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

# Bangladesh National Strategy for Maternal Health

## 2019-2030

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

পরিবার পরিকল্পনা অধিদপ্তর

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

# Bangladesh National Strategy for Maternal Health 2019-2030

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# MESSAGE FROM THE MINISTER
## Ministry of Health and Family Welfare

Bangladesh has achieved immense success in health sector; the expansion of health care, the increased number of human resource & skill in health sector, the range of hospitals and other services organizations, incredible success in public health, the widespread growth of medical education, significant reduction of maternal and child mortality, exciting increase of life expectancy, etc. have made the Health Sector of Bangladesh is a wonder. Such big success has been achieved for the current government's firm commitment to ensure public health and development. I strongly believe that this progress of Bangladesh will continue and we will be able to achieve the sustainable development targets (SDGs) health indicators. From the time of Bangabandhu, the health sector has received special importance from the government. Constitution, all five-year plans of the country, political patronage, budget allocation, public relations, innovative initiatives to provide health care and the support & guidance of Prime Minister Sheikh Hasina made health sector a huge success. In spite of all these successes, in order to reach the developed country as a healthy nation, we still have to pass a long way, to increase the quality of service, to ensure universal health protection, to prevent every mother and child mortality. We still have a lot to do to improve the quality of healthcare, especially the mother, newborn and child health care service still not reached the desired level. Although there is good scope for receiving care of mother and child healthcare, there is a shortage in health centers in terms of service quality. Among other factors, the main obstacles in the field of mother and newborn services are the lack of skilled workforce and poor management and the lack of an updated national strategy. Ministry of Health and Family Welfare has formulated National Maternal Health Strategy 2019-30, with all the necessary components for the development of mother health and with specific guidance in direction. This strategy will play a vital role in the improvement of maternal health, maternal illness and death and, above all, the improvement of maternal and child health. We believe that, follow these strategies, formulate a national action plan, formulate and implement the committee at the level of the ministry and the directorate, formulate necessary funding, assistance and proven method, employing manpower and developing their skills will play an important role in the development of child and mother health. In the end, I would like to thank all of those who have contributed in making this strategy, and I hope that our collective efforts will continue to bring about a sustainable change in mother and child health in Bangladesh.

**Zahid Maleque,** MP
Hon'ble Minister
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

# MESSAGE FROM THE STATE MINISTER

## Ministry of Health and Family Welfare

I am happy to know that the National Mother Health Strategy is going to be published in order to provide Mother Care. Under the Fourth Sector Programmme Essential Services Package, the strategy will play an important role in reaching healthcare at different levels of healthcare and improving the quality of health services provided. I would like to congratulate all of my colleagues working in the Ministry of Health and Family Welfare and technical experts from various organizations who have worked tirelessly in preparing the strategy.

In the case of the reducing of maternal death rate, often the name of Bangladesh is mentioned as an example of success. This has happened because of the current government's strong commitment. As our progression depends largely on the health of the mothers and the infants, so the issue of maternal and child health is always kept at the forefront of the ministry's agenda. That's why we tried our best to reach the mothers who need the healthcare most by establishing community clinics and strengthening the health care centers established at the union level. We believe that we have made basic healthcare available to the mothers. But it is not a big achievement to bring thing under control, we need to ensure 'numbers' as well as the 'quality'. And, it has been mentioned in the strategy. These strategies will act as a guideline for those who are providing reproductive healthcare, healthcare services to mothers and newborns systematically. Therefore, systematic and standard strategic formulations are very important to ensure the minimum standard of service. Let's work together to build a healthy and prosperous Bangladesh.

**Murad Hassan,** MP
Hon'ble State Minister
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

# MESSAGE FROM THE SECRETARY
## Health Service Division

The progress Bangladesh made in the health sector in the last ten years has been praised internationally; as a result, HE Prime Minister Sheikh Hasina received a couple of awards for her contribution to developing this sector. Enhancing the capacity to deliver maternal and child health services, reducing maternal and child mortality and increasing access to quality health services have played leading roles in achieving it.

Capitalizing the experience we already have gathered achieving the Millennium Development Goals (MDGs) on reducing maternal and child mortality, the health sector of Bangladesh has been active to attain the targets of Sustainable Development Goals (SDGs). The Maternal Health Strategy has been designed to provide clear strategic directions to harmonize all the initiatives being taken to ensure quality health services to reduce maternal and child mortality.

The strategy describe the essential standards and procedures for service provision of maternal health care, family planning, antenatal care, intrapartum spacing care, emergency obstetric care, immediate newborn care, postpartrum care, adolescent and reproductive health care, prevention and treatment of cervical and breast cancer. So it covers the entire spectrum of maternal healthcare.

The strategy is comprehensive and is an excellent guideline for both the service providers as well as the managers and supervisors. It is also a wonderful tool for policy-makers and health program evaluators. I believe we can accelerate improvement in maternal and newborn health care, two important areas that demand particular attention, if we use the strategy at all levels of care. I congratulate the MoH&FW for developing the strategy. I know that a large number of experts representing both the government and non-government organizations have worked hard to develop the strategy. I thank them for doing a great job.

**Md. Ashadul Islam**
Secretary, Health Service Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

# MESSAGE FROM THE SECRETARY

## Medical Education and Family Welfare Division

Record of Bangladesh in the areas of maternal, newborn and child health has been quite impressive over the last two decades. The maternal mortality ratio has been reduced from 322 to 194 per 100,000 live births from 2001 to 2010. The infant and under-five mortality rates have fallen sharply – from 66 in 2000 to 38 in 2011 and from 94 to 46 respectively over the same period. I think these achievements are results of continuous efforts of the government, especially of the present government, that has put maternal, newborn and child health at the top of its development agenda.

However, there is no scope for being complacent. Because, there are areas where progress has been rather slow. For instance, neonatal mortality is 28 per 1,000 live births and contributes 61% of the total under-five deaths.

Newborn deaths are often the result of improper care during pregnancy, delivery and postnatal periods. A combination of several factors such as absence of skilled birth attandants during delivery, harmful traditional practices, poor access to emergency care for complications and reluctance of the expectant mothers to seek care from health facilities for delivery. We need to employ a comprehensive and standardized maternal health care regime to address these issues and improve the situation. The Maternal Health Strategy provides clear strategic directions for reaching all women with the life-saving services. The Maternal Health Strategy for maternal health are basically a timely answer to that need. I congratulate the people who worked relentlessly for developing the much-needed guideline.

The SOPs for Maternal Health services will serve as a guideline for managers and workers providing maternal, newborn and reproductive health services in a structured way. This is of vital importance because service providers at different levels of the health system have different levels of skill and expertise, so a single source of procedural guidelines, when followed diligently, will help standardize the maternal and child healthcare.

Finally, I thank the development partners who have all along been part of this endeavor. I believe together we can help improve the lives of mothers and children of Bangladesh thus building a healthy, happy and prosperous country.

**G. M. Saleh Uddin**
Secretary, Medical Education and Family Welfare Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

# PREFACE

The National strategy for Maternal Health 2017-2030 is very important to achieve the Sustainable Development Goal by 2030. To implement this strategy, two standard operating processes has been developed.

The Maternal and Neonatal Health Standard Operating Procedures is a companion to the National Strategy for Maternal Health 2017-2030. Its purpose is to provide a standard framework to guide and facilitate the implementation of the National Strategy for Maternal Health.

The development of the National Strategy for Maternal Health and the Maternal and Neonatal Health Standard Operating Procedures was carried out by five Technical Sub-committees. Each Sub-committee guided the development of content for its area of focus: 1) Antenatal Care; 2) Labor and EmoNC; 3) Postpartum and Neonatal Care; and 4) Adolescent Health, Reproductive Health, and Family Planning. The fifth group was cross-cutting and addressed Management Information Systems (MIS), Quality Assurance (QA), Monitoring, and Supervision.

In total, more than 100 technical experts and professionals contributed to produce this strategy documents. The National Technical Committee managed the overall content review of each document and coordinated with the ministerial-level Steering Committee for final approval and endorsement. Congratulations all contributors for their outstanding and tireless efforts.

**Profs. Dr. Abul Kalam Azad**
Director General
Directorate General of Health Services

# FOREWORD

The development of the National Strategy for Maternal Health represents a great achievement. For the first time, a comprehensive, standardized set of evidence-based clinical guidelines for maternal and newborn health is available for providers across Bangladesh along with the strategy. The Maternal health strategy aims to promote state-of-the-art practices, as well as improve and harmonize the quality of maternal and child health services. The wealth of expertise that contributed to their development deserves tremendous recognition.

To ensure the health and well-being of all women and newborns, the Standard Operating Procedures must be available and accessible to providers at every level of the health system. This will ensure that they truly have national reach. To achieve what we want to achieve by 2030 – a maternal mortality ratio of 70 per 100,000 live births and neonatal mortality ratio of 12 per 1,000 live births – we have to work together. Among many other things, we need to continue improving the modern contraceptive prevalence rate, births in health facilities with skilled birth attendants, access to emergency obstetric and neonatal care, referral systems, and sexual and reproductive health services for adolescents. We also need to employ multi-sectoral approaches in order to reduce inequities and sustain access to quality services for the poorest families.

These goals are achievable. By employing the Maternal Health Strategy and Maternal Health Standard Operating Procedures, we can transform the lives of the next generation. Together, we can end preventable maternal and neonatal deaths and improve the quality of life for all Bangladeshis by implementing National Strategy for Metarnal Health.

**Dr. Kazi Mustafa Sarwar**
Director General
Directorate General of Family Planning

# MESSAGE OF THE DIRECTOR GENERAL
## Nursing and Midwifery

I am excited to see the National Strategy for Maternal Health getting published. I believe the strategy would help improve the quality of maternal health services and bring down maternal and newborn death rates in Bangladesh.

Over the last two or three decades, we have seen a significant expansion in the coverage of healthcare services but this progress has not been matched by improvement in the quality of care. As we all know, the last several years have witnessed a relatively slower rate of fall, especially in the maternal mortality rates.

Bangladesh has a vast network of healthcare centers spread across district, upazila, union level; but the provision and quality of care provided at the different levels of centers can vary significantly. It is important to ensure that there is a standard in the quality of care at all the levels and hence the need for the strategy. The strategy will guide for improving service provision of maternal health care as well as family planning, antenatal care, intrapartum care, emergency obstetric care, immediate newborn care, postpartrum care, adolescent and reproductive health care, prevention and treatment of cervical and breast cancer.

I understand the development of the strategy has taken the time of efforts of a large number of people. I thank them for their excellent work. I also thank my colleagues at the ministry as well as our development partners who have provided support to develop the strategy.

**Tandra Sikder**
Director General
Directorate General of Nursing and Midwifery

# PREAMBLE

Developing the Maternal Health Strategy has been a huge undertaking. A lot of time and resources have been employed to carry out the task. Five Technical Sub Committees (TSC) were formed by the National Technical Committee (NTC). More than 100 technical experts and professionals have contributed to the development of this national documents. The NTC will submit both documents to the National Steering Committee (NSC) for final approval and endorsement. It has been due to their hard work and expertise these documents are now seeing the light of the day.

A lot of people have been part of the development of this national documents. Naming them all would not be possible. But special mention has to go to the Director General of both the Directorate General of Health Services and Directorate General of Family Planning whose leadership proved critical to get on with the work. Finally, it was Dr. Mohammad Sharif, Director, MCH, DGFP, whose coordination played an instrumental role in making these document, happen in the first place.

Others who have directly or indirectly contributed to putting together these very important materials deserve our sincere and heartfelt gratefulness.

**Dr. Sultan Md. Shamsuzzaman**
Director, DGHS and Line Director, MNC&AH
Directorate General of Health Service

# ACKNOWLEDGEMENT

Bangladesh's achievement in the health sector, particularly in the area of maternal and child health, over the last two decades is internationally recognized. This is the result of effective implementation of the Health Nutrition Population Sector Program (HNPSP). General health consciousness of people has increased and so has access to and utilization of health care services by people. However, we are not contented with this performance. We still have a long way to go.

A combination of requirements has to be met to speed up progress in cutting down maternal and newborn mortality rate – access to skilled birth attendants, emergency obstetric care services, functional health facilities, strengthening supervision and monitoring with strong involvement of the community. The Directorate General of Family Planning is managing a large number of Mother and Child Welfare Centers and Union Health Family Welfare Centers that are mandated to provide a wide range of services, including maternal and newborn care services. The DGFP has recently launched a special drive to strengthen the UH&FWCs across the country to provide round-the-clock delivery and newborn care services.

I am confident that compliance with the SOPs would help standardize the maternal health service delivery at different tiers of the health system. I thank the MoH&FW for accomplishing the comprehensive SOPs. My gratitude also goes to the individual experts from many national and international development organizations whose hard work made the SOPs a reality.

**Dr. Mohammed Sharif**
Director, (MCH-Services) &
Line Director- MCRAH
Directorate General of Family Planning

# ACRONYMS

| | |
|---|---|
| **ANC** | Antenatal Care |
| **BCC** | Behavior Change Communication |
| **BDHS** | Bangladesh Demographic and Health Survey |
| **BEmOC** | Basic Emergency Obstetric Care |
| **BEmONC** | Basic Emergency Obstetric and Newborn Care |
| **BMA** | Bangladesh Medical Association |
| **BMDC** | Bangladesh Medical and Dental Council |
| **BMI** | Body Mass Index |
| **BMMS** | Bangladesh Maternal Mortality and Health Care Survey |
| **BNA** | Bangladesh Nursing Association |
| **BNC** | Bangladesh Nursing Council |
| **BNF** | Bangladesh Neonatal Forum |
| **BNMC** | Bangladesh Nursing and Midwifery Council |
| **BPA** | Bangladesh Paediatric Association |
| **BPS** | Bangladesh Perinatal Society |
| **BSMMU** | Bangabandhu Sheikh Mujib Medical University |
| **CBE** | Clinical Breast Examination |
| **CC** | Community Clinics |
| **CEmOC** | Comprehensive Emergency Obstetric Care |
| **CEmONC** | Comprehensive Emergency Obstetric and Newborn Care |
| **CES** | Coverage Evaluation Survey |
| **CG** | Community Group |
| **CHCP** | Community Health Care Provider |
| **CMSD** | Central Medical Stores Department |
| **CPR** | Contraceptive Prevalence Rate |
| **CSBA** | Community-based Skilled Birth Attendant |
| **CSG** | Community Support Group |
| **DEPB** | District Evidence-based Planning and Budgeting |
| **DGDA** | Directorate General of Drug Administration |
| **DGFP** | Director General of Family Planning |

| | |
|---|---|
| **DGHS** | Director General of Health Services |
| **DH** | District Hospitals |
| **DNS** | Directorate of Nursing Services |
| **DSF** | Demand Side Financing |
| **EPPM** | Ending Preventable Maternal Mortality |
| **FP** | Family Planning |
| **FWAs** | Family Welfare Assistants |
| **FWV** | Family Welfare Visitor |
| **GoB** | Government of Bangladesh |
| **HA** | Health Assistant |
| **HCFS** | Health Care Financing Strategy |
| **HMIS** | Health Management Information System |
| **HNP** | Health Nutrition and Population |
| **HNPSP** | Health Nutrition and Population Sector Programme |
| **HPNSDP** | Health Nutrition and Population Sector Development Programme |
| **HPSP** | Health and Population Sector Programme |
| **HR** | Human Resources |
| **HSS** | Health System Strengthening |
| **ICT** | Information and Communication Technologies |
| **IEC** | Information Education & Communication |
| **IMR** | Infant Mortality Rate |
| **IPMS** | Individual Performance Management System |
| **IUD** | Intra Uterine Device |
| **LBW** | Low Birth Weight |
| **LGD** | Local Government Division |
| **LLP** | Local Level Planning |
| **MCWC** | Mother and Child Welfare Centers |
| **MDG** | Millennium Development Goal |
| **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 |
| **MPDR** | Maternal and Perinatal Death Reviews |
| **MPDSR** | Maternal and Perinatal Death Surveillance and Response |
| **MTR** | Mid Term Review |
| **NGO** | Non-Governmental Organization |
| **NIPORT** | National Institute of Population Research and Training |
| **NMR** | Neonatal Mortality Rate |
| **OBGS** | Obstetrical and Gynaecological Society of Bangladesh |
| **OF** | Obstetric Fistula |
| **OPMS** | Organizational Performance Management System |
| **PHC** | Primary Health Care |
| **PMR** | Perinatal Mortality Rate |
| **PNC** | Postnatal Care |
| **PRSP** | Poverty Reduction Strategy Paper |
| **RMNCAH** | Reproductive, Maternal, Newborn Child and Adolescent Health |
| **SACMO** | Sub-Assistant Community Medical Officer |
| **SIAPS** | Systems for Improved Access to Pharmaceuticals and Services |
| **SOP** | Standard Operating Procedure |
| **SSK** | Shasthyo Shurokhsha Karmasuchi (Health Protection Scheme) |
| **STI** | Sexually Transmitted Infection |
| **TFR** | Total Fertility Rate |
| **TQM** | Total Quality Management |
| **UHC** | Upazila Health Complexes |
| **UH&FWC** | Union Health and Family Welfare Center |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Children's Fund |
| **USAID** | United States Agency for International Development |
| **WFHI** | Women Friendly Hospital Initiative |
| **WHO** | World Health Organization |

# INTRODUCTION

Over the past decades, Bangladesh has made significant progress in reducing maternal and child mortality and achieved MDGs 4 and 5. The momentum generated by this globally recognized progress presents an opportunity to further accelerate these achievements. From 2015, we have started our journey towards the goal of Sustainable Development goal.

The broad objective of the Bangladesh National Strategy for Maternal Health (BNSMH) 2017-2030 is to guide the Ministry of Health and Family Welfare (MOHFW) and the Government of Bangladesh (GoB) 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.

The Strategy upholds principles of rights and equity, acknowledges that efforts are needed for strengthening health system and enhancing managerial capacity at national and local levels, and call for co-operation among other government sectors as well as the private sector, both profit and nonprofit, and development partners.

