need to be shared in weekly/monthly meeting for quality assurance. An uniform checklist need to be developed for regular supervision & monitoring. The following tables are provided below that outline the activities of supervision and monitoring;

Person responsible	Organization	Responsibility	Observation/activity
National Level Line Directors, Directors, Program Manager, Deputy Program Managers	DGHS, DGFP, DGNM	• Implementation of MNCAH and other relevant MNH operation plan activities • Resource allocation and fund management • Supervision and monitoring • Coordination and advocacy • Procurement of logistics and commodities • Use of data and reporting • Capacity building of service providers • Quality assurance of maternal health services	

List of personnel involve in supervision and monitoring under DGHS

Directorate General of Health Services has health facilities from community to national level where maternal health services are provided;

Unit name	Level	Supervisor
Community Clinic (CC)	Community level	UH&FPO
EPI Outreach Center	Community level	MT-EPI, AHI, HI, UH&FPO
Household		
Union Health Center/RD	Union level	UH&FPO
Upazilla Health Complex	Upazilla level	Civil surgeon, Deputy Civil Surgeon, UH&FPO, RMO, Consultant OBGYN, Public Health Nurse
District Hospital (Sadar & General Hospital)	District Level	Hospital Superintendent/Hospital Director, Civil surgeon, Respective Consultants, RMO
Medical College Hospital	Divisional & District level	Director Hospital, Professor, Respective Consultants,
Specialized Hospital	Divisional & District level	Director Hospital, Professor, Respective Consultants

List of personnel involve in supervision and monitoring under DGFP

Directorate General of Family Planning has health facilities from community to national level where maternal health services are provided;

Unit name	Level	Supervisor
Satellite clinic	Community level	FPI, UFPO, MO(MCH-FP), DDFP

Household		
Union Health & family Welfare Center	Union level	UFPO, MO(MCH-FP), DDFP
MCH unit Upazilla Health Complex MCWC	Upazilla level	UFPO, MO(MCH-FP), DDFP, District Consultant (FPCS/QIT), MO-Clinic, MO(MCH-FP), District Consultant (FPCS/QIT),
MCWC	District Level	DDFP, District Consultant (FPCS/QIT), ADCC, MO(CC), MO-Clinic
Specialized Hospital	National level	Director Hospital, Consultants

List of personnel involve in supervision and monitoring under DGNM

Nurses under the Directorate General of Nursing & Midwifery are posted at the upazilla and above level. In the recent year midwives are deployed at the union and upazilla level. Both nurses and midwives are providing maternal health care services at the health facilities from upazilla to national level

Unit name	Level	Supervisor
Upazilla Health Complex	Upazilla level	Public Health Nurse, Nursing Supervisor
District Hospital	District Level	Nursing Superintendent, Deputy Nursing Superintendent, Nursing Supervisor
Medical College Hospital	Divisional/District level	Nursing Superintendent, Deputy Nursing Superintendent, Nursing Supervisor
Specialized Hospital	National level	Nursing Superintendent, Deputy Nursing Superintendent, Nursing Supervisor

Supervisory visits and Meetings

Supervisory visits	Responsible persons	Frequency	Activity	Tool needed
Routine Field visits	CS, UHFPO, UFPO, MO (MCH-FP) Public Health Nurse	8/month	• Review client flow • Observe /review provision of care as per protocol(ANC, PNC, Delivery care, counselling) • Check record keeping • Check logistic, drugs and equipment status (Stock register) • Ensure use of job aids	An uniform, standard tool will be developed and used
Joint Supervisory Field visit	CS, UHFPO, District Consultant (FPCS/QIT) along with representative from development partners	As Needed		
Supervisory Field visit from National level	Line Directors, Directors, Program Managers, Deputy Program Manager from DGHS, DGFP, DGNM	As Needed		