The Bangladesh National Strategy for Maternal Health 2001 was developed based on the then health needs, commitments and knowledge. Over the last three decades, Bangladesh has undertaken newer strategies and policies in alignment with the MDGs, further national and international commitments have been made and new knowledge has emerged about effective interventions and policies for maternal and neonatal health. Most of these advancements have been incorporated into Health Nutrition and Population (HNP) sector programs and maternal health related plans. Through successive sector programs (HPSP, HNPSP and HPNSDP and Mid Term Review), the Government affirmed a strong commitment to maternal health and the focus moved towards newer directions. The Poverty Reduction Strategy Paper (PRSP), the National Adolescent Reproductive Health Strategy 2017 and the National Neonatal Health Strategy and Guidelines 2009 envisage the achievement of universal coverage with quality care for mothers and newborn babies.

Changing reproductive needs and behaviors, emerging evidence about effective interventions and service delivery modes and better understanding of the determinants of maternal health call for a new vision of how to achieve better maternal and neonatal outcomes and generate an increased awareness of the benefits of improved maternal health for the whole country.

The MoHFW initiated a process for updating the Bangladesh National Strategy for Maternal Health 2001, by ensuring wide participation in the process within the Ministry and outside, including professional bodies, development partners, UN organizations, international and national NGOs and institutions. The consultative process included review of program evaluation reports and global evidence on effective policies and interventions.

The Strategy is aligned to global commitments and initiatives such as the United Nations Secretary General's Global Strategy for Women's and Children's Health and its accompanying 'Every Woman

Every Child' initiative, the 'Every Newborn Action Plan', the 'Ending Preventable Maternal Mortality' initiative, and is complementary to 'A Promise Renewed', a global effort to accelerate action on maternal, newborn and child survival.

The Strategy also calls for the involvement of other sectors of the Government in adopting and implementing policies to address the underlying factors which impact on maternal and neonatal health outcomes. Investments in the earliest years, starting from pre-conception through early childhood yield the highest returns for the social and economic development of a society. Investments in maternal health should therefore be seen as a key development issue and consequently a whole-of-government concern.

Changes occurring in key social and economic dimensions such as urbanization, women's education, employment and status, income growth and distribution, are rapidly modifying reproductive and care-seeking behaviors with important implications for the planning of health services and particularly of the required workforce. The Strategy therefore needs to be conceived as a dynamic process requiring periodic review and updating.

This strategy moves from a situation analysis which acknowledges the progress made and identifies the challenges within and beyond the health sector (Chapter 1) to identify objectives, targets, guiding principles and main strategic directions (Chapter 2). The latter are then further elaborated and detailed by describing: the service delivery mode to provide maternal health services along the life course and across the continuum from community to facility level (Chapter 3); the key components of the health system that need to be strengthened (Chapter 4); the policies and interventions which are needed to reduce the inequities in health outcomes and access to care (Chapter 5), to improve the quality of services (Chapter 6), to foster community engagement (Chapter 7) and to promote inter sectoral collaboration and multi sectoral action (Chapter 8). Chapter 9 identifies steps and mechanisms for effective implementation, accountability and impact evaluation.

# CHAPTER 1

# SITUATION ANALYSIS

## 1.1 The Global Context: emphasis on a broader policy approach

Every year, complications from pregnancy and childbirth claim nearly 300,000 women's lives globally with an additional 3 million neonatal deaths and 2.6 million stillbirths[1]. Moreover, millions of women and children suffer long term consequences of poor maternal health and poor access to healthcare. The high maternal and neonatal mortality and morbidity in many parts of the world reflect gaps in coverage, equity and quality of health services as well as underlying adverse social conditions from poverty to low education, poor nutrition and gender discrimination[2]. Both maternal and neonatal outcome indicators show huge gap among and within countries.

In response to the persisting challenges, the UN Secretary General launched The Global Strategy for Women's, Children's and Adolescents'Health in 2015[3]. The strategy calls for better synergy and accountability among all involved partners and calls the governments to focus on country-led health plans, comprehensive, integrated packages of essential interventions and services, health systems strengthening, health workforce capacity building and integrated action between different sectors. WHO and the Partnership for Maternal, Newborn and Child Health developed a Global Review of Key Interventions related to RMNCH[4] and a Policy Guide for implementing, essential interventions for RMNCH strategies and plans[5]. The guide emphasizes the role of sectors outside health those have impacts on RMNCAH outcomes by affecting demand for and delivery of health services, such as Finance, Education, Social Welfare, Agriculture, Justice and others.

The 67th World Health Assembly (WHA) held in Geneva in May 2014 endorsed the Every Newborn Action Plan, the Ending Preventable Maternal Mortality (EPMM) initiative, and the Every Mother Every Newborn initiative focusing on access and quality of health services around child birth. A review of success factors which contributed to reduce maternal and child mortality globally, showed that maternal and child health outcomes are the result of enabling policies and interventions across all sectors.

## 1.2 Bangladesh: progress and persisting gaps

### 1.2.1 Maternal health

The country has made a significant progress in decreasing maternal mortality ratio (MMR) from 322 to 194 per 100,000 live births between 2001 and 2010[7]. However, as per UN estimate, the MMR has further reduced to 176 per 100,000 live births in 2015. This was mostly due to fertility decline, better care-seeking practices and improved access to higher level care, with contributing factors represented by improvements in women's education and employment, income and access to communication. The majority of maternal deaths are due to hemorrhage (31%) and eclampsia (24%), followed by obstructed or prolonged labor 3% (BMMS 2016)[21]. During the last 10 years, maternal deaths due to abortion, eclampsia and hemorrhage have dropped by 85%, 50%, and 35% respectively[8]. 73% of maternal deaths occur during postnatal period and 56% die within 24 hours of delivery indicating the importance of early postnatal care (PNC) to reduce maternal mortality[7]. As per the data of 2016, the cause of maternal deaths shows that though maternal deaths due to hemorrhage remained same, deaths due to eclampsia has increased by 4% compared to 2010. Death due to abortion has increased by 7 times. But death rate due to obstructed labor has decreased from 7% to 3%. Everyday around 15 mother dies due to maternal causes (MMR 176 per 100,000 LB).

Nutrition plays a crucial role in determining maternal health outcomes in Bangladesh. One third of Bangladeshi pregnant women are underweight and 42% of ever married women of reproductive age (15-49 years) are anemic[8]. A body mass index (BMI) of less than 18.5 is observed among 24% of ever married women of reproductive age, twice as much in rural compared to urban areas (14% vs. 28%)[8]. 13% of women in reproductive age are severely stunted (less than 145 cm) leading to prolonged/ obstructed labour, the proportion of which, out of the causes of maternal death has remained unchanged for a decade in Bangladesh[7]. Fifty percent of women suffer from iron deficiency anaemia and 2.8% from night blindness[(7)]. Thirty five percent of ever married women (15-49 years of age) live in an overall food insecure environment, whereas 65% of lowest wealth quintile are food insecure[8]. Though women's nutritional status has improved slightly over the years, maternal malnutrition still contributes to a high rate of maternal mortality and underweight babies. At the same time, overweight and obesity are increasing, thus contributing to Non-Communicable Diseases (NCDs) and pregnancy-associated metabolic risks.

Pregnancy and delivery complications bring an unacceptable burden on women in Bangladesh. Obstetric Fistula (OF) affects 71,000 women[9]. Dyspareunia and chronic pelvic infections cause disability, marital disharmony and loss of working ability. Infant mortality increases by 85% to 100% in case of childbirth that results in an OF[9]. The consequences also include depression, with high risk of death or developmental delay for the child and severe social repercussions, since a woman's value in society and her own sense of self worth is seen as related to her ability to bear healthy children and fulfill her role as a wife.

### 1.2.2 Neonatal health

Bangladesh has experienced a dramatic decline in infant (from 87 to 38 per 1,000 live births) and under-five mortality (from 133 to 46 per 1,000 live births)between 1993 to 2014, though the reduction in neonatal mortality is rather slow (from 52 to 28 per 1,000 live births)[8]. Sixty one percent of under-

five deaths and 73% of infant deaths occur during the first month of life. While under-five mortality (46 deaths per 1000 live births) continues to decline at a rapid rate, but neonatal mortality rate has been reduced only from 52 (1993) to 28 (2014) per 1000 live births[8]. The main causes of neonatal death in Bangladesh are birth asphyxia (21%), prematurity/low birth weight (11%), severe infection (34%), and acute respiratory infection (10%), showing that the majority proportion are preventable and curable causes[10]. Estimated number of still births is similar to the number of early neonatal deaths[1]. These figures suggest the existence of significant gaps in both obstetric and neonatal care.

The extent of low birth weight (LBW), a well known risk factor for neonatal and infant mortality as well as for adverse developmental outcomes, is not well documented since most women deliver babies at home, and neonates are rarely weighed. A survey conducted in 2004 revealed that 36% of neonates, one of the highest prevalence in the world, were LBW[11]. Although over 90% of Bangladeshi mothers continue breastfeeding their infants up to 20-23 months of life, initiation in the first hour of life, which is associated to neonatal survival, is only at 47%[8].

### 1.2.3 Reproductive health

After a decade-long plateau in fertility (1993-1994 to 2000) at around 3.3 children per woman, all subsequent surveys have shown decline in the total fertility rate (TFR), from 2.7 to 2.1 between 2007 and 2017[8]. Three out of five married women in Bangladesh use a contraceptive method, and more than half (54%) use a modern method. However, more than one out of three users of contraception has discontinued a method within 12 months of starting its use, and 2% of currently married women in Bangladesh have an unmet need for family planning services, 7% for limiting births and 5% for spacing births[8]. The high level of unwanted or unintended pregnancies results in a high proportion of MR procedures (653,000 MR procedures performed and 78,000 women treated for complications of MR in 2010), and in a high level of induced abortion (646,500 induced abortions in 2010, with an abortion rate of the 18.2 per 1,000 women aged 15-44 years. 231,000 women were treated for complications and an estimated 26% of all women seeking an MR at facilities were turned away, and about one in ten of those who had an MR were treated for complication(s)[12].

Cervical and breast cancer are the two most common cancers among women in Bangladesh, causing significant disabilities and deaths. Cervical and breast cancer screening programs has been implemented and Doctors, SSNs, FWVs and paramedics from 320 centers of 64 districts have been trained to perform visual inspection of the cervix with acetic acid (VIA) for cervical cancer screening and clinical breast examination (CBE) at service centres and referring screen positive women to different Medical College Hospitals (MCHs) and BSMMU for further evaluation and management.

### 1.2.4 Child marriage

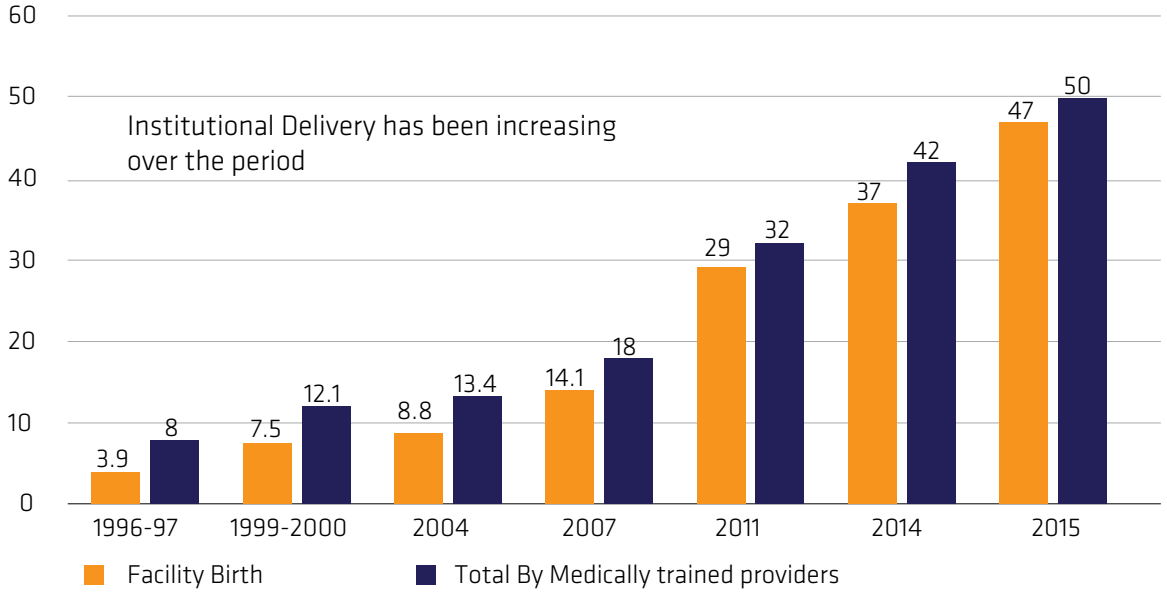
Childbearing begins early in Bangladesh, 41.4% women giving birth by age 18 and nearly 58% by age 20[13]. Adolescent pregnancies still pose significant challenges as one-fifth of adolescents in the country face the risks of early child bearing, mainly as a consequence of early marriage. 59% of adolescent girls (15-19 years) are married by age 18 and 21% by age 15[13]. The adolescent birth rate is very high (113 births per 1,000 women of age 15-19) which contributes to four-fold risk for maternal death with respect to the total population of women of fertile age[13]. Child marriage carries a series of adverse consequences

on women's health, newborn and child health, and represents a key issue to be addressed to make further progress in maternal health. Besides being a serious reproductive health issue, child marriage is a children's and women's rights issue, since it has deep social implications on female education and overall status.

### 1.2.5 Coverage gaps

There has been a modest increase in antenatal care (ANC) during the last decade. Currently, 64% of pregnant women received at least one ANC by a skilled health provider, and only 31% received four or more antenatal visits by skilled provider. The coverage is lower in rural (58.6%) and among poorest quintile women (35.6%) compared to the urban (78.8%) and the richest women (90%). Over the past ten years, the proportion of deliveries by medically-trained providers has tripled, from 13.4% in 2004 to 18% in 2007 and 42% in 2014[9]. As per Coverage Evaluation Survey (CES), 2015 SBA coverage has gone up to 49% and almost achieved MDG 5 target in 2015 (see figure 1).

**Figure 1. Trends in deliveries assisted by medically trained providers and in facility based deliveries from 1996-7 and 2014 (source: BDHS 1997-2014)**




The increase in medically assisted deliveries has been mostly due to an increase in institutional deliveries. However, the majority of births still occur at home and are mostly performed by unskilled individuals (63% BDHS 2014). Among the skilled delivery (37%, BDHS 2014), most are happening at facility level such as 38% in urban areas compared to 17% in rural areas. About half of the facility deliveries are held in the private sector (24.6%), whereas only 12.8% are happening at public facilities. The percentage of births delivered by C-section has been increasing over time, from 4 percent in 2004, to 9% in 2007, to 17% in 2011, and to the current level of 23% percent. In the recent survey the rate has increased to 31%. Urban women are twice as likely as rural women to deliver by C-section (38% in urban areas and 18% in rural areas). Among women with secondary or higher education and women in the highest wealth quintile, half of births were delivered by C-section.

Although three quarter of maternal deaths occurs during postnatal period, only 36.4% of women received postnatal care by a medically trained provider within two days of delivery[9] (urban at 56% versus rural at 29.5%). Among institutional births, 85.8% women received the first postnatal health checkup by a medically trained provider within the first two days after delivery. Only 5.4% women who delivered elsewhere received a PNC checkup by a medically trained provider, showing that the overwhelming majority of women receiving PNC receive it in health facilities[8].

### 1.2.6 Equity gaps

Bangladesh has been making progress in reducing the gap between the poorest and the richest women in the use of facilities for delivery, as shown by the BDHS findings. According to BDHS 2014, 15% of births in the past three years to women in the lowest wealth quintile were delivered in a health facility compare to 70% of births in the highest wealth quintile, a ratio of 1 to 5 [(8)]. The corresponding ratios in the BDHS 2004 and the BDHS 2011 among births in the three years before the survey were 1 to 13 and 1 to 6, respectively. Urban-rural and intra-urban inequities have been identified in all recent surveys.  For example MMR in Khulna division is 64, while it is 7 times as much as (425 per 100,000 live births) in Sylhet.

Women living anywhere other than slums are most likely to receive at least four ANC compared to women living in slums (58% versus 29%). Similar patterns are reported for institutional delivery, which is higher among women living in places other than slums (65%) than in slums (37%)[8]. Rapid urbanization is creating an unprecedented mix of opportunities and challenges. Easier communication and outreach combine with very poor hygienic and environmental conditions and a wide array of social problems including domestic violence.

### 1.2.7 Quality gaps

As coverage increases, poor quality remains a growing concern, since coverage without quality results in missed opportunities to improve outcomes, and lead to unsafe or delayed procedures and treatment and implies costs for both the system and the households. There is no systematic assessment of quality of maternal care in Bangladesh such as long waiting times, lack of cleanliness, short consultation time with providers, disrespectful care, irregular availability of drugs, unexpected costs of service were reported by a study[14]. Recent data from Maternal and Perinatal Death Surveillance and Response (MPDSR) showed that, 65% of neonatal deaths occur within the first six hours of birth, which points particularly to poor care at delivery. Market forces push towards increased, and often inappropriate, use of diagnostic and treatment procedures (e.g. cesarean sections) in private facilities where quality of care is yet to be addressed by the government.

Efforts to ensure quality of care in MNH services are still sporadic. Maternal and Newborn health care standards have been adopted from the global WHO MNH Standards, following the WHO Quality of Care framework and RMNCAH Quality of Care framework has also been developed. Initiatives have been undertaken to introduce MNH quality of care standards at facility and community level and periodic assessment by assessor team. Quality Improvement of MNH services through 5S-PDCA, accreditation of facilities through the Women Friendly Hospital Initiative (WFHI) by DGHS and UNICEF,

Standard-Based Management and Recognition (SBM-R), Maternal and Perinatal Death Surveillance and Response (MPDSR), Joint Supervisory Visit (JSV) are some of the on-going Quality Improvement (QI) initiatives for evidence generation and modeling for further scale-up.