Meetings

Meetings	Person Responsible	Frequency	Discussion

Maternal Health National Action plan Implementation Committee meeting	LD-MNCAH (DHHS) LD-MCRAH (DGFP)	4/Year	• Quarterly MH performance data and target (routine data, DHIS2) • Share findings from supervisory visits, including problem identification and resolution
Divisional MNH committee meeting	Divisional Directors	4/Year	• Quarterly MH performance data and target (routine data, DHIS2) • Share findings from supervisory visits, including problem identification and resolution
District Health Coordination meeting/MNH committee meeting	Civil Surgeon	1/month	• Include maternal health as an agenda • Share monthly progress on maternal health using routine data • Share findings from supervisory visits, including problem identification and resolution
District Family Planning Coordination meeting	Deputy Director Family Planning	1/month	• Include maternal health as an agenda • Share monthly progress on maternal health using routine data • Share findings from supervisory visits, including problem identification and resolution
Upazilla Health department monthly staff meeting/MNH Committee meeting	UHFPO	1/month	• Include maternal health as an agenda • Share monthly progress on maternal health using routine data • Share findings from supervisory visits, including problem identification and resolution
Upazilla Family Planning department monthly staff meeting	UFPO, MO(MCH-FP)	1/month	• Include maternal health as an agenda • Share monthly progress on maternal health using routine data • Share findings from supervisory visits, including problem identification and resolution • Promote pregnancy registration
Community health provider monthly coordination meeting	UHFPO	1/month	• Include maternal health as an agenda • Share monthly progress on maternal health using routine data • Share findings from supervisory visits, including problem identification and resolution • Encourage CHCP for demand generation for MH services through CG &CSG members

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Annex 1: List of contributors

Core Committee for National Plan of Action Plan for Maternal Health 2019-30

1. Chair - Director General of Health Services
2. Co- chair - Director General of Family Planning
3. Co- chair- Director General, DGNM
4. Member Secretary – Program Manager, MNH, DGHS

Members

1. Chief (Planning) MOHFW
2. Line Director MNC&AH, DGHS
3. Director MCH & Line Director MCRAH, DGFP
4. Line Director, Community Based Health Care (CBHC)
5. Director MIS, DGHS
6. Director MIS, DGFP
7. Director Nursing Services
8. Director Hospitals & Clinics, DGHS
9. Director, Finance, DGFP
10. Chief, Bureau of Health Education, DGHS
11. Program Manager MCH, DGFP
12. Representative UNICEF, Bangladesh
13. Representative WHO, Bangladesh
14. Representative UNFPA, Bangladesh
15. Representative USAID, Bangladesh
16. Representatives, MaMoni MNCSP
17. President OGSB
18. Chair and Rapporteurs of 5 Technical Sub Committee

Terms of Reference of Core Committee

1. Provide technical guidance to all sub-technical committees
2. Review the work of the sub-technical committees
3. Work for endorsement of the draft action plan in the ministry
4. Coordinate the sub-technical committees for harmonization of the action plans

Technical Sub Committees

1. Technical Sub-Committee for Preconception and Antenatal Care (ANC)

Chair: Prof. Dr. Laila Arjumand Banu, Ex-President, OGSB
Member Secretary: Dr. Jaynal Huq, PM, Adolescent Health DGFP
Rapporteur: Golam Mohiuddin Khan, Nutrition Specialist, UNICEF,
Dr Mahbuba Khan (WHO)

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III. Dr. Mahbuba Khan, WHO
IV. Golam Mohiuddin Khan (Sadi), Nutrition Specialist, UNICEF
V. Dr. S.M. Asib Nasim, Consultant, World Bank
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X. Tania Sultana, C4D Specialist, UNICEF
XI. Dr. A.S.M. Moniruzzaman, Maternal Health Advisor, USAID's MaMoni MNCSP Jhpiego

XII. Prof. Afzalunnessa Chowdhury, OGSB

2. Technical Sub-Committee for Midwifery care/Normal delivery/BEmONC/CEmONC

Chair: Prof Sameena Chowdhury, President, OGSB
Member Secretary: Dr. Azizul Alim, DPM MNH, DGHS
Rapporteur: Dr. Dewan Hoque (UNFPA),
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XI. Momtaj Begum, Representative, Bangladesh Midwifery Society
XII. Dr. Riad Mahmud, Health Specialist, USAID
XIII. Prof. Rowshan Ara Begum, OGSB

3. Technical Sub-Committee for Post Natal Care & Post-Partum Family Planning (PPFP)

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XII. Dr. Mahfuza Mousumi, Program Director, Jhpiego

4. Technical Sub-Committee for Ante Partum Hemorrhage (APH), Post Partum Hemorrhage (PPH), Pre-eclampsia and Eclampsia

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VII. Prof Nazneen Kabir, OGSB
VIII. Prof Latifa Shamsuddin, OGSB
IX. Dr. Ziaul Matin, Health Manager, UNICEF
X. Rondi Anderson, UNFPA
XI. Dr Ehsan, RI, ICDDRB
XII. Prof. Saria Tasnim, OGSB

5. Technical Sub-Committee for Maternal, Perinatal Death Surveillance & Review, Maternal Mortality, Gender Based Violence Responses

Chair: Prof. MA Halim, Professor, Kumudini Medical College
Member Secretary: Dr. Md. Mushair-ul-Islam, Program Manager, Maternal Health Program Office, DGHS
Rapporteur: Dr. ASM Sayem, Health Specialist- Maternal and Adolescent Health (UNICEF)
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XI. Dr. Bilkis Begum, Kumudini Medical College
XII. Tahmina Huq, Programme Officer, Gender, UNICEF Bangladesh

Terms of Reference of Technical Sub Committees

1. Develop of action plan in the specific thematic areas following 7 strategic directions of Maternal Health Strategy 2019-30
2. Consult with other thematic group for avoiding any duplicated actions/ joined action plan
3. The rapporteur is responsible to compile all the findings and put in to a word file
4. The rapporteur will present on behalf of the team in the core technical committee
5. Following all national guidelines and policies while developing the action plan
6. Develop the action plan as per structural guideline provided from the core committee
7. Bridge technical and programmatic knowledge for implementable action plan

Compiled by Dr. Monira Parveen, Consultant, UNICEF

Annex 2: List of documents reviewed

1. Maternal Health Standard Operating Procedures (SOP) Volume 1& 2
2. Guideline on Antenatal Care
3. Standard Clinical Management Protocols and flowcharts for Emergency Obstetric and Newborn Care 2019
4. Guideline on Intrapartum Care and Post Natal Care
5. National Reproductive Maternal Neonatal Child Adolescents Health Quality Improvement Framework
6. National Guideline on Maternal and Perinatal Death Surveillance and Response
7. Eclampsia and PPH Action Plan in Bangladesh 2017-2022
8. Bangladesh Essential Health Service Package
9. Standard for improving quality of maternal and newborn care in health facilities
10. WHO recommendations for Antenatal care for a positive pregnancy experience
11. Bangladesh National Maternal Health Strategy
12. Bangladesh Adolescent health action plan
13. Bangladesh Health facility survey preliminary report
14. Bangladesh Demographic and Health Survey 2017

15. Bangladesh Maternal Mortality and Health Care Survey 2016
16. National Strategy for cervical cancer prevention and control Bangladesh
17. Health Sector Response to Gender Based Violence Protocol for Health Care Providers
18. Gender Equity strategy 2014
19. Multiple Indicator Cluster Survey 2019, Bangladesh
20. National Strategy for Obstetric Fistula 2017-2022

Annex 3: Right Sizing for Maternal Health Interventions

Background:

Health systems are faced with challenges of providing adequate and quality health care globally with limited number of health care workers amidst increasing disease burden, ever increasing population and limited resources. The application of provider-population ratio, doesn't match the changing human resource needs of health care organizations. Institutional staffing norms based solely on population or institutional size do not adequately take into consideration these variations of need within a country. This create real problems in health service provision, not only through under- or over-provision of health service staff but also through the inappropriate allocation of different cadres of staff. In the developing world there has been continued difficulty in ensuring an adequate and appropriate distribution of health service providers to deliver both preventive and curative health services equitably across a country. Public sector health services are, as a consequence, experiencing new pressures to improve the quality, quantity and accessibility of the services they provide. To meet this emerging necessity, Bangladesh government recruited thousands of doctors, nurses, midwives and other cadres during the last decade in the public sector. Midwifes are the new cadre recruited and deployed in the recent years to the upazilla health complexes to provide maternal health care.

This inevitably leads to a closer examination of the basis on which staff are distributed throughout the health service and how they can be used more efficiently and effectively in raising the health of the population as a whole. One significant development in this has been increased attention to monitoring performance and efficiency in the constituent organisations of the health service. Allied to these is the need to change the roles that different cadres of provider discharge, emerging in part from new views of health professional roles, partly through a changing technology for health interventions and partly through a requirement for greater skills in the workforce to meet the growing public expectation.

Rightsizing is the act of paring down a workforce and reorganizing management to find the optimum staffing level for increased cost-efficiency and productivity. Understanding rightsizing

implementation strategies can help to optimize workforce with as little negative impact as possible.