## 1.3 Building on achievements to strengthen health system and promote multi-sector action

### 1.3.1 Achievements and persisting issues on the supply and demand side

Bangladesh is a globally recognized case of success in achieving progress in maternal and child health[16]. These progresses have been achieved through a combination of policies which dramatically changed the demand and supply of health services and had a direct impact on health related practices, particularly on reproductive behaviors. Policies which have been consistently adopted over the last decades to promote women's education, employment, and status have played a major role. Factors that have improved health coverage and outcomes include: i) implementation of community based approaches through investments in community health workers; ii) partnership agreements with NGOs to reach the most deprived populations; and iii) adoption of innovative technologies and interventions[17,18]. The infrastructure for comprehensive delivery care, including district hospitals (DH), upgraded mother and child welfare centers (MCWC) and upgraded upazila health complexes (UHC) has been created. GoB has started educating professional midwives, in two tracks, three years direct entry diploma course and post basic upgrades for existing nurse, midwives. In addition, CSBAs are being trained in safe delivery skills to provide greater coverage of community services and adequately skilled staff to an increased number of BEmOC and CEmOC facilities. Approaches to support demand through vouchers have been piloted in several areas of the countries. The NGO sector, one of the largest and the most dynamic in the developing world, has played a critical role in poverty reduction and in innovating approaches and in supplementing the efforts of the public sector.

However, as shown by data reported in the previous section, despite the progress in maternal health and a significant reduction in inequity, access to and effective utilization of essential reproductive maternal and neonatal services are still far from sufficient, and a significant proportion of women remains excluded from access to quality reproductive and maternal care. Issues to be addressed are both on the supply and on the demand side, and require action within and beyond the health sector.

On the supply side, the challenge is making the existing facilities adequately equipped, including energy, water supply and hygiene requirements and availability of skilled human resources. Initiatives have been undertaken to make selected upgraded UH&FWCs functional for conduction of 24/7 normal deliveries through a program to train FWVs in basic midwifery skills and ensure residency in the same facility. Although there has been considerable recruitment during the HPNSDP 2011-16 with vacancy rates declining to around 15% in 2014 (20% in 2011), the human resource/population ratio is still disproportionate. There has been a considerable push on training of Community Skilled Birth Attendants (CSBAs) and over 8,900 FWAs and Female HAs have been trained in public and private training institutions. Vacancies, poor retention at posts, absenteeism, inadequacy in required skills, and insufficient number of dedicated midwifes for normal delivery are the main challenges. CEmONC services are often non-functional in most of the designated UHCs due to unavailability of an obstetrician and anesthesiologist pair. After 10years of implementation, the CSBA program has

been only partially effective in increasing skilled attendance at home delivery. Government trained CSBA could perform better if given proper supervision and health system support, building on the experience of NGO-run CSBAs projects.

On the demand side, most births still take place at home, because many women have low decision-making authority about where to deliver their babies, leaving these critical decisions to husbands, mother in laws or other family members. Informed decisions on service utilization from reproductive services to antenatal, delivery and postnatal care are prevented by the low status of the woman within the family, low awareness and poor recognition of health risks, lack of information on available services and providers in the area. Direct and indirect costs of care are still too high for many women. Although several demand side issues depend on social, economic and cultural factors, health services can contribute to improve reproductive health literacy and generate demand for services by adequate communication strategies and materials, including the use of ICT, outreach activities, improved communication skills of health providers at all levels. Mechanisms, such as vouchers, community based insurance and subsidized care can overcome financial barriers and prevent catastrophic expenditure.

Ensuring adequate financial resources is a key issue to be addressed to achieve equitable and effective coverage for essential MNH interventions. Currently, Bangladesh spends 3.4% of GDP on health, which in per capita terms is US$ 16.2 (US$ 46 PPP) according to National Health Accounts 1997-2007. The main source of finance for total health expenditure is out-of-pocket spending by households (64%) followed by government spending (26%), and external resources (8%). Public/Government health spending is less than one percent of the GDP. Only 5.6% of the total government budget was spent on health in financial year 2011-12 and the budget allocation request for health stands at 4.87% in 2012-13 (MOF 2012). As acknowledged by the HNPSDP MTR 2014, the current level of government spending is not sufficient to ensure universal access to quality maternal health services.

Besides financial and human resource constraints, other factors causing bottlenecks in the supply of and demand for maternal health services include: i) lack of a coherent system to support equitable access to services among poor people; ii) insufficient managerial capacity, particularly at local level; iii) divide between family planning and health services which impedes functional integration and better use of existing resources; iv) lack of clearly defined and functioning referral system; and v) lack of regulatory and quality control systems and mechanisms.

### 1.3.2 Need for a whole-of-government, multi-sector approach

An increasing amount of evidence shows factors that have impacts on reducing maternal and child mortality include improving women's education, status and role in society, fertility control, poverty reduction, improved nutrition, improved living environments, as well as cross cutting dimensions such as good governance and innovation[6]. In Bangladesh, progress in many social determinants has contributed to the results achieved so far in reducing maternal and child mortality, but persistent gaps represent obstacles to further progress. Poverty still has a very important impact on access to services and maternal outcomes. One out of three women are undernourished, and consequently, at risk of adverse obstetric and neonatal outcomes. Illiteracy is still prevalent in over 40% of women with impact health related behaviors and utilization of health services. Adverse environmental conditions in some areas contribute to rapid urbanization and growing slum population. Gender also remains a key factor in access to food, as women are last to eat in the family and even in food secured families,

one in seven women is undernourished. Addressing malnutrition therefore implies a series of actions that go well beyond food security and nutritional education, to address gender issues and cultural norms. Low status of women within the family and society still contributes to low demand for services and poor service utilization.

Henceforth, this strategic document emphasizes the need to strengthen several key health system issues to deliver equitable and quality reproductive, antenatal, delivery and postnatal care. Calls for renewed efforts to address social determinants through engagement and collaboration of the whole government and calls for collaboration of all sectors of society, as indicated in the Perspective Plan of Bangladesh 2010-2021: Making Vision 2021 a reality.

## 1.4 Updating Bangladesh National Strategy for Maternal Health

The Government affirms its commitment to maternal health through successive implementation of the health sector programs: HPSP, HNPSP and HPNSDP with appropriate adoption and formulation policies and strategies. Through the successive sector programs, the focus in maternal health programs has moved towards newer dimensions and directions by adopting and adapting the emerging evidences and interventions to accelerate progress towards national and global targets, particularly the status of millennium development goals 4 and 5. National Health Policy 2011 embarks on reducing maternal and child mortality by 2021, improving maternal and child health as well as ensuring skilled delivery in all villages in Bangladesh. Furthermore, the Poverty Reduction Strategy Paper, National Adolescent Reproductive Health Strategy 2006 and National Neonatal Health Strategy and Guidelines 2009 envisage the priorities and strategies for universal coverage with equitable care for both mother and neonate. The growing evidences during the last few decades and the recommendations in World Health Report 2005 and The Lancet Maternal and Neonatal Survival Series and The Lancet Maternal and Child Nutrition Series 2008 & 2013 formed a strong basis for updating the Maternal Health Strategy 2001.

National Nutrition Policy, 2015 also envisage the priorities and strategies for universal coverage with equitable nutritional status of the people, especially disadvantaged groups, including mothers, adolescent girls and children; to prevent and control malnutrition which will contribute to survival and good health of women and adolescent girls

The Strategy sturdily recognizes the importance of a sector wide approach, partnership and collaboration in the implementation of the full range of maternal health components, including sexual-reproductive and neonatal health as integral parts. Annual and Midterm performance of HPNSDP identified program gaps and strongly suggested the four strategies i.e. i) skilled birth attendants at all births including community based skilled birth attendant (CSBA) training and services ii) promote institutional deliveries and iii) equitable access to EmONC services are central to all programs and interventions and

duly consider equity and quality issues as a strong point for designing and implementing programs in the coming years. Besides, the government showed strong commitment for addressing adolescence as a critical group for integrated nutrition, reproductive health and family planning services, which ultimately affect the maternal health and pregnancy outcomes.

The National Strategy for Maternal Health 2001 was developed based on the then health needs and commitments to the Alma Ata declaration and ICPD 1994. It was mostly focused on service delivery, awareness building, antenatal care, safe delivery, postnatal care and emergency obstetric care.

However, with growing evidences and global commitments, including the millennium development goals, the scopes for accelerating progress in maternal and neonatal health have been widen by adapting evidence based strategies and actions. During the past decade after the 2001 strategy, Bangladesh has already undertaken newer strategies and policies to align with the MDGs and other national and international commitments. These incorporations into the sector programs was done to adjust the inputs under sector wide approach (SWAP) and different maternal health related policy and evaluation findings: PRSP, National health policy, Neonatal health strategy 2009, and Adolescent Reproductive Health Strategy 2006, the Annual Performance Reviews (APR 2012) and Midterm Review (MTR) of sector programs etc.

Based on emerging needs and solutions in maternal health and grown national consensus, the Ministry of Health and Family Welfare initiated a process for updating the National Strategy for Maternal Health 2001. The ministry has ensured wide participation of stakeholders in the ministry and outside, including the professional bodies, development partners, UN organizations, international and national NGOs and Institutions in the process.

Thus, an updating of the strategy became necessary to address challenges by incorporating evidence based interventions and strategies towards achieving related MDGs. The current effort will incorporate the inputs from national programmers, development partners, UN, professional bodies and experts. The updating process will synchronize approaches in avoidance of duplication of program or resource investment. Innovations and research in the field will be considered in meeting gaps and scaling up. The updating also envisages integration of maternal, neonatal and child health across geographic, economic, social and equity differentials along with mainstreaming nutrition into maternal health program.

### 1.4.1 Steps undertaken

The updating process took series of reviews of program evaluation reports, evidence, strategy and policy documents by experts, technical group meetings and stakeholder consultative workshops for consensus building on critical issues and finalization. The table below summarized the key events in chronology.

**Table 1: The major steps followed during updating the Strategy 2001**

| Time | Events |
|---|---|
| Feb – May 2011 | DGHS-MOH&FW-Development Partners (DP) meeting for committee approval and developing action plan for updating BNHMS, 2001 approved by MOH&FW |
| Aug 2011 | National Consultation meeting at MOH&FW and decision taken for updating the 'Bangladesh National Strategy for Maternal Health 2001' |
| Oct 2011 | Formation of National Technical Committee and Five Technical Sub-Committees (TSC) to work on different strategic areas |
| Jul – Sept 2012 | Selection of TSC members, finalized Terms of Reference and working modalities; Reference documents collected and distributed to TSC members for review; Orientation of members of all five TSCs for working modalities, time line, and the Terms of reference |
| Oct 2012 - Dec 2013 | Meetings of five TSCs and sub-groups held, individual draft TSC output document prepared on strategy |
| Jan 2013 – November 2014 | Recruitment of five National Consultants for compilation of recommendations of five TSCs on strategy<br><br>Share the Draft 1 on Strategy with National Technical Committee for feedback and updated the first draft to draft 2<br><br>An international consultant collated and synchronized draft 2 upon consultation with MOH&FW, DGHS, DGFP, DPs, professional bodies and other stakeholders and preapared final draft of the strategy. Suggestions/ Opinions from expertise of regional and head offices of different international organizations |
| December 2014 to August 2015 | Broader Consultation at sub-national and national level for consensus building, external independent review by international experts and updating of the final draft |
| September - November 2015 | Endorsement of draft Strategy by National Technical committee and submitted to MOH&FW for final approval |
| January 2016 | Send to the MoHFW for approval |
| August 2016 | Approved by National Steering Committee, chaied by Hon'ble Secretary, MoHFW, with recommendations |
| December 2016 | Recommendations incorporated |
| May 2017 | National Technical committee Meeting held |
| September 2017 | Recommendations incorporated and approved by the MoHFW |
| January 2018 | Translation of strategy |
| December 2018 | Meeting at MoHFW for approval of the strategy |
| January - March 2019 | Correction of strategy as per recommendation |
| April 2019 | Final approval of the strategy by the ministry |

# CHAPTER 2

# GOAL, TARGETS, GUIDING PRINCIPLES & KEY STRATEGIES

## 2.1 Vision and Mission

### Vision

All Bangladeshi women will live with their heads held high, smiling in the fulfillment of their right to safe motherhood.

### Mission

To promote an enabling policy environment and nurture a socio-cultural movement that views the reduction of maternal mortality and morbidity as a fundamental women's right and a key developmental issue for the nation.

The experience in Bangladesh shows that reducing maternal and neonatal mortality and morbidity is both a product of and an entry point for key strategic women's rights issues, such as equity, disparity and violence. Strategies and interventions will therefore require a focus on enhancing a woman's status, dignity and self-esteem.

Efforts will foster a policy environment whereby all women enjoy the highest attainable level of health through adolescence, pregnancy, childbirth and beyond, free from long term suffering due to sequel of obstetric complications.

## 2.2 Goal and Targets

The overarching goal of the Bangladesh National Strategy for Maternal Health (2019-30) is to accelerate the reduction of maternal and neonatal mortality and to reduce the burden of maternal and neonatal morbidity.

To achieve this goal, the strategy aims at creating the conditions to make skilled attendants at birth available to all women, and equitable access to quality delivery care in appropriately equipped and staffed health facilities available to the highest proportion of women. To reduce risks and achieve the best outcomes for both mothers and babies, the provision of delivery care must be accompanied by the provision to all women of reproductive health services and of pre-conceptional, antenatal and post-partum care.

The strategy sets a series of key coverage and impact targets which are summarized in Table 1.

**Table 2: Key coverage and impact targets 2015 to 2030**

| Indicators | 2015-17 | 2020 | 2025 | 2030 |
|---|---|---|---|---|
| Institutional delivery | 47.1 % | 50% | 70 % | 85% |
| Deliveries attended by a skilled birth attendants (SBA) | 50%* | 60% | 80% | 90% |
| Four antenatal care (ANC 4+) from a medically trained provider | 37.2% | 50% | 80% | 100% |
| Postnatal care within 48 hours from a medically trained provider | 36% | 50% | 80% | 100% |
| Contraceptive Prevalence Rate | 62.5% | 75%* | 80%* | 85%* |
| Total Fertility Rate | 2.1 | 2.0 | 1.7 | 1.5 |
| MMR (per 100,000 live births) | 172*** | 145 | 100 | 70 ** |
| NMR (per 1,000 live births) | 17*** | 16 | 14 | 12 |

*Projected target based on The HPNSDP (2011-2016) and HPNSP (2017-2022) result framework

** Reduce MMR to 70 by the year 2030 according to Sustainable Development Goal (SDG)

*** Bangladesh Bureau of statistics (SVRS-2017)

## 2.3 Guiding Principles

The maternal health strategy followed nine guiding principles to emphasize key issues in the country context. The guiding principles has been applied to different key strategies to adopt holistic approach to achieve the overall improvement of maternal and neonatal health using a life cycle approach. The life cycle approach to health is a concept that emphasizes on prevention and early intervention at every stage of reproductive life. This strategy formulated seven key strategies including cross cutting themes like health systems strengthening, gender and equity.

BNHMS (2017-30) has formulated the following set of guiding principles mentioned below:

### 2.3.1 Ensure a continuum of care approach in delivering maternal health services

The health system should ensure access to evidence-based maternal and neonatal health care for all women along the different stages of the life cycle and full integration and adequate communication cross all levels of health service delivery structure, from outreach and community to facility.

### 2.3.2 Strengthen key components of the health system

Policies and plans will ensure adequate financing, improve managerial capacity at all levels, provide adequate training, deployment and retention of health professionals, adequate supplies and infrastructural facilities, and set an effective monitoring system complemented by operational research.

### 2.3.3 Enforce women's rights and improve equity

Maternal and neonatal heath service delivery will be fully responsive to the national commitment to women's and children's right to health. Discrimination against women and girls will be fought by eliminating child marriage and domestic violence, promoting gender equality for all program interventions. Hard to reach areas and urban slums will be prioritized. Participation of the disadvantaged and marginalized groups will be ensured.

### 2.3.4 Adopt mechanisms and build capacity to ensure quality of care

All public and private facilities should establish a system for continued improvement in quality of care using quality management frameworks and systems. The Standard Operating Procedures (SOP) will be the basis of all quality management and related regulatory mechanisms. Attention will be paid to ensure quality of care while increasing the coverage of essential interventions.

### 2.3.5 Promote innovation and operational research

Emphasis will be put on innovation in service delivery and communication strategies. Operational research will be promoted to build evidence on cost effective interventions to improve supply, and access to, and demand for health services.

### 2.3.6 Engage and empower communities

Community empowerment and engagement will be promoted as key to improving access and utilization of MNH services and ownership and sustainability of programs, mobilize resources and improve the accountability of health services. Communication activities will be instrumental to mobilizing individuals, families and communities and promoting community participation.

### 2.3.7 Foster partnership with the private sector

Partnerships with both the non-profit and profit private sector will be encouraged for complementing, supplementing and integrating programs and interventions, filling service gaps and avoid duplications. The contribution of the private sector to maternal health service delivery will be fully recognized, and a regulatory framework will be set and enforced to ensure equitable access and quality throughout the public and private service providers.