Bangladesh's public health system remains highly centralized, with planning undertaken by the Ministry of Health and Family Welfare and little authority delegated to local levels. It delivers health services through its nationwide infrastructure by employing doctors, nurses, midwives, pharmacists and a huge number of auxiliary health workers. The public healthcare services are organized along four levels: community level healthcare (provided by the domiciliary health providers and community clinics), primary level healthcare (provided in Rural Health Centers, Union Subcenters, Union Health & Family Welfare Centers, and Upazila Health Complexes), secondary level healthcare (provided in District Hospitals, General Hospitals, Chest Disease Clinics, Tuberculosis Clinics, and Leprosy Hospitals), and tertiary level healthcare (provided in Post Graduate Medical Universities, Specialized Hospitals, Medical College Hospitals). Ministry of Health and Family Welfare recruit doctors, nurses, midwives centrally and deploy to fill up the vacancies. Availability of posts (for different cadre of health care providers) at the different level of health care facilities are proportionate to the number of beds available. Retention and absenteeism are two major problems in rural and hard to reach areas.

Maternal health intervention packages at different level of the health system (community clinic, outreach, Union level facilities, UHC, DH and specialized hospitals) are clearly spelled out in the Maternal Health Standard Operating Procedures (SOP), Volume1 and Bangladesh National Strategy for Maternal Health 2019-2030, Annex 1.

Purpose:

This report examines the expected number of deliveries (one of the key maternal health intervention) at a upazilla in a year and to understand the requirement of health care providers(doctor, nurse, midwife) with right skills to deliver quality care in a upazilla health complex, to increase the number of deliveries in these facilities (in alignment with national maternal health strategy) to achieve the national target of institutional deliveries. It is anticipated that the report will generate stimulating discussion amongst all stakeholders working in the maternal health arena.

Methodology:

Upazilla health complex are identified for conduction of normal deliveries and other basic emergency obstetric and newborn care, whereas district hospitals, medical college hospitals and other specialized hospitals are expected to manage the complicated cases including comprehensive emergency obstetric and newborn care. Bangladesh health facility survey (2017) reports that 92% upazila health complexes (UHCs) are most likely to provide the full

range of basic client services including normal delivery. UHCs are either 31 bedded or 50 bedded hospitals and are providing primary health care services including maternal health services (ANC, PNC, deliveries, newborn care, family planning). The post of doctors, nurses are allocated as per bed numbers, however the performance varies amongst UHCs.

Current Situation:

DHIS2 data was examined to find the actual number of deliveries conducted in the upazilla health complexes to understand the caseload. Table 1 (data from DHIS2) shows the number of deliveries conducted at the health care facilities under DGHS (Medical College Hospitals, District Hospitals and Upazilla Health complexes) in 2019.

Table1: Number of deliveries conducted in public health facilities under DGHS in 2019

Facility	NVD	C-Section	Total
Medical College Hospital	57320	62395	119715
District Hospital	79075	39740	118815
Upazilla Health Complex	169586	13640	183226
Total	305981	115775	421756

43.4% of all deliveries (under DGHS health facilities) and 55.4% of normal deliveries are conducted at upazilla health complexes in 2019. DHIS2 2019 report from 415 upazilla health complexes show the highest number of NVDs conducted is 2,970 in a year in Muktagacha Upazila Health Complex (Mymensing) and lowest is 5 deliveries in a year in Dakhin Surma Upazila Health Complex, Sylhet. More than 60% of the UHCs (250 out of 415 UHCs) are conducting less than 365 deliveries in a year mean less than 1 delivery per day. Only 5% of UHC (23 UHCs) are performing more than 1,000 deliveries in a year (3-8 deliveries/days) and are the highest performing UHCs. Rest of the 34% UHCs are performing 366-1,000 deliveries in a year meaning 1-3 deliveries per day. All UHC's has junior consultant (OBGYN) and 12 nurses' position and recently ministry is deploying midwives to provide maternal health services. However, 95% UHCs are performing only 1-3 deliveries per day which is very low, possibly due to vacancies, retention issues and absenteeism which are the major challenges in the rural and hard to reach areas. Beside this ministry is upgrading selected Union health & family planning centers under DGFP and some selected community clinics to perform normal deliveries.

Analysis & Recommendations:

This exercise has been done in connection with developing the national action plan for maternal health 2020-30. One of the key strategies for maternal health is to increase skilled birth attendance and increase institutional deliveries. The action plan prioritizes to Implement facility

readiness plan at all UHCs for basic emergency obstetric & newborn care services including normal deliveries.