### 2.3.8 Institutionalize intersectoral collaboration and multi sector engagement

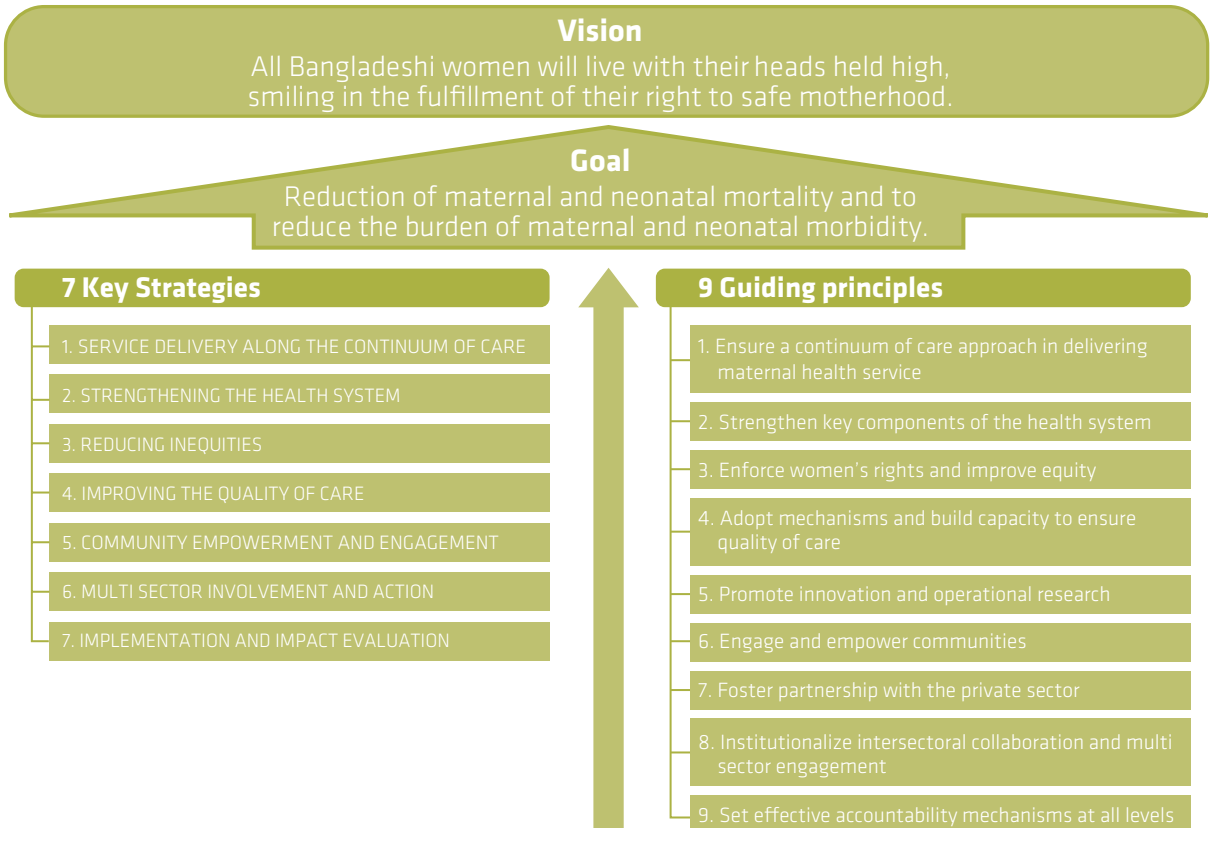
The Strategy will be a multi-sector initiative. The MOHFW will promote intersectoral collaboration and multi-sector Government involvement to address the underlying determinants of maternal and neonatal health. An ad hoc inter-ministerial mechanism will be established to coordinate and monitor action across sectors and ensure alignment with Government provisions and inform future sector plans and financial allocation.

### 2.3.9 Set effective accountability mechanisms at all levels

Mechanisms will be established to ensure accountability at all levels, from the Government to the community, and will include input and output indicators, timelines and responsibilities. The impact of the strategy on coverage, equity and quality of services and achievements with respect to targets will be assessed periodically, and aligned with sector wide reviews.

## 2.4 Key Strategies

1. SERVICE DELIVERY ALONG THE CONTINUUM OF CARE
2. STRENGTHENING THE HEALTH SYSTEM
3. REDUCING INEQUITIES
4. IMPROVING THE QUALITY OF CARE
5. COMMUNITY EMPOWERMENT AND ENGAGEMENT
6. MULTI SECTOR INVOLVEMENT AND ACTION
7. IMPLEMENTATION AND IMPACT EVALUATION



# CHAPTER 3

## KEY STRATEGY 1
## SERVICE DELIVERY ALONG THE CONTINUUM OF CARE

This strategic document calls for ensuring universal access to, and utilization of a comprehensive and integrated maternal and newborn care package of interventions along the different stages of life cycle and across the different levels of health systems.

## 3.1 Continuum along the life cycle

Preventive and curative interventions to be delivered by service levels and stages are summarized in annex 1. Programs need to ensure continuity of interventions along life stages to maximize benefits. Information from medical records should be retrievable at any service delivery point to ensure continuity and consistency of care. Information system and tools, such as maternal health cards should allow information keeping relevant to each stage.

### 3.1.1 Adolescence care

Insufficient progress has been made on prevention of child marriage, early pregnancy, unsafe abortion, violence and promotion of healthy reproductive behaviors among adolescents. Both girls and boys need to be addressed with gender-focused and youth-friendly approaches, in collaboration with the educational sector and communities. ICT and social networks will be used to disseminate information and promote healthy behaviors.

**Table: 3.1.1 Adolescence care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| A comprehensive costed Plan of Action on National Adolescent Health Strategy, 2017-2030 with special focus on Adolescent Friendly Health Services, nutrition, family planning, care-seeking and promote Adolescent Sexual and Reproductive Health Rights | | | |
| Establish hot-lines and contact points to avoid stigma and to address adolescent sensitivities and need for confidentiality | | | |
| Strengthen approaches to reach adolescents, with greater engagement of boys, through school based programs and peer-to-peer groups. Life skills education should be inclusive for both school and out of school adolescents | | | |
| Provide training for service providers, including skills and attitude to provide adolescent friendly services | | | |
| Start and scale up Human Papilloma Virus (HPV) vaccine for adolescent girls to prevent cervical cancer, integrate selected adolescent health interventions with HPV | | | |

Related documents: National Strategy for Adolescent Health, 2017-30 and 'National Plan of Action 2018-2030'

### 3.1.2 Pre-conceptional and Antenatal Care

Pre-pregnant women's health needs include screening for malnutrition, iron and folate supplementation, immunization against tetanus, HBV and HPV vaccines, FP counseling, prevention of HIV/AIDS, STIs and congenital anomalies. Pre conceptional care needs to be incorporated in training

curricula and job description of community workers and health professionals. ANC is the first service contact between mothers and health systems which provides opportunities to deliver a package including health education/counselling, identification of complications, monitoring the well-being of both mother and fetus, and referral when indicated. The strategy recommends a minimum of four ANC visits by a medically trained provider, a birth preparedness plan and promoting facility based care. Screening, management and/or referral for conditions responsible for indirect obstetric deaths will be introduced.

**Table: 3.1.2 Pre-conceptional and Antenatal Care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Ensure iron and folic acid and calcium supplementation | | | |
| A minimal package of ANC should be introduced for all frontline health workers | | | |
| FWVs and/or midwives working at UH&FWCs should conduct ANC sessions at the outreach centers (preferably at CC) and ensure advance notification of pregnant women and follow-up for drop outs | | | |
| Pregnancy registration of all pregnant women with mobile number should be ensured (e-tracking) | | | |
| Birth preparedness plans should be discussed with pregnant women and her families | | | |
| Access enhancing strategies for community clinic-based ANC, including fixed days and visible identifier for service should be established | | | |
| Follow-up and reminder for subsequent ANC visits through call centre and household visits by frontline health workers to ensure default tracking is ensured | | | |
| Strengthened outreach and communication strategies for urban slums, hill-tracts and other hard to reach areas should be ensured | | | |
| Standard Operating Procedures for screening, management, referral and counseling for conditions responsible for indirect obstetric deaths and delivery complications should be implemented | | | |
| Integration of postpartum family planning during antenatal visit by providing appropriate counselling on family planning methods | | | |

### 3.1.3 Delivery Care

Skilled attendants at delivery and emergency obstetric care have a pivotal role in maternal and neonatal health and survival. The strategy focuses on universal skilled care at child birth with emphasis on institutional delivery, which facilitates immediate lifesaving management for newborns and mothers.

Cultural beliefs as well as perception of poor quality and high cost need to be addressed. An enabling, safe infrastructural environment for both mothers and providers will be a priority. High coverage of ANC and skilled attendants at delivery can be achieved at the Union level through deploying and ensuring residency of three FWV/Paramedics at these centers. The strategy promotes provision of 24/7 normal delivery care at UH&FWCs with referral linkage with UHCs or District Hospitals. UHCs will provide normal delivery care in addition to their role as referral centers. Strengthening union level facilities will reduce the burden of normal delivery care at the UHCs and above. The number of union level facilities to provide 24/7 delivery care in an UHC will be defined based upon population density and access issues. CSBAs conducting deliveries at home should be considered as a transition strategy until all childbirths will occur at health facilities. In response to increasing community demand, selected Community Clinics (CC) can be upgraded to provide normal delivery care. All human resources, infrastructural and clinical standards as delineated in the SOPs should be strictly followed, while considering CC for provision of delivery care. UHC placed at strategic locations should be upgraded for BEmONC and CEmONC, with appropriate human resources, infrastructure and equipment. CEmONC services will be strengthened and expanded using locally adopted best practices for 24/7 availability and accessibility. These facilities should be backed up with emergency referral transport.

**Table: 3.1.3 Delivery Care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Emphasis will be given to institutional delivery including facility readiness with skilled providers, infrastructure, and equipment and referral linkage to higher facilities | | | |
| Union level health facilities (USC, UH&FWCs) will be upgraded and strengthened to provide 24/7 essential delivery and newborn care with referral linkage to EmONC centers | | | |
| Deployment of midwives for union, upazila and district level facilities, and rotation for midwives posted at UH&FWC to high volume facilities to learn case-management of complications will be ensured | | | |
| Targets will be set for facility delivery considering facility capacity, availability of skilled HR and distribution of facilities of each upazila | | | |
| Differential strategies will be set for urban slums, hill tracts and other hard to reach areas, with CSBAs considered as a primary option for hard to reach areas | | | |
| Follow up through CSBA and other community workers of delivered women and newborn after discharge from facilities will be ensured | | | |

### 3.1.4 Postnatal Care

The postnatal package includes care of both mother and newborn to promote FP, healthy behaviors and nutrition, identify complications and facilitate timely referral for treatment. All women must receive an early PNC visit either at home or a facility, irrespective of birth place or birth attendant. Since

PNC coverage is currently very low, the strategy envisages notification of delivery, both at facility and home, so that health services can plan and ensure comprehensive PNC visits.

**Table: 3.1.4 Postnatal Care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Institutionalized system set up for delivery notification (mobile phone, notification slip) to health authority and union based micro-planning to ensure early PNC visit | | | |
| First postnatal visit provided at the place of delivery and comprehensive counselling offered to women and her families before discharge from facilities | | | |
| Comprehensive postnatal care package integrating maternal, newborn, child , nutrition and family planning components to be delivered | | | |
| Integration of postpartum family planning by providing quality counselling on family planning methods during PNC visit and immunization | | | |
| Postnatal care, irrespective of place of delivery, provided at home to all women by trained providers, in case families fail to seek care from the facilities | | | |
| Strengthened outreach and communication strategies to be ensured for urban slums, hill-tracts and other hard to reach areas | | | |
| Referral linkage ensured to manage complications of the mother and the newborn | | | |
| Specific week day identified and announced across the country when specific maternal health services like ANC and PNC can be provided from service delivery points like CC, UH&FWC and UHC and NGO-run clinics | | | |

Related documents: National Neonatal Health Strategy and Guidelines

## 3.2 Continuum of care across levels

Continuity of care across levels is necessary to ensure consistency of case management, timely management of complication as well as effective communication links. Women need to be facilitated in their access to facilities, particularly when referral is necessary. Continuity of care is also needed for the appropriate management of pregnancy and delivery related morbidity.

### 3.2.1 Community level services

Field staff Health Assistants (HA) and Family Welfare Assistants (FWA) provide MNH services through home visitation and outreach activities. Community Health Care Providers (CHCP) have been deployed

at 13,500 revitalized CCs to deliver MNH services at the doorstep of the community. Moreover, about 8500 FWAs and female HAs have been trained as CSBA to provide home based antenatal care, safe delivery and immediate newborn care and referral services. The 'Community Group' and the 'Community Support Group' will work together for promotion and utilization of MNH services and early referral using referral hubs. Postnatal cares (home-based and in CCs) should be delivered by community micro-planning as a routine practice to ensure 100 percent coverage of essential interventions.

The CCs are engaged in provision of basic MNH services as outpatient centres. Basic services include informing women and their families on pregnancy and delivery related health risks, assisting them in managing health risks, and developing a birth and emergency plan, including access to emergency transport, funds and communications. They also include counselling on birth spacing and family planning services, couple registration, listing of pregnant women, early detection and referral of high-risk pregnancies, and reporting of maternal and neonatal deaths. The providers should ensure provision of MNH services as well as postpartum follow-up care for mothers and their babies. Every birth should be notified to the nearest health facility or designated provider.

Use of CSBAs will be considered as an interim option with major focus on hard-to-reach areas only, and will require adequate support (supervision, mentoring, logistics, line management, reporting, quality assurance, upward referral linkage and support). Experiences and lessons learnt from the private CSBA programs should be reviewed and the best practices and lessons incorporated.

**Table: 3.2.1 Community level services**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Family Welfare Visitors (FWV) to conduct planned outreach services to provide antenatal care and promote facility based care | | | |
| CHCPs to be trained to conduct community micro-planning (involving key Community Support members) to ensure 100 percent coverage and to increase utilization among the catchment area population | | | |
| CHCPs should be trained to provide quality antenatal care and referral (female CHCPs are now receiving CSBA training) | | | |
| Community clinics (CC) will be better equipped and upgraded according to SOPs to community hubs for Behavior Change Communication (BCC), health promotion, initial screening, early referral and follow-up services. Selected CCs can be upgraded for delivery services in selected areas with specific needs | | | |
| CSBAs (public and private) to operate in hard-to-reach areas only and to be linked to respective UH&FWC for reporting, mentoring, refresher training and coordination | | | |

### 3.2.2 Facility based services

The operation plans under HPNSDP are designed to deliver MNH services, including the signal functions by two levels: Basic Emergency Obstetrics and Newborn Care (BEmONC) and Comprehensive Emergency Obstetrics and Newborn Care (CEmONC). Facilities need to be adequately equipped and staffed according to SOPs from primary to tertiary level. MOHFW emphasized the need to strengthen, expand and sustain an adequate number and strategically located CEmONC UHCs. District hospitals work as referral centres for obstetric and neonatal emergencies and will have 24/7 CEmONC services. MCWCs provide selective EmONC services including caesarian sections and refer complicated cases to district hospitals and medical college hospitals.

### 3.2.2.1 Basic Emergency Obstetric and Newborn Care

A BEmONC facility with skilled health professionals is capable of delivering the seven signal functions as per SOPs. At the minimum, these tasks can be performed by a midwife who is either under supervision by a medical doctor, or has referral arrangements with a hospital or doctor trained in the management of maternal and newborn emergencies. UHCs, selected UHFWCs and private/NGO clinics will be strengthened to provide 24/7 Basic EmONC services and will be equipped with necessary skilled health professionals such as doctors, nurses, midwives and medical technologists, infrastructure and equipment. BEmONC shall be supported by emergency transport and communication facilities.

**Table: 3.2.2 (A) Basic Emergency Obstetric and Newborn Care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| 24/7 B-EmONC made available from UHCs within 1 hour travel time (considering seasonal variation) from every household, with services provided by appropriately trained Senior Nurses, FWVs or midwives | | | |
| All facilities will be linked with appropriate referral support (including transport) with a C-EmONC facility | | | |
| For each BEmONC facility, designated technical consultation support will be available | | | |

### 3.2.2.2 Comprehensive Emergency Obstetric and Newborn Care

A CEmONC facility is capable of performing the nine signal obstetric functions, including caesarean delivery services, blood transfusion, and other specialized obstetric interventions. It is also capable of providing newborn emergency interventions like newborn resuscitation. All Medical college hospitals, 62 DH and GH and 132 UHCs are providing CEmONC services. MCWC provide selective EmONC services including conduction of caesarian section and refers complicated cases to district hospitals and medical college hospitals because of limited skilled human resources.

**Table: 3.2.2 (B) Comprehensive Emergency Obstetric and Newborn Care**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Facilities (MCH, DH, MCWC and strategically located UHCs) providing 24/7 CEmONC to be made available within 2 hour travel time (considering seasonal variation) from every household | | | |
| Mapping, using GIS and other methods, of optimum numbers of upazila and district based CEmONC facilities to be undertaken in all districts based on experience in 24 districts | | | |
| Infrastructure and HR capacity assessment of MCWC to be carried out to identify needs to provide 24/7 CEmONC | | | |
| Exchange of skilled HR among health facilities run by DGHS and DGFP to ensure availability of CEmONC, if shortage of a specific HR occurs | | | |
| Monitoring mechanisms in place to ensure 24/7 availability of designated service providers at the CEmONC facilities | | | |
| CEmONC facilities standards to include a minimum number of pairs (2 pairs for UHC, 3 pairs for district hospital) of obstetrician and anesthesiologist (or appropriately trained Medical Officer), a trained pediatrician and 24/7 blood transfusion facilities | | | |
| The quality improvement committee will improve the quality of the maternal health services and facility maternal and perinatal death surveillance system will be in place to develop action plan | | | |

### 3.2.3 Referral system

The existence of a referral system linking the different levels is crucial to ensure continuum of care and timely and effective management of risk conditions and complications. A fully functional referral system includes: i) clear criteria for referral to a higher level; ii) communication mechanisms including medical records, ideally to be ensured through ICT; iii) periodic meetings and audits conducted to revise criteria, ensure consistency of case management across levels, perform critical case reviews; iv) an emergency transport system.

**Table: 3.2.3 Referral system**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Formal arrangements/communication mechanisms/ referral criteria and protocols developed | | | |
| Extensive transport network to facilitate referral (referral hub, persons to network families and providers) | | | |

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Community and local government supported transport systems promoted to help vulnerable families reach appropriate health care facilities | | | |
| National ambulance services run by government or in collaboration with the private sector supported by hot-line or call centers to be explored | Pilot | | |
| Pre referral case-management protocols at lower level facilities (UHC, UH&FWC) to facilitate referrals | | | |
| Facilitation services at referral facilities (referral staffs at facility, hand-holding, use of NASG) needed to reduce delays in case management | | | |

## 3.3 Issues to be fully incorporated in the continuum of maternal health care services

### 3.3.1 Maternal morbidity

There is need for further preventive and treatment facilities to strengthen capacity for raising awareness, training, identification and rehabilitation. Currently there is only one regional fistula training, treatment and rehabilitation centre in Dhaka. Fistula prevention and treatment services are provided mainly at Medical college level. Uterovaginal prolapse is another common complication which needs to be addressed by proper management of labor and postpartum period, and better family planning. Cervical and breast cancer screening programs have been implemented and Doctors, Senior Nurses, FWVs and paramedics from 320 centers of 64 districts have been trained to perform visual inspection of the cervix with acetic acid (VIA) for cervical cancer screening and clinical breast examination (CBE) and referring positive women for further evaluation and management. However, both public awareness campaigns and screening procedures need to be expanded, including the establishment of a larger network of referral centres.

**Table: 3.3.1. Maternal morbidity**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Prevention of sequelae such as fistula and Uterovaginal prolapse to be fully integrated into management of normal labor and delivery | | | |
| Capacity for management of obstructed labor/prolong labour in district and upazila level to prevent obstetric Fistula | | | |
| Capacity for diagnosis of cervical and breast cancer to be improved, registry established, and an adequate network of referral centres established | | | |

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| New treatment site at all medical college hospitals and rehabilitation centres for obstetric fistula to be established | | | |
| Technology and operational research to be promoted on maternal and reproductive related morbidities | | | |

### 3.3.2 Family planning

The GoB has been implementing family planning programs through a nationwide community and facility based FP service delivery system extending to the domiciliary level. FP activities need to be fully integrated and protocols harmonized to be effectively and efficiently delivered at the community level. FP programs will strengthen prevention of early childbearing, healthy timing and spacing and emergency contraception to avoid unwanted pregnancies. FP counseling should consider a woman's needs, based on family size and fertility intention, and providers should provide options to choose a method of their preference.

**Table: 3.3.2 Family Planning**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| FP activities at the community level and related protocols to be fully integrated and harmonized with MNH activities, including postpartum care | | | |
| Emphasis on postpartum family planning (IUD, tubectomy) through building capacity of service providers (doctors, nurses and FWVs) | | | |
| FP issues to be further addressed by community approaches and communication strategies, including the media | | | |
| Where possible and appropriate, service delivery should be functionally integrated among DGHS and DGFP | | | |

### 3.3.3 Menstrual regulation

Menstrual regulation has been included as one of the method for family planning. It is worth mentioning that unsafe abortion, with its burden of complications, needs to be addressed primarily on the prevention side, by reducing unwanted or unintended pregnancies through better access to different methods of family planning (FP), and on the case management side, through information and service delivery modes which ensure that safe procedures and effective management of complications are widely available and free of charge. Menstrual Regulation (MR) procedures need to be phased out as a measure of birth control.

**Table: 3.3.3 Menstrual Regulation**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Post Abortion Care (PAC) made accessible at all B-EmONC facilities including linkage with specialized centers for reproductive problems and supply of equipment (MVA kits, misoprostol and antibiotics) for proper management of complications | | | |
| Inclusion of Misoprostol in essential drug list, and approval for use for MR | | | |
| Strengthen MR services in health facilities managed by DGHS | | | |
| Improved integration of FP counseling in post abortion care | | | |
| Strengthened work at the community level to raise awareness and increase the use of PAC services | | | |

## 3.3.4 Services for HIV positive women

This service delivery model is articulated in the National Guidelines for the Prevention of Mother to Child Transmission (PMTCT) of HIV and congenital syphilis, and takes into consideration the characteristics of the HIV/AIDS epidemic in the country. The delivery approach combines targeted intervention for women in specific population groups through existing programs and providers with universal coverage of services for pregnant women in targeted geographic settings with high HIV prevalence.

**Table: 3.3.4 Services for HIV positive women**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Integration of PMTCT with ANC services as envisaged in the national PMTCT guideline | | | |
| Services for HIV positive women need to be available in the public and private health facilities | | | |

[Related documents: National Guidelines for the Prevention of Mother to Child Transmission of HIV and congenital syphilis in Bangladesh]

## 3.3.5 Nutrition

The strategy will mainstream nutrition along the life cycle through integrated program interventions and inter sector collaboration, starting at the ministerial level and reflected at the community level. The intergenerational malnutrition cycle needs to be broken by strategies to improve nutrition of adolescent girls, women, infants and young children by improving both food security and nutrition literacy.

**Table: 3.3.5. Nutrition**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| **Mainstreaming of nutrition at all service delivery points** | | | |
| Appropriate nutrition counseling for adolescent, pregnant and lactating women | | | |
| Nutritional supplements provided at primary and secondary school | | | |
| Nutritional education offered at secondary school | | | |
| Community based food security plans at outreach | | | |
| Nutritional surveys to identify at risk cases and monitor achievements | | | |
| Capacity of CCs to be strengthened to ensure that they become first-line community based centers to provide promotional, preventive and first-line curative nutritional care | | | |

[Related documents: National Nutrition Policy]

## 3.3.6 Violence against women

Violence against women and girls is a pervasive human rights violation that devastates lives, fractures communities, and stalls development. In collaboration with the Ministry of Women and Children Affairs (MOWCA), MOHFW will carry out expansion and strengthening of the one stop crisis centers to serve the affected women. Capacity of health care providers should be built to pay special attention to women who are victims through psychosocial counseling, medical service and linkage with legal aid support. Based on lessons learnt and experiences, these could be scaled up.

**Table: 3.3.6 Violence against women**

| Strategic Directions | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Scaling up of Women Friendly Hospital Initiative(WFHI) to ensure medical service, psychosocial counseling and linkage with legal support for the women victim of violence | | | |
| One stop crisis centers expanded and integrated with WFHI | | | |
| Awareness and capacity to detect violence against women built through CG, CSG and frontline workers of DGHS and DGFP in coordination with other ministries such as MOWCA and Ministry of Social Welfare | | | |

[Related document: Women Friendly Hospital Initiatives Guidelines]

# CHAPTER 4

KEY STRATEGY 2

# STRENGTHENING THE HEALTH SYSTEM

The implementation of the maternal health service delivery model and related strategic directions described in this document require that all health system components are strengthened. With reference to existing national plans, provide strategic directions to ensure enabling policy environments in key components of health system.

## 4.1 Governance and Management

### 4.1.1 Coordination between DGs Health Services and Family Planning

Maternal health care services are provided by both DGHS and DGFP. An effective coordination mechanism must be in place, from national to community level, to avoid duplication of efforts, services and sharing data as well as a joint action plan to improve the situation to ensure full utilization of the available services. This duplication in service provision poses a challenge for implementing efficient referral networks, quality assurance, supervisory support, and data recording and reporting with lack of systems for triangulation at all levels.

**Table: 4.1.1 Coordination between DGs Health Services and Family Planning**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Ensure data sharing, integration of information platforms and triangulation between DGFP and DGHS | | | |
| Ensure joint development of standards for capacity building and quality assurance including joint development and revision of curricula and inclusion of all providers in relevant training programs | | | |
| Coordinate the utilization of human resources available at both DGFP and DGHS for efficient MNCH service provision | | | |
| Harmonize BCC messages, tools and approaches | | | |

### 4.1.2 Decentralized Planning and Management

In Bangladesh, funding allocation and budgets for district health systems have always been centrally managed. Local managers lack the capacity to analyze data, and take action for local priorities. Effective implementation of the strategy will require, and at the same time will support, the implementation of District Evidence-based Planning and Budgeting (DEPB) to strengthen district and upazila health systems response focused on local needs. DEPB is inclusive of differential programming and resource allocation to narrow the equity gap between poor and rich, urban and rural populations and between geographic regions and ethnic strata. Systematic analysis of bottlenecks to identify appropriate correction action has been introduced by MOHFW, UNICEF and WHO to develop Evidence based MNCH Plans (also known as LLP) should be scaled up in districts/upazilas after customizing lessons learnt and wide stakeholder participation, to achieve effective MNCH coverage. Capacity of the district/ upazila managers have been built to identify, analyze and prioritize problems in their local context and identify solutions.

**Table: 4.1.2 Decentralized Planning and Management**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Consolidate learning from evidence based MNCH planning experience of MoHFW and UN agencies to harmonize and use updated Evidence Based Planning toolkit for nationwide use | | | |
| Ensure necessary decentralized financial and administrative authority delegated to local health managers | | | |
| Institutionalize capacity building of health managers on planning and management | | | |

### 4.1.3 Supply and Logistics

This strategy focuses on more effective and efficient logistic systems through reduction of distribution times, minimizing system losses, establishing management control, installing greater accountability and generating regular and reliable inventories. An improved coordinated procurement and distribution system is required to minimize stock outs, motivate employees and improve client confidence in facility and community care. With support from USAID, the SIAPS project is an online tracking system for tracking stock status, the scope of which is now being enhanced to reach up to the levels of service delivery points. This will help tracking procurement status and inventory for goods (medicines, equipment etc.) in CMSD. An effective coordination between the CMSD and Line Directors should improve performance in procurement and logistics management. DGHS and DGFP will explore and coordinate alternate and decentralized procurement systems for meeting the needs at local level. The logistics and supply mechanism under both directorates will be strengthened to ensure availability of commodities, which includes contraceptives, DDS kits, Medical and Surgical Requisites (MSRs) forms, registers and equipment. The logistics management information system need to be linked with HMIS with real-time interfacing.

**Table: 4.1.3 Supply and Logistics**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| DGHS and DGFP to coordinate procurement systems and strengthen logistics and supply mechanism to ensure availability of all relevant commodities | | | |
| Fully automated logistics/asset management systems should be functional from the service delivery points at all levels | | | |

# 4.2 Resource Allocation and equitable financing

## 4.2.1 Resource allocation for MH

Adequate financial resources are critical for improving and sustaining the delivery of MNH health care. Additional resources will be needed to fund critical investment requirements. The magnitude of the challenges of scaling up and financing health services to establish universal coverage should not be underestimated, nor the burden put on families by health care costs. It has been estimated that 4-5 million people per year are pushed into poverty because of health care related costs.

Equitable access to essential interventions will not be achieved with the current government expenditure on health. This strategy, in accordance with recommendations of the HPNSDP MTR, strongly urges to review current public and private health expenditure, with a view to increasing per capita expenditure so that a greater proportion of the population including the vulnerable section has access to the essential MNH and EmONC package of health services. The improvement of EmONC facilities, especially designated UHC and MCWC, will require additional resources.

## 4.2.2 Equity focused schemes

User fees should be abolished or kept low enough as not to exclude any mother or child in need, and protecting all mothers and children against the financial hardship that may result from paying for care. The Health Care Financing Strategy (HCFS) 2012-32 proposed specific interventions to generate more resources, improve equity and increase health care access especially for the poor and vulnerable. The HCFS has proposed to introduce a national social health protection scheme that targets the formal sector with mandatory payroll taxation, subsidizes people below the poverty line, and allows the non-poor informal sector to join the scheme voluntarily. Proper steps should be taken to ensure complete financial coverage for all essential maternal health services under these schemes. The HCFS also recommended scaling up demand side financing schemes like maternal health voucher scheme, introduction of performance-based-payments and need-based resource allocation. MOHFW should advocate for an additional share from the national budget and implement all interventions recommended by the HCFS.

**Table: 4.2.2 Equity focused schemes**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Revise the current and future public health expenditure to ensure equitable access to the essential MNH packages of health services | | | |
| Introduce health protection schemes for the poor population based on lessons learnt from different models of community health insurance schemes | | | |
| Scale up conditional maternal health vouchers based on review of demand side financing programme | | | |

## 4.3 Human Resource Development and Management

### 4.3.1 Human Resource plan for MNH

The availability of a quantitatively and qualitatively adequate workforce represents the greatest challenge to be addressed to implement the MHS. An essential requisite is to develop and adopt a HR strategy and corresponding plan, and an integrated human resource information system, as recommended by the HPNSDP MTR. An HR strategy and plan for MNH should encompass all the health workforce issues including financing, recruitment, deployment, transfer, promotion, career planning, monitoring and capacity building. It should be based on analysis and projections regarding work load, geographic and socioeconomic equity determinants for service delivery. Such a plan should first set the baseline of current availability of the various health professionals, look at current training capacity and output, then develop projections of future needs, taking into account the current shift from home deliveries without skilled attendants to home deliveries with SBA and to institutional deliveries, and be aware that the intermediate step may be bypassed due to rapidly changing care seeking behaviors and provision of delivery services by the private sector.

Since recruitment and retention continue to present major challenges, the HR plan should cover gender-sensitive employment, deployment, capacity building/training and incentives for working in hard to reach areas, and take into account the rapid changes which are occurring in access to institutional deliveries and the requirements of the health professionals needed at the various levels of the system.

Annex 2 and SOPs provide standards for staff requirements at different levels. On average, one UHC per district would be required instead of current 159 UHCs for CEmONC to manage the remaining number of obstetric cases and two EmONC pair have been recommended for those UHCs to provide 24/7 c-EmONC services. It would be more strategic to ensure availability and retention of EmOC pairs in designated EmONC facilities. MCWCs do not have a regular post of MO for anesthesia. MO-MCH from sador upazila are attached at MCWC to provide anesthesia in addition to his/her normal function in maternal, child health and family planning services. The strategy recommends to create a regular MO-Anesthesia post for MCWC. There is no provision of basic lab facility in MCWC and FWC. For MCWC, a basic lab should be set up to ensure routine blood and urine test. Hence, a new post for Medical Technologist (Lab) has been recommended. In order to ensure quality and immediate newborn care, each CEmONC facility should have at least one consultant pediatrician and at least one medical officer trained on newborn care.

### 4.3.2 Plans to train and deploy adequate numbers of skilled personnel

The Government initiated a three-year midwifery diploma course under Bangladesh Nursing and Midwifery Council (BNMC) to train 3000 midwives to be deployed at UHCs, DHs and MC Hospitals. In addition, a 'Post-basic 6 month midwifery training' of nurses who have completed three-year nursing diplomas was started as an interim strategy. Certified midwives will be available from 2015 onward, creating the need for ensuring funds for their employment.

The Government is implementing an accredited CSBA training since 2003 in both government (FWA and female HA) and non-government sector, in order to deploy over 13000 CSBAs in the country. Bangladesh Nursing Council certifies and registers the successful trainees to work as CSBAs to perform defined functions: counseling, antenatal care, safe delivery, newborn care and postnatal care. To improve performance, all CSBAs will be supervised and supported with supplies and refresher trainings under a government supervisory framework. All public, NGO and private CSBAs will report through the respective FWVs to the upazila government system into the MIS. The supervisory and reporting system has to be established under the health system. Female CHCP who sit in the community are included into the CSBA training to enable them to provide ANC, PNC and neonatal care at household level and delivery care at CCs in selected areas.

To ensure skilled birth attendants at each child birth, the current initiatives include: i) implement and expand the 3-year Diploma in Midwifery program in both public and private sectors; ii) register as certified midwives nurses after a six-month certificate course in advanced midwifery and allow them to work dedicatedly in midwifery services at facility or community level; iii) continue with the training of FWVs for 18 months, with additional six months specifically devoted to midwifery to be certified as midwives, to support the 24/7 normal delivery at UH&FWCs and MCWCs; iv) continue CSBA training as interim strategy in both public and NGO/private sector.

All the above initiatives, their outputs and timing, need to be closely monitored in view of the rapidly evolving needs, particularly in delivery care. Options for the GoB may include different combinations of the above initiatives to match the evolving needs.

Given the shortage of qualified staff, the institutions for medical, nursing, midwifery and medical technology education will have to be expanded in both public and private sectors. The Strategy promotes review and updating of the curriculum by incorporating evidence-based interventions.

Professional bodies, institutes and legal authorities (OGSB, BNF, BSMMU, ICMH, BNC, BMDC etc.) will have to ensure standardization of training curriculum and quality assurance of the training in both public and private sector. Operation plans include activities under DGHS, DGFP and NIPORT to support required in service trainings in the subject. The Government and its partners should support improving capacity for development and implementation of standardized training in maternal health services. Training institutions like FWVTI, RTC, Nursing Institutes, MATS, District hospitals, Medical Colleges and Institutions ICMH, MCHTI, MFTC), OGSB hospital/ NGO/ Private institution/hospitals etc. will be linked to service hospitals with adequate patient flow for appropriate skill training in midwifery and EmONC services. Training centers can be accredited by the specific regulatory bodies like BMDC, BNC, DGHS, and DGFP etc. to serve as Training Centre of excellence.

In ensuring a competent MNH workforce at place with regular updating of skills and skill mix, training and post training support and organizational adjustments to ensure provider friendly working environments are essential. Accountability and supervision will aim to reach standards for achievements/ accomplishments and quality of care. Demarcation/clarity of roles and responsibilities would also be required in addition to appropriate job descriptions as a part of performance improvement process. Individual Performance Management System (IPMS) and Organizational Performance Management

System (OPMS) should be introduced along with continuous assessment of skills and validation of competencies, integrated by supportive supervision, and followed by refresher training based on need for selected health providers. District health teams should be mentored by regional resources (e.g. medical colleges and professional bodies) on advanced technical and quality issues in particular.

### 4.3.3 Innovative policies to fill vacancies and ensure retention

MOH&FW will work on issues like shortages, mal-distribution, absenteeism and skill-mix imbalance; task shifting approaches at all levels should be considered to complement these skill gaps. Directives under the Bangladesh Health Workforce Strategy 2006 and lessons learnt from various country programs will be considered in finding solutions to HR gaps /shortage in hard-to-reach/rural areas by provision of incentives, or contracting/hiring of HR at local level. Innovative policies have been effectively experienced under decentralized evidence-based planning system (DEPB) at district level.