EPI population projection data (2020) has been used to estimate the expected number of deliveries in each upazilla. EPI population projection data shows estimated number of deliveries in 2020 is **3,441,465.**
BDHS 2017 data reported Institutional delivery is 50%.
Among this, public facility delivery: 14%
private facility is 32% & NGO facility: 4%

Govt target for institutional delivery is 85% by 2030
Target for public facility delivery is estimated to be 50% by 2030 (considering that there will be incremental increase of delivery at private and NGO facilities)

Place of delivery in the public sector:

- Community Clinics
- Union Health & Family Welfare Center
- Upazilla Health Complexes
- District Hospitals
- Maternal & Child Welfare Center
- Medical College Hospitals
- Specialized Hospitals /Maternity Hospital under DGFP

It is expected that district hospitals (DH), medical college hospitals (MCHs) are places for complicated deliveries and manage referral of maternal complication.

Upazilla is considered as a unit for planning of quality NVD services (To achieve the govt target of public facility delivery) and should be focused for facility readiness, deployment of midwives, provision of drugs, equipment and quality assurance. Each upazilla need to set up target for facility delivery considering the population, estimated annual birth.

Upazilla can be categorized considering the population and estimated annual birth;
Total number of Upazilla: 483
A wide range of estimated population among the upazillas in Bangladesh; as high as 2,152,274 to as low as 27,892.
Average population in Upazilla: 320,000
Highest number of population & estimated birth in 2020:
Gazipur Sadar Upazilla: Estimated Population 2,152,274; Estimated birth: 34,883
Lowest number of population:
Thanchi Upazilla: Estimated population: 27,892, Estimated birth: 757

Lowest number of estimated birth: Juraichhari Upazila (Rangamati), Estimated birth: 486

Table 2: Upazillas can be categorized as follows considering the population, estimated annual birth;

Upazilla	Number of upazilla	Estimated Birth/year	Estimated Average birth /year	Estimated Average birth /day	Estimated Average birth /day if target 50% deliveries at public facility	HR requirement for UHC	Additional facility
Category A	35	upto 2500	1552/year	5/day	2.5/day	4 Midwives Consultant (OBGYN)	
Category B	145	2501-5000	3736/year	10/day	5/day	4 Midwives Consultant (OBGYN) MO	
Category C	158	5001-7500	6252/year	17/day	8.5/day	8 Midwives Consultant (OBGYN) MO	Identify 1 UHFWC
Category D	77	7501-10,000	8623/year	24/day	12/day	8 Midwives Consultant (OBGYN) MO	Identify 2-3 UHFWC Deploy Midwives at union level
Category E	68	>10,000	13,606/year	37/day	18.5/day	8 Midwives Consultant (OBGYN) MO	Identify 2-3 UHFWC Deploy midwives at union level

Table 2 shows in case of an ideal scenario, if 50% of all estimated deliveries are conducted at the upazilla health complexes, 70% UHCs has to conduct an average of 2.5-8.5 deliveries per day which is doable, if skill midwives are deployed in adequate number as proposed in the maternal health strategy. However, in 30% of upazillas with an expected average delivery of 12-18.5 per day, additional facilities such as union health and family welfare centres need to be upgraded and facility readiness plan implement to conduct normal deliveries. Union health and family welfare centres can be prioritized in the hard to reach areas (haor, char) for conducting deliveries. Mapping of the upazillas for maternal health service providers including private and NGO facilities can be an important action for further planning.

Annex 4: Future Actions

- For rightsizing, a caseload analysis by using internationally recognized methodology such as “Workload Indicator of Staffing Needs (WISN)” can be done. This can be an important tool for advocacy with ministry for key HR deployment

- 95% of UHC are performing 1-3 deliveries/days which seems suboptimum considering the number of human resources that are currently available. It is imperative to conduct a qualitative assessment to understand why UHCs are not utilized for deliveries and plan to address those barriers.
- Mapping of the upazillas for maternal health service providers including private and NGO facilities
- Set up target for each upazilla and regular use of performance data by the managers in the departmental meeting for monitoring. Priority should be given to the low performing districts
- Advocacy with DGNM and MOHFW to prioritize high performing upazilla health complexes specially for nurse and midwife's deployment
- Special attention to be given for the hard to reach upazillas for HR retention and explore innovative approach

Annex 5: List of Editors

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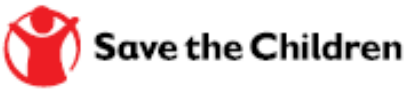

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