To ensure retention of critical HR at district hospital and strategically located UHCs to offer C-EmONC services, the following options should be considered: i) specific non-monetary incentive plan including service seniority, scopes for higher education, in-service training, privileged posting option etc.; ii) other non-financial benefits such as housing and vehicles; iii) loans for undergraduate medical education with repayment by service in hard-to-reach areas; iv) review of policies regarding working deputation and attachment;

**Table: 4.3.3 Innovative policies to fill vacancies and ensure retention**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Adopt a HR strategy and plan with specific indications and projections of needs for the various typologies of health professionals involved in maternal health services at all level | | | |
| Harmonize current training plans of midwives and C-SBA between DGHS and DGFP taking into account projections on needs to achieve target of skilled birth attendant coverage | | | |
| Ensure sustained funding for the employment of new certified midwives | | | |
| Re-designate nurses who have completed 6 month post basic midwifery training and deploy as dedicated midwife in labor unit | | | |
| Introduce team performance based payment as opposed to individual payment and combine quality parameters with quantitative outputs in order to qualify for payment | | | |
| Establish supervisory, mentoring and reporting system for midwives and CSBAs | | | |
| Promote three-year midwifery course in private sector to fill the midwifery need | | | |
| Preference to be given to trained CSBA for admission to three-year midwifery course | | | |
| Enroll unemployed diploma nurses in the Post basic 6 month midwifery training and consider them to fill the created post of midwives | | | |

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Increase the numbers of training facilities with sufficient training capacity and patient flow in both public and private sector | | | |
| Develop innovative incentives to fill vacancies in hard-to-reach areas and ensure retention | | | |
| Introduce Individual Performance Management System (IPMS) and Organizational Performance Management System (OPMS) along with continuous assessment of skills and validation of competencies | | | |

## 4.4 Monitoring, Evaluation & Accountability

The great diversity of interdependent actions to be undertaken and the presence of a multitude of actors in maternal health service delivery – particularly the very large private sector – imply the need for a well-designed and effectively managed monitoring and evaluation framework. Progress in inputs, outputs, outcomes and impact should be effectively monitored so that course-corrections, reallocation of resources and policy changes can be done on time. The focus will be on routine and real-time information system, supported by periodic special national surveys. Periodic program reviews and evaluations will be critical for ensuring that needed changes are identified and implemented in time.

### 4.4.1 Monitoring indicators

To monitor progress input, output, outcome and impact indicators are needed (see box below).

**Box 1. Proposed indicators for monitoring and evaluation**

Impact Indicators: Maternal Mortality Ratio, Neonatal Mortality Rate (early and total), Stillbirth rate (fresh still birth), Perinatal Mortality Rate, LBW rate, Total Fertility Rate, Maternal anemia, BMI, short stature.

Coverage Indicators: Contraceptive Prevalence Rate, Antenatal Care from medically trained provider, Skilled Birth Attendants, Facility-Based Deliveries, C-Section Rate, Postnatal Care from medically trained provider, Early initiation of breastfeeding.

Output Indicators: Number of Antenatal Care Visits by provider type/level, Number of deliveries attended by provider/facility type/level, Number of Postnatal Care Visits, Number of C-Sections conducted.

Input Indicators: Number of CEmONCs designated, capacitated, made functional and accredited; Number of functioning 24/7 CEmONCs (reported quarterly); Number of BEmONCs designated, capacitated, made functional and accredited; Number of functioning 24/7 BEmONCs (reported quarterly); Number of Facilities for Safe Blood Supply designated/established; Number of Transportation and Communication Systems established; Proportion of population living within 1-hour travel of a 24/7 functional BEmONC facility; Proportion of population living within 2-hour travel of a 24/7 functional CEmONC facility.

Each of these indicators will be defined in operational terms and by type of data, and measurement tools and procedures developed and implemented. Equity breakdown (by SES and TR/rural/urban) needs to be ensured. Tools and protocols will also be developed to enable analysis and use of this data at the local, regional and national levels.

### 4.4.2 Maternal and Perinatal Death Surveillance and Response (MPDSR)

MPDSR is a non-blaming and non-punitive approach which fosters participation at all levels for identifying maternal and neonatal deaths and stillbirths. DGHS and DGFP will coordinate to track all maternal deaths in the country without gaps and duplications. Their joint effort will ensure notification and review of all maternal and newborn deaths. Maternal and Perinatal Death Surveillance and Response, currently implemented in 22 districts by MOH&FW, UNICEF and other development partners, and needs to be scaled in 64 districts. MPDSR helps program managers analyze factors contributing to the maternal death and identify solutions, by identifying the "causes of the causes" through a systematic and participatory process. MPDSR involve all levels of health workforce from community and facility. Front line health workers including HAs and FWAs notify deaths at community level. First line supervisor, Health Inspectors, Assistant Health Inspectors or FP Inspectors perform death reviews. Facility based death reviews are undertaken jointly by facility health managers and service providers. Upazila and District MPDSR committees review information and develop appropriate local actions. The field workers also conduct social autopsy at the community to prevent the next death. The national guideline has been developed by the Health Economic Unit of MOH&FW for the implementation of MPDSR throughout the country. MPDSR data has been incorporated in web-based DHIS-2 of Management Information System (MIS) of DGHS which is capturing real time information on every death. Every district need to develop a comprehensive action plan based data and need to implement to reduce the cause specific mortality. Through MPDSR, it is now possible to generate district wise MMR and NMR which helps a manager to monitor their progress. This is the only tool which is crucial to achieving SDGs in maternal and newborn health by 2030.

### 4.4.3 Implementation of the monitoring system

Key structural elements of the monitoring and evaluation system include an oversight group of MOHFW and partners, and a lead technical entity responsible for managing the system. Ideally, these should not be stand alone for maternal health, but be part of a broader process including MNCAH, RH/FP and maternal nutrition. Implementation of a monitoring and evaluation system will include: i) the development of annual work plans and report; ii) the definition of indicators in operational terms to identify data collection methods (e.g., routine health management information system, surveys, periodic reviews and focused evaluations; iii) a review of the existing measurement tools and procedures and development of new tools when needed; iv) use of ICT to ease data collection, analysis, and sharing.

Investments are required to build capacity of managers and staff on collection and use of data in planning, decision making, and result-based management. To the extent possible, data collection and use should be included in performance appraisal. Investments will also be needed to address workload-related and logistic challenges. Collaboration from the private sector on data collection will be included as part of licensing standards.

Special Surveys including BDHS, MICS, UESD, SPA, BMMS need to be included in multi-year plans as part of the overall M&E framework, involving lead agencies, technical oversight mechanisms, analysis and interpretation. Data should always be disaggregated by region and economic conditions.

Annual and mid-term program reviews are currently part of the implementation of the national health sector program. These are important mechanisms for stock-taking and course-corrections. Attention should be given on making the MNH component more effective. Effective coverage of MNH interventions should be monitored through the above listed indicators at household/community, outreach and clinical/health facility. Analyzing "determinants of coverage" for each tracer through the use of a bottleneck analysis will allow the identification of the health system constraints. Six-monthly sub-national reviews of MNH programs should be held at the district and divisional levels. This will help managers to better self-assess their own performance and strengthen program implementation and making progress. Build capacity to use data for monitoring and planning.

**Table: 4.4.3. Implementation of the monitoring system**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Designate a lead technical entity to coordinate and supervise RMNCH monitoring activities | | | |
| Design and develop fully automated HMIS, linking all levels of service delivery points | | | |
| Create and adopt a standard indicator system within MNCAH and RH/FP | | | |
| Implement a M&E system at the different levels within District Evidence Based Planning and Budgeting (DEPB) | | | |
| Build capacity to use data for monitoring and planning | | | |
| Incorporate MNCAH-RHFP data analysis and use in graduate and post graduate training | | | |
| Scale MPDSR in 64 districts with specific action plan | | | |

## 4.4.4 Accountability

The GoB and its partners will demonstrate that the investments translate into tangible results and long term outcomes. Accountability for service delivery will focus on coverage equity and quality of care at all levels as well as on impact on maternal and neonatal health outcomes, using, among others, the indicators listed in section 4.4.1 Targets and related responsibilities set by the Inter-Ministerial Committee will be the basis for monitoring and accountability at national level. For Voice and Accountability (VA), several approaches have demonstrated in Bangladesh. For example, HMIS of DGHS has initiated 'SMS' based Grievance Redress System and documenting minutes of meetings in Hospital Management Committee (HMC) in DHIS2. Joint GoB-UN MNH initiatives has modelled several innovations like formation of health service user forum through civil society, client exit interview, setting up information desk, revive HMC, organize public hearing, setting suggestion box and displaying complains and actions in display board. Several other agencies also piloted other VA activities through citizen participation. There is also an urgent need to address gender based violence through health sector. Lessons learned from these accountability mechanisms will be consolidated to develop an

accountability framework. This will be defined for cross sector actions and corresponding targets within definite timelines and responsibilities. A third party entity should be deployed to monitor, document, and report on results, accountability and governance in health service delivery. The revitalization and the regular meeting of Hospital Management Committee chaired by local members of the parliament will also contribute to general oversight and accountability.

**Table: 4.4.4 Accountability**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Strengthen Management committee at different tiers of health facilities including CG, UHFWC MC, Hospital Management Committee chaired by the local Member of Parliament (MP) | | | |
| Institutionalize logging client views through suggestion boxes, direct texting of concerns, client satisfaction surveys as part of facility surveys and devise mechanism to make health managers accountable on those concerns | | | |
| Establish Health Service User Group / Watch Forum by Civil Society Participation through public private partnership | | | |
| Strengthen SMS based client government mechanism initiated by HMIS, DGHS | | | |

# 4.5 Partnership with NGOs and the private sector

## 4.5.1 The role of the private sector in providing MH services

The multiplicity of stakeholders and agents engaged in health is a characteristic feature of Bangladesh and has quite significantly contributed to the achievements in maternal and child health. NGOs provide a substantial proportion of services in urban areas and there is a rapidly increasing utilization of private sector services for delivery care. The proportion of institutional deliveries provided by the private for profit sector has more than doubled over the last decade and already represents about 50% of the total deliveries. There is a wide variety in the quality of services provided by the private sector, and the financial burden for users also varies from quite substantial to services provided for free. There is concern about the induction of inappropriate and excessive use of diagnostics and treatments by the private for profit sector. The unacceptably high and still increasing proportion of deliveries by CS in the private sector is the most worrying example of inappropriate practice, which carries unnecessary costs and increased risks for the mother and the newborn baby. Private facilities are often staffed with health personnel employed in the public sector, thus creating potential conflict of interest and posing further governance challenges.

The Strategy calls for inclusion, engagement and active participation of profit and non-profit private sector in attaining the goal of reducing maternal and neonatal mortality and morbidity and at the same time envisages to develop and enforce a regulatory framework. The MOHFW will therefore promote and initiate partnership models with the fast growing private sector as well as with the non-profit sector to increase coverage, ensure quality and accountability and optimize use of financial as well as human resources.

### 4.5.2 Regulatory mechanisms to ensure equitable access and quality of MH services

To ensure equitable access and quality care, all private sector providers and facilities should be brought under a strong regulatory framework.

The MH SOPs represent the basis for regulatory mechanisms as well as for specific agreements on the provision of services. Based on SOPs, a renewable licensing and certification system should be devised and enforced which should primarily be subject to equity and quality parameters. Safety net for the poor (e.g. in urban areas) should be considered as a pre-requisite to getting licensed. Adaptation and expansion of DSF approach in selected areas should be considered. Obligations of the private sector include contribution to data collection, through full inclusion in and participation to HMIS to be included in the certification and accreditation systems.

**Table: 4.5.2 Regulatory mechanisms to ensure equitable access and quality of MH services**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| MOHFW will further promote partnership with the private for-profit sector as well as private non-profit sector (NGOs) to implement equity-focused MNH service models | | | |

## 4.6 Innovation, research and technology transfer

Innovation is essential in improving cost-efficiency and results and is a well recognized development-enhancing factor. Bangladesh has a unique and globally acknowledged record in health research that ensured assessment, revision and improvements of a number of innovative approaches in health delivery, particularly at community level (17). Besides health services/operational research, a key area for innovation is represented by the use of ICT.

### 4.6.1 Operational research

Operational research is essential for evaluating and improving the design of health intervention, policies and service delivery modes. Capacity to conduct, and even participate, to operational research outside well recognized Research Institutes is currently low and capacity building is needed, starting from pre-service training and in-service courses.

To ensure that research capacity is expeditiously enhanced and sustained, the focus should be on institutions (possibly starting with a small set of 3-4 training institutions) and research teams. Collaboration with development partners will be crucial to ensure technical assistance and establish mechanisms for providing broad oversight and coordination. This will ensure that research resources are aimed at answering policy-relevant questions, adequate funding is provided, and findings are disseminated rapidly, appropriately and their translation to policy is supported.

Among research priorities, the following broad areas can be mentioned: i) qualitative research to identify the underlying factors influencing demand for delivery services, particularly for FP and delivery care. Results should guide the development of policies regarding communication strategies and

service delivery models; ii) epidemiological research to understand emerging trends and contributing factors of maternal, neonatal and reproductive mortality and morbidity; iii) biomedical and technology research as well as operational research to improve prevention, diagnosis and treatment of long-term obstetric complications; iv) cost-effectiveness studies of task-shifting models, pay-for-performance schemes, targeting or differential programming of health services and demand-side financing schemes; v) referral models like the use of ambulance network through public private partnership; vi) innovation in use of ICT (see below); vii) innovation in community involvement in health care.

### 4.6.2 The role of ICT in maternal health

ICT is a tool to share individual and population data among providers and levels of the system, to improve communication with users – e.g. to ensure compliance with ANC and immunization, and to ensure timely referrals. ICT is changing the scenario of maternal health and adolescent health by contributing to disseminate information and improve use of services as the availability of mobile phones is rapidly increasing. Building on current projects and experiences, a more strategic role of ICT will be developed to support action to cover hard to reach areas, facilitate communication between outreach workers and users and between front-line workers and health facilities, and use social networks to promote healthy behaviors among adolescents and young people.

International collaboration and partnership will be further promoted to foster technology transfer and to take advantage of international experiences in cost-effective preventative and treatment interventions and service delivery models.

**Table: 4.6.2 The role of ICT in maternal health**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Promote operational research to improve cost effectiveness and evaluate innovative approaches in service delivery | | | |
| Foster collaboration with development partners, research and training institutions to build capacity and provide support for operational research | | | |
| Promote the use of ICT as a strategic tool for communication among services and providers and to promote healthy behaviors, disseminating information, improving access and effective utilization of services and address emergency cases | | | |
| Technology transfer will be promoted through international collaboration and inter-institutional partnerships | | | |

# CHAPTER 5

## KEY STRATEGY 3
## REDUCING INEQUITIES

Wide inequities in maternal and newborn health outcomes still prevail in Bangladesh, resulting in violation of essential human rights and in obstacles to social and economic development. The HPNSDP 2011-2016 sets a ratio of less than 1 to 4 in access to facility based delivery between women in the lowest and the highest quintiles to be achieved by 2016 from the 2011 ratio of 1 to 6. The Strategy adopts this target and further proposes to reduce this ratio to 1 to 3 by the year 2025 as well as the poorest to richest quintile differentials in MMR and NMR by half.

In order to make further progress in reducing the existing equity gaps in access and effective utilization of health services and particularly to ANC, delivery and postpartum care, action needs to be taken on both the supply and the demand side, requiring action within and beyond the health sector. Multi sector action, as described in Chapter VIII, will be crucial to achieving sustainable results. Within the health sector, reducing health inequity for women requires general country-wide provisions for ensuring equitable access to quality MNH services for the poor, as indicated in section 4.2.2, and stronger and differentiated service delivery modes for specific areas and population groups. In Bangladesh, socio-economic and geographic inequities hit different population groups and may also coexist in some areas. The strategy calls for differentiated strategies to be applied and for innovative approaches to be developed and assessed in service delivery, while recognizing the value and the need for a strengthened collaboration with development partners and NGOs to effectively address the existing gaps, particularly in urban and hard to reach areas.

## 5.1 Socio-economic inequity

The existing gaps in access and utilization of maternal health services by the poorest need to be addressed through a variety of approaches, taking into account the richness of experiences and the contribution provided by the NGO sector. In line with the reform agenda of the Health Sector Program in Bangladesh, the MOHFW piloted the DSF scheme in 21 Upazila in 2007 and 2008, which was scaled-up in 53 Upazila in 2010. In the financial year 2017-2018 after adding another 2 Upazila now DSF scheme is ongoing in 55 Upazila. The aim was to increase utilization of maternal health care services by the poor. A voucher entitles its holder to receive free maternal health care services including ANC and PNC, safe delivery and treatment of complications (including caesarean sections and assisted vaginal delivery) from designated facilities or skilled providers in the community. Service recipients receive cash incentives, transport subsidies, and a gift box. Service providers also receive incentives to distribute vouchers and to provide services covered by the voucher scheme. DSF is to be seen as an interim solution to increase facility delivery/ delivery by skilled attendants among the poorest. The MOHFW has recently started a community insurance scheme known as Shasthyo Shurokhsha Karmasuchi (SSK) for ensuring universal access to health care by the poorest. There are also about fifty social protection schemes to support the poorest administered by various ministries other than ministry of health. Limited coordination, poor governance and overlapping among these schemes have constrained comparative evaluation and transfer of intended benefits to the poorest women and children, and need to be addressed.

**Table: 5.1 Socio-economic inequity**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Develop interim scale up plan for DSF schemes based on reviews of current schemes | | | |
| Select the upazilas for DSF schemes and develop an exit plan for each of the selected upazilas | | | |
| Strengthen the technical capacity of the DSF cell at local and national level | | | |

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Maternal voucher scheme and provider payment should be de-linked to avoid incentives to inappropriate practice (e.g. to inappropriate cesarean sections) | | | |
| Provider-side incentives to be included separately under a Pay for Performance program | | | |

## 5.2 Geographical inequity

HPNSDP - MTR 2014 emphasized that HR issues plague service delivery in hard-to-reach areas and identified the need of incentives for the providers as a key strategic priority.

A policy on introducing incentive packages (financial and non-financial) for hard-to-reach/rural areas was developed and technical assistance support was requested for initiation of piloting. Also, motorcycles and bicycles have been distributed to upazila level managers and family planning inspectors (FPI) to intensify the supervision and monitoring. To enhance CPR and reduce TFR in hard-to-reach areas, which are also low performing, more than 800 FWVs have been posted to fill the vacant positions; however, it appears that some positions are still vacant. The NGOs are working with DP support in hard to reach areas with the aim of ensuring delivery of quality health care services at affordable prices. The strategy calls for consolidating lessons learnt from good performing divisions like Khulna and replicate them in Sylhet, Chittagong and Barisal divisions.

**Table: 5.2 Geographical inequity**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| In depth analysis of the complexity and bottlenecks in hard-to-reach areas and tailored strategies to improve quality and coverage of MNH services for hills, tea garden, chars, and haors | | | |
| Special support to improve communications should be sought through inter-sectoral collaboration | | | |
| Sub-contracting to NGOs working in hard to reach areas having chronic HR shortage | | | |
| Home delivery strategies by CSBAs (private and public) should be emphasized to increase coverage in hard-to-reach areas | | | |
| Consolidating lessons learnt from good performing divisions and replicate effective models in other areas | | | |

## 5.3 Urban Areas

Rapid urbanization is an emerging problem with important impact on maternal health. The average urban population growth rate is 3.5% per annum. However, the slums are growing at a much faster pace at about 7% per annum. Of the total urban population (50 million) in the country 28.4 % are poor and 14.6 % live in extreme poverty, and deserve special attention in view of the specific risks caused by living in urban slums. Urban health warrants special attention given the insufficient capacity of the Ministry of Local Government, Rural Development Co-operatives versus their constitutional mandate to provide health care for the urban population. The Urban strategy should be approved as soon as possible and put into action by the Local Government Division (LGD).

**Table: 5.3 Urban Areas**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Strengthen the capacity of Health Departments of city corporations and municipalities in planning, management and monitoring of health services | | | |
| Strengthen inter-ministerial committee to harmonize roles and responsibility of MoHFW and MoLGRD | | | |
| Coordination committees of MOHFW and LGD should meet regularly to review and guide the process of health care delivery in the urban areas including harmonization of NGOs and public sector work | | | |
| Subsidize the cost of health services for the urban poor by both NGOs and private clinics | | | |
| Assess the current maternal health voucher scheme and explore feasibility of introducing it in urban settings | | | |

# CHAPTER 6

KEY STRATEGY 4

# IMPROVING THE QUALITY OF CARE

Although still insufficiently assessed in its dimensions and causes, poor quality of care is a growing concern. Quality of care is particularly relevant for MH since failure of effective and timely management and of preventive interventions may have fatal or long lasting consequences for both the mother and the newborn baby. Furthermore, respectful and patient-centered care should be reaffirmed as a right for all women and newborn babies, and a duty for all health professionals.

Ensuring quality implies that first, the minimum requirements for infrastructure, staff, and commodities (as in Standard Operating Procedures) and for referral mechanisms are met. Second, that Quality Management systems are set at all levels. While a first, fundamental step to quality has been made by developing the SOPs because they represent the standards to which facilities and providers must adhere to deliver health services, appropriate methods need to be adopted and capacity built to implement the SOPs, monitor their implementation, provide supportive supervision and introduce review systems.

The issue of quality improvement has only recently received attention by the MOHFW which adopted the Total Quality Management (TQM) approach for Quality Improvement (QI) of MNCH services through capacity building of both the DGHS and DGFP. These efforts need to be strengthened and sustained to ensure that increased coverage in maternal health services, particularly delivery care, is coupled by good quality.

## 6.1 Implementing a quality management system for maternal care

### 6.1.1 National framework for quality improvement

Maternal and Newborn health care standards have been adopted from the global WHO MNH Standards following the WHO Quality of Care framework and RMNCAH Quality of Care framework has also been developed. Initiatives have been undertaken to introduce MNH quality of care standards at facility

and community level and periodic assessment by an assessor team. According to the principles of QI cycles, the following steps are necessary: i) assess the current performance for MNH based on SOPs and identify gaps. The existing checklists/assessment tools for measuring performance can be used for systematic assessments at country level and as a part of self-assessment at the facility level; ii) analyze gaps and their root causes, which lead to the identification and selection of the most appropriate set of interventions to eliminate/minimize gaps and to bring desired changes; iii) development of an action plan, based on the above analysis, with targets, timeframes and shared responsibilities agreed by all relevant staff; iv) implementation of the action plan. Recognized and evidence based quality improvement methods, i.e. 5S-PDCA, TQM etc. should be applied at scale based on the best practices and lesson learned from the on-going initiatives supported by different development partners. Periodic assessment/re-assessment of the quality is a pre-requisite for improving the quality of MNH services complying the WHO quality standards and statement (WHO MNH Standards). There should be assessor teams at regional and national level for periodic assessment/re-assessment for continuous quality improvement of MNH services. Service delivery points/facilities should be accredited based on approved standards and criteria and continuously assessed and monitored for improvement of quality incrementally. a System should be developed for continuous mentoring and coaching by the technical experts and programme people for capacity building at facility level. Strategies to recognize and reward achievements are-

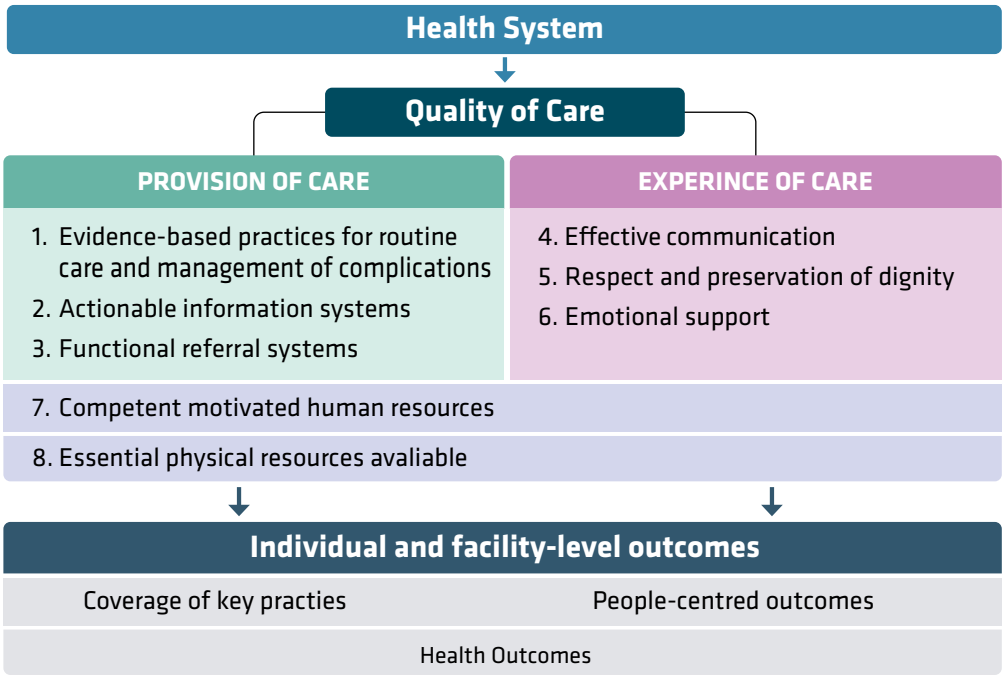



Figure: WHO Quality of Care Framework

crucial to ensure adherence by health providers and hence sustainability. They may be both financial (pay for performance) and non-financial (training opportunities, career progression etc.) incentives and motivational training for the managers and service providers.

On this broad conceptual basis, a national strategic framework and action plan for quality improvement for MNH has been developed (in alignment with WHO QI Framework) and followed, including roles, responsibilities and activities at national, district and facility levels. At the facility level, the QI cycles following the globally practiced 5S-PDCA (TQM) approach should be promoted and implemented by facility-based QI team.

MPDSR described in section 4.4.2 ia a powerful instrument in identifying clinical and social causes of deaths, gaps/bottlenecks and build awareness about quality gaps and take team-based solutions. Supportive supervision by experienced professionals is highly effective in implementing clinical guidelines and foster a peer-to-peer approach to quality improvement. Standard Based Management and Recognition is another quality improvement intervention that has been adapted to the context of Bangladesh and showed promising results.

Capacity building of facility based teams and supervisory committees should be prioritized. The Strategy calls for renewed efforts and systematic approaches to improve quality of MNH care. This will require harmonizing current QI initiatives of MOHFW and other partners within a national RMNCAH framework for QI in MNH under the overall umbrella of Health System Strengthening (HSS) initiatives of the MOHFW. The national strategic framework and action plan for quality improvement for MNH will be linked to relevant operation plans of DGHS and DGFP and include the RH components.

The institutional QI structures proposed at national and sub-national levels should promote, oversee, and monitor QI of MNH services at different levels as per the protocol set out by the national QI framework. Program managers from DGHS and DGFP and obstetric, paediatric and nurse/midwife professional experts will participate in supervisory and monitoring visits using standardized checklist for QI in MNH care. QoC indicators mentioned in the SOPs need to be integrated into the routine health system monitoring to reflect the status of quality of care in MNH services.

### 6.1.2 Strengthening and enforcing licensing and certification mechanisms and introducing accreditation systems

The MOH&FW shall strengthen systems for licensing (registration and renewal process of license) for all MNH care providers, facilities and the training institutions to maintain standards and quality of care. Institutional, management and technical capacity of various national regulatory bodies (BMDC, BNC, etc.) will be strengthened to increase effectiveness and efficiency in the enforcement of the regulatory framework.

Inclusion of mandatory skill-based test for doctors and nurses during renewal of BMDC and BNC registration is necessary. A similar approach should be expanded to other paramedical cadres like midwives, Sub-Assistant Community Medical Officers (SACMO) from both public and private sectors. The legal framework contained in the Medical and Dental Council Act of 1980, the Drug Act of 1940, revised in 1946, the Drug Control Ordinance 1982 and the National Drug Policy 2005 shall be uphold for health care practice and service delivery both in public and private/NGO sectors.

Health system shall establish a process under which a facility or institution will be required to meet the criteria/ standard set down by an authority to acquire certification in MNH service provision or in provision of MNH relevant trainings. The introduction of accreditation systems, under which a health facility is accredited to excellence in the delivery of specific or comprehensive services, should also be considered. There are some experiences in health system on establishing accreditation system like 'Accreditation of Women Friendly Hospital' under DGHS. These experiences should be consolidated and expanded in their scope for developing a comprehensive accreditation system for MNH services. Accreditation, which should be seen as a step by step process aimed at meeting the optimum requisites, should include, among the required standards, the establishment of a facility-based QI team. Quality improvement systems, including accreditation, can be linked with individual,

team or facility-based performance based incentives. Hospital certification to minimum standards and accreditation to excellence systems should also be applied for the fast growing private sector. An independent regulatory body is required for ensuring independence and transparency in certification and accreditation systems through site visits.

**Table: 6.1.2 Strengthening and enforcing licensing and certification mechanisms and introducing accreditation systems**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Develop and operationalize a national strategic framework and action plan for QI in RMNCH | | | |
| Include quality indicators in monitoring and evaluation plan of RMNCH | | | |
| Strengthen capacity of facility based QI teams and supervisory system | | | |
| Institutionalize joint supervision and monitoring of QI activities by managers from DGHS and DGFP and by professional associations | | | |
| Strengthen systems for licensing and certification for service providers, facilities, as well as for training institutions | | | |
| Establish accreditation process, ideally linked to performance-based incentives | | | |

# CHAPTER 7

## KEY STRATEGY 5
## COMMUNITY EMPOWERMENT AND ENGAGEMENT

Community empowerment and engagement can improve access and utilization of MNH services, support families, women to adopt behavior and practices to ensure maternal and neonatal survival, and provide financial and transport support to the poorest families during emergency referral. Communities may raise their voice and contribute to accountability of health service delivery from facility, outreach and household level.

## 7.1 Fostering community engagement in identifying problems and solutions in health services provision

NGOs have played a substantial role in providing services at community level, promoting community participation and empower women through a wide series of approaches that have reached global resonance and appreciation. BNHMS acknowledges the role of NGOs in promoting community and women's empowerment and intends to build on these experiences to further sustain action to ensure the engagement of communities in the planning and monitoring of MNH services. Community engagement is also essential to ensure that achievements are sustainable beyond the duration of donor-based projects and programs. Community engagement can illuminate potential grassroots sources of funding and resource mobilization.

Involving communities ensures better accountability in health service delivery. The introduction of social auditing mechanisms can allow communities to provide feedback to health administrators. A linkage should be created between local health authorities and NGO-driven community groups to maximize the community support for MNH services.

The Community Groups and Community Support Groups formed under each CC may be involved in the identification of MNH problems, as well as in the planning, financing and implementation of solutions. Lessons and experiences of different MNCH programs could be scaled-up. The role of 'Union Parishad' in MNH services could be expanded through strengthening the Union Education, Health and FP Standing Committees. Representation and participation of the disadvantaged and marginalized groups are particularly important and efforts should be made to promote it, in collaboration with NGOs.

## 7.2 Empowering communities and women through communication

Communication activities working on mobilizing individuals, families and communities for maternal neonatal and child health are broadly aimed at empowering women, promoting community participation and building awareness about roles and responsibilities of community health workers and other community resources.

Maternal health specific communication objectives include: i) increasing knowledge of caregivers on key household and community practices for maternal and neonatal health and survival; ii) creating demand for maternal, and neonatal care services iii) increase political and local opinion leaders' support for MNH; iv) increasing access to antenatal care for pregnant mothers, to skilled birth attendants, institutional delivery and EmONC facilities; v) improving health workers' communication skills to provide quality health services; vi) enhancing the capacity of civil society, NGOs and the private sector to respond to MNH care needs.

The MHS strategy also calls for a specific focus on: i) role, self-esteem and value of women in society and the discrimination they face throughout their life cycle; ii) consistency of messages on MNH behavior, practices and care seeking across programs; iii) prevention of child marriage and early pregnancy and promotion of birth spacing; iv) safe sexual and reproductive health, nutrition of women along life cycle, and exclusive breast feeding; v) educating women and family on danger signs, preparedness for obstetric emergencies, antenatal care, institutional delivery, skilled birth attendants at home, postnatal care including referral of obstetric and neonatal complications; vi) participation of husband, mother, mother-in-law, family and community in pregnancy and delivery related matters; vii) raising social voice on violence against women.

The HPNSDP has paid great emphasis on Behaviour Change Communication (BCC) as a cross cutting intervention. This has the dual effect to increase awareness and the level of knowledge in the community about MNH issues and to increase the uptake of preventive, control and treatment services among vulnerable populations at the national, regional and community level. It may also achieve the effect of increasing the support by local champions to community utilization of MNH services.

BCC targets primary beneficiaries (adolescents, pregnant women, mothers) directly, while secondary (including family members peer groups, service providers, community leaders and groups, etc.) and tertiary groups (policy makers) will play direct and indirect role as influencers of primary beneficiaries in improving knowledge, attitudes, beliefs and behaviors.

**The BCC activities to be promoted will include:**

1. One to one counseling at facility or/and home
2. Courtyard meetings/ group counselling with pregnant mothers, lactating mothers, newly married women, their husbands and mother-in-laws to provide correct information on MNH
3. Training and orientation of service providers on counseling, community group meetings and use of IPC materials
4. Effective use of IEC materials e.g. posters, billboards, flashcards, pictorial cards, health cards, adapted to local culture, language on MNH
5. Entertainment education through community and local media for specific geographical areas
6. Development, production and use of appropriate and innovative BCC/IEC materials including use of mass media and social networks.

Participation of the community health workers, Union Parishad members, local opinion leaders and religious leaders will enhance community support for seeking care and referral services. Best practices such as the 'Community support systems' can build a participatory community group where all actors for maternal health can institute their functions from planning, implementing, monitoring and improving BCC activities.

**Table: The BCC activities to be promoted will include**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| Ensure active participation of Community Groups and Community Support Groups in the identification of local MNCH bottlenecks and in development of local level action plans in response | | | |
| Engage locally elected representatives, members of community groups and community support groups to monitor service delivery | | | |
| Expand the role of 'Union Parishad' in MNCH services through strengthening the Union Education, Health and Family Planning Standing Committees | | | |
| Incorporate BCC activities in job description of all community health workers from government and NGOs | | | |
| Build capacity on BCC among service providers at all levels and incorporate BCC in training curricula | | | |
| Create demand for MNCH care and facilitate access to health facilities as well as immediate referral through coordinated media strategy and engagement of multiple stakeholders | | | |
| Ensure promotion of consistent BCC messages on MNCH care seeking pattern and services | | | |

# CHAPTER 8

KEY STRATEGY 6

# MULTI SECTOR INVOLVEMENT AND ACTION

The critical importance of a multisector approach to MH has been emphasized both in the Introduction and in section 1.3.2. Global strategic directions and tools to guide governments to assess, develop and revise their RMNCAH strategies and plans according to a comprehensive health system and whole-of-government approach should guide action in this direction (3,5).

## 8.1 The MH Strategy as a multisector initiative

Women's education, water and sanitation, environmental and climate change, food security, communications and urbanization are all factors that have an important impact on maternal health and need to be addressed through intersectoral collaboration and multisectoral action. Progress in such a variety of crucial areas requires that MOHFW engages actively, intensively and systematically to improve coordination within the Ministry, to set collaboration mechanisms with other ministries and agencies, and to promote a whole-of-government awareness and action on the issues regarding RMNCAH. Among multi sector perspectives, as recently emphasized in the WHO Policy Compendium for RMNCAH, there is a right based approach. Bangladesh is signatory to the ICPD, Beijing Platform for action, CRC and CEDAW and has the obligation to eliminate discrimination against women in the enjoyment of all civil, political and cultural rights. An essential framework is needed for promoting and protecting the rights of girls and women throughout their life cycle, and for attempting to eliminate inequality, violence, malnutrition, discrimination and gender based disparities. The issue of child marriage is an example of the overt violation of the human rights, which requires the engagement of the whole Government.

## 8.2 Key actors to be involved within the Government and at societal level

Within the Government, key roles should be played by: Ministry of Local Government, Ministry of Rural Development & Cooperatives, Ministry of Education, Ministry of Primary and Mass Education, Ministry of Women & Children Affairs, Ministry of Social Welfare, Ministry of Food & Disaster Management,

Ministry of Agriculture, Ministry of Fisheries & Livestock, Ministry of Information, Ministry of Commerce, Ministry of Finance, Ministry of Law, Ministry of Home Affairs and NGO Affairs Bureau, among others.

For improving effective program collaboration and integration, an inter-ministerial committee under the chairmanship of the Honorable Minister for Health and Family Welfare will be formed to serve as a forum for coordinating the activities of all ministries and agencies. Such a committee should define a work plan to include specific targets within the main areas for multisector action. The stewardship role of MOHFW will be strengthened, with the aim of involving other allied ministries, partners, and the private sector in creating a positive environment, within which the health systems for maternal health can be governed appropriately.

The MOHFW will also work with the civil society organizations, faith-based organizations, community based organizations, professional bodies like Obstetrical and Gynaecological Society of Bangladesh, Bangladesh Perinatal Society, Bangladesh Neonatal Forum, Bangladesh Paediatric Association, Bangladesh Nursing Association, Midwifery Association, Bangladesh Anesthesiology Society and Bangladesh Medical Association for improvement of maternal and neonatal health.

## 8.3 Main actions to be included in a multisector action plan for MH

Main actions to be included in the multisector Action Plan for improving MNH are listed in box 2.

**Box 2. Main actions to be included in a multisector Action Plan for improving MNH**

- Action to eliminate extreme poverty through redistributive economic and social policies, cash transfers and family benefits for the poorest
- Action to improve food security and nutrition through agricultural development policies, food fortification programs and food vouchers for children
- Action to increase female literacy to ensure universal girls' enrolment and completion of primary and secondary school
- Action to promote gender equality, fight gender based discrimination at all levels of society, including government services, and legislation adopted for minimum age at marriage
- Action to enforce the minimum age at marriage legislation
- Action to ensure adequate access to clean water and adequate sanitation to all population groups
- Action to ensure or subsidize emergency transport
- Action to improve awareness about the importance of appropriate family practices including nutrition and reproductive health, to be conducted through the school system
- Financial resources provided to the health sector should be gradually increased and allocated to ensure that health services are reaching the poorer section of the population

Corresponding targets for all the above listed actions should be set by the Inter ministerial Committee and set as a benchmark for monitoring and accountability. Recommended levels and investment plans to strengthen maternal and child health services should be adequately reflected in multi-year plans, SWAPs and PRSPs.

The multisector approach should be reflected at local level as well. It is important that various actors, facilities and care providers within a locality establish a well-coordinated network to meet the varying needs, including communication and transportation support. Upazilla Parishads and Education, Health and Family Planning Standing Committees under Union Parishads are mandated to provide local oversight to the service availability and quality. Adequate support needs to be provided to strengthen these elected bodies and to promote their role in local oversight, resource mobilization, local accountability and community engagement. Partnership between MOHFW and MOLG is particularly critical in urban health, emphasized in section 5.3. This partnership should be institutionalized and structured based on well researched needs assessment for both the ministries.

## 8.4 The role of international agencies and other development partners

The MoHFW directorates namely DGHS, DGFP, DNS, and NIPORT will maintain and further strengthen, as recommended by the HNPSDP-MTR, the current coordination mechanisms for health sector policy and strategy with the development partners, UN organizations, NGOs and private sector for effective program implementation and innovation in addressing the identified gaps in coverage, equity and quality of care. Multi-lateral and bi-lateral development partners will continue to align their financial and technical inputs and support the GoB in ensuring the absorptive capacity and supplementing resources in critical areas according to HNPDSP-MTR recommendations.

This partnership will be informed by the principle of supplementing and complementing program approaches towards enhancing efficiency and impact. Partnerships should be strategic and roles should be determined based on comparative advantages of parties involved.

**Table: 8.4 The role of international agencies and other development partners**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| An inter-ministerial committee chaired by the MOHFW will be formed to serve as a forum for coordinating the activities of all Ministries and Agencies | | | |
| Local elected bodies will strengthen their role in multisector mobilization around MNH issues | | | |
| Current coordination mechanisms with development partners, UN organizations, NGOs and private sector will be strengthened for effective program implementation and innovation | | | |

# CHAPTER 9

## KEY STRATEGY 7
## IMPLEMENTATION AND IMPACT EVALUATION

A live strategy requires effective implementation mechanisms, starting from an operational plan to be developed in conjunction with sector programs, and in alignment with overall perspective development plans, with a precise accountability framework. At the same time, the strategy needs to take into account, social and economic changes and therefore, be conceived as a dynamic process requiring periodic review and updating based on impact evaluation and review.

## 9.1 Implementation steps and mechanisms

The MH Strategy 2019-2030 will be translated into action by reflecting the principles and strategic directions and propositions into the national sector programs, and initiatives under DGHS, DGFP, NIPORT, DNS, Community Clinic Project and those supported by development partners, UN Agencies, international and national NGOs, and by the private sector. Line directors will take the lead in the preparation of an action plan and reflect the strategy directions in their respective Operational Plans.

An action plan, including all the strategic directions and defining key responsibilities and timeline will be developed by MOH&FW with distinction made between actions that can be implemented within the HNPSDP 2011-16 and actions that need to be included in the next HNPSDP, to be fully implemented and financed.

MOHFW, DGHS and DGFP will take the lead to bring all stakeholders, experts and development partners to reach consensus on strategy and policy updates on emerging maternal health issues during the development and review of HPNSDP.

As indicated in section 8.2, an Inter-ministerial Committee under the chairmanship of the Honorable Minister for Health and Family Welfare will be formed to serve as a forum for coordinating the activities of all ministries and agencies. Such a committee should define a multi-year action plan which will include specific coverage and impact targets, based on those indicated in section 2.2, as well as targets set for each main area for multisector action, and related responsibilities. Targets will be set as a benchmark for monitoring and accountability.

Advocacy conferences will be held to gain support for implementation of the strategy, mobilize the media to document MNH interventions, and illustrate plans, disseminate key messages and involve champions to highlight the cause in various forums and events.

## 9.2 Monitoring impact and updating the strategy

The strategy needs to look ahead and incorporate the effects of its implementation as well as of population dynamics and behavior change. Given the rapidity of these developments, the strategy needs periodical review to monitor progress, as well as incorporate evolving needs and challenges. Updates will align with national sector program evaluations. The MOHFW, through its line directors, will initiate discussions among the relevant stakeholders to identify gaps and emerging needs and align strategies accordingly. This revised maternal health strategy will inform the strategic action on maternal health services of the upcoming health sector program as well as other national strategic plans such as human resource plans by the MoHFW.

The targets indicated in chapter 2, enriched by the targets identified for cross sector action in chapter 8 by the Inter-ministerial Committee for MH, and the indicators mentioned in section 4.4, will represent the basis for monitoring the implementation and the impact of the Strategy.

Acknowledging the rapid changes occurring in key upstream determinants such as education, women's employment and status, income growth and distribution and urbanization and the consequent rapid transition in reproductive and care seeking behaviors, with important implications on the planning of health services and particularly of the required workforce, the MH strategy will need review and updating within 5 years from its implementation.

**Table: 9.2 Monitoring impact and updating the strategy**

| Strategic Direction | 2019-22 | 2023-26 | 2027-30 |
|---|---|---|---|
| A costed action plan of all the strategic directions and defining key responsibilities and timeline will be developed by MOH&FW | | | |
| An accountability framework for sector and multisector actions will be defined together with operational plans | | | |
| Impact and coverage targets indicated in chapter 2, enriched by the targets identified for cross sector action in chapter 8 by the interministerial Committee for MH, together with the indicators mentioned in section 4.4 will be the basis for monitoring the implementation and the impact of the Strategy | | | |
| Independent agency and civil society groups will be involved in monitoring, implementation and impact, and ensure the implementation of Citizen's Charter | | | |

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# Annex 1

## Evidence-based Interventions along the Continuum of Care

| Area | Adolescence & Pre-pregnancy | Pregnancy (Antenatal) | Child Birth | Postnatal (Maternal/Neonatal) | |
|---|---|---|---|---|---|
| | | | | Mother | Neonate |
| | | | | Universal postnatal visit for mother and neonate within 48 hours | |
| **Home** | • Information to prevent STIs, HIV<br>• Couple registration, Pre-pregnancy counseling, and Birth spacing<br>• Iron and folate supplementation and de-worming<br>• Advice on Family Planning Methods and Emergency Contraceptive | • Pregnancy Registration<br>• Birth and newborn care preparedness plan<br>• Promote facility based ANC care,<br>• Danger signs<br>• Iron and folate supplementation<br>• Calcium supplementation<br>• Risk based Prevention and Treatment of malaria with insecticide treated nets and antimalarial drugs | • Promote facility deliveries, in opted home delivery ensure the delivery by a SBA<br>• Refer women with obstetric complications<br>• Social support during childbirth for early decision making and transfer if need of referral<br>• Initiate BF and advise for exclusive BF | • Assessment of maternal wellbeing<br>• Prevention and detection of complications (e.g. infections, bleeding, anaemia)<br>• Counseling on hygiene, self care, nutrition and postnatal danger signs<br>• FP advices (long term or permanent methods)<br>• Initiate BF and advise for exclusive BF<br>• Anaemia prevention and control (iron and folate supplementation) | • Immediate thermal care (to keep the baby warm)<br>• Early Initiation of BF<br>• (within the 1st hour)<br>• Hygienic cord and skin care<br>• Chlorhexidin at umbilical cord stump<br>• Awareness on neonatal danger signs and early referral<br>• Birth registration |
| **Outreach** | • Information to prevent STIs, HIV<br>• Couple registration, Pre-pregnancy counseling, and Birth spacing<br>• Iron- folate supplementation and de-worming<br>• Family Planning & Emergency Contraceptive, Menstruation Regulation service and PAC package<br>• TT Immunization | • Pregnancy Registration<br>• Promote facility based ANC<br>• Awareness building on Birth and emergency preparedness, Danger signs<br>• TT immunization<br>• Iron and folic acid supplementation<br>• Calcium supplementation to prevent preeclampsia<br>• Prevention and treatment of malaria with insecticide treated nets and antimalarial drugs | • Promote facility deliveries | • Counseling on hygiene, self care, nutrition and postnatal danger signs<br>• FP advice (long term or permanent methods)<br>• Initiate BF and advise for exclusive BF<br>• Anaemia prevention and control (iron and folate supplementation) | • Cord and skin care<br>• Awareness on neonatal danger signs and early referral<br>• Birth registration |

| Area | Adolescence & Pre-pregnancy | Pregnancy (Antenatal) | Child Birth | Postnatal (Maternal/Neonatal) | |
|---|---|---|---|---|---|
| | | | | Mother | Neonate |
| | | | | Universal postnatal visit for mother and neonate within 48 hours | |
| **Community clinic** | • All of the above plus:<br>• Screening for cancer of the cervix and of the breast | • All of the above plus:<br>• Monitoring of maternal and fetal well-being including nutritional status during ANC<br>• Detection of complications during pregnancy (e.g., anaemia, hypertensive disorders, bleeding, mal-presentations, multiple pregnancy)<br>• Treatment of mild to moderate pregnancy complications (mild to moderate anaemia, urinary tract infection, vaginal infection) | • All of the above, plus:<br>• ( provided the CC fulfills all requirement of labor room as per SOP)<br>• Care during delivery and immediate care of the newborn baby; if needed newborn resuscitation<br>• Detection and referral of obstetric complications | • All of the above plus:<br>• Provision of contraceptive methods<br>• Treatment of some problems (e.g. mild to moderate anaemia, mild puerperal depression, mastitis) | • All of the above plus:<br>• Promotion, protection and support for exclusive BF<br>• Eye infection prophylaxis<br>• Immunizations<br>• Monitoring and assessment of well being and response to maternal concerns<br>• Treatment of local infections (skin, cord, eye, mouth) |
| **UH & FWC** | • All of the above plus:<br>• Screening and management of signs/symptoms of domestic violence and sexual assault<br>• Screening for cancer of the cervix and of the breast<br>• Management or referral of problems | • All of the above plus:<br>• Confirmation of pregnancy<br>• Monitoring of maternal and fetal well-being including nutritional status<br>• Detection of complications of pregnancy (e.g., anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy) | • All of the above plus:<br>• Care during delivery and immediate care of the newborn baby; if needed newborn resuscitation<br>• Monitoring progress of labour, maternal and fetal well-being with partograph<br>• Supportive care and pain relief | • All of the above plus:<br>• Provision of contraceptive methods<br>• Treatment of minor problems (e.g. mild to moderate anaemia, mild puerperal depression, mastitis)<br>• Pre-referral treatment of some complications (e.g. severe postpartum bleeding, puerperal sepsis) | • All of the above plus:<br>• Eye infection prophylaxis<br>• Immunization<br>• Treatment of local infections (skin, cord, eye, mouth)<br>• Identification, initial management and referral of a newborn with any sign of severe illness, injury or malformation |

| Area | Adolescence & Pre-pregnancy | Pregnancy (Antenatal) | Child Birth | Postnatal (Maternal/Neonatal) | |
|---|---|---|---|---|---|
| | | | | Mother | Neonate |
| | | | | Universal postnatal visit for mother and neonate within 48 hours | |
| | | • Treatment of mild to moderate pregnancy complications (mild to moderate anaemia- urinary tract infection, vaginal infection)<br>• Pre-referral treatment of severe complications (pre-eclampsia, eclampsia, bleeding, infection and complicated abortion) | • Pre-referral treatment of severe complications (pre-eclampsia, eclampsia, bleeding, infection and complicated abortion)<br>• Active management of third stage of labour | | • Care of preterm / low birth weight: support for breast feeding, Kangaroo Mother Care at home or referral to higher facility as per SOPs |
| **Upazila Health Complex** | • Screening for risk conditions (anaemia, rubella)<br>• Preventive measures (Iron-Folate, 5 TT doses) | • All of the above plus:<br>• Treatment of severe pregnancy complications (anaemia, severe pre-eclampsia, eclampsia, bleeding, infection, other medical complications)<br>• Treatment of abortion complications<br>• Management of mal-presentations, multiple pregnancy<br>• Syphilis testing and treatment of syphilis (woman and her partner)<br>• Induction of labour to manage prelabour rupture of membranes at term (initiate labour) | • All of the above plus:<br>• Treatment of selcted severe complications in childbirth and in the immediate care of newborn<br>• postpartum period, including caesarean section, blood transfusion and hysterectomy<br>• Induction and augmentation of labour<br>• Caesarean section to save the life of the mother/baby<br>• Prophylactic antibiotic for caesarean section<br>• Active management of third stage of labour to prevent postpartum haemorrhage | • Screening for HIV<br>• Congenital syphillis<br>• Treat maternal anaemia<br>• Detect and manage sepsis (serious infections after birth)<br>• Counselling for postpartum Family planning and birth spacing<br>• Management of postpartum haemorrhage plus surgical procedures<br>• severe postpartum infections<br>• severe postpartum depression<br>• Tubal ligation and vasectomy<br>• Contraceptive Implants | • Neonatal resuscitation with bag and mask (by trained health workers)<br>• Kangaroo mother care for preterm (premature) and for less than 2 kg babies<br>• Extra support for feeding small and preterm babies<br>• Presumptive antibiotic therapy for newborns at risk of bacterial infection<br>• Case management of neonatal sepsis, meningitis and pneumonia |

| Area | Adolescence & Pre-pregnancy | Pregnancy (Antenatal) | Child Birth | Postnatal (Maternal/Neonatal) | |
|---|---|---|---|---|---|
| | | | | Mother | Neonate |
| | | | | Universal postnatal visit for mother and neonate within 48 hours | |
| | | • Antibiotic to prevent sepsis/in premature rupture of membrane<br>• Safe MR services and Post abortion care | • Management of postpartum haemorrhage by use of uterine massage and uterotonics<br>• Screen and manage HIV (if not already tested)<br>• Induction of labour for prolonged pregnancy<br>• Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction; breech presentation, episiotomy, repair of genital tears, manual removal of placenta) | | |
| **District hospital and Medical College Hospitals** | • Screening for risk conditions (anaemia, rubella)<br>• Preventive measures (Iron-folate, 5 TT doses) | • All of the above plus:<br>• Treatment of severe pregnancy complications (anaemia, severe pre-eclampsia, eclampsia, bleeding, infection, other medical complications)<br>• Treatment of abortion complications<br>• Management of mal-presentations, multiple pregnancy | • All of the above plus:<br>• Treatment of severe complications in childbirth and in the immediate<br>• postpartum period, including caesarean section, blood<br>• transfusion and hysterectomy<br>• Induction and augmentation of labour<br>• Caesarean section | • Screening for HIV, provision of ART (selected DH & all MCH)<br>• Treat Congenital syphilis<br>• Treat maternal anaemia<br>• Detect and manage sepsis (serious infections after birth)<br>• Counseling for postpartum Family planning and birth spacing<br>• Management of postpartum haemorrhage plus surgical procedures | • Neonatal resuscitation with bag and mask<br>• Kangaroo mother care for preterm and for less than 1800 gm babies<br>• Extra support for feeding small and preterm babies<br>• Initiate prophylactic antiretroviral therapy for babies exposed to HIV |

| Area | Adolescence & Pre-pregnancy | Pregnancy (Antenatal) | Child Birth | Postnatal (Maternal/Neonatal) | |
|---|---|---|---|---|---|
| | | | | Mother | Neonate |
| | | | | Universal postnatal visit for mother and neonate within 48 hours | |
| | | • Syphilis testing and treatment of syphilis (woman and her partner)<br>• Antenatal Corticosteroids to prevent respiratory distress syndrome in preterm babies<br>• External Cephalic Version<br>• Induction of labour to manage prelabour rupture of membranes at term (initiate labour)<br>• Antibiotic to prevent sepsis/in premature rupture of membrane<br>• Safe MR services and Post abortion care | • Active management of third stage of labour<br>• Management of postpartum haemorrhage (uterine massage and uterotonics)<br>• Screen and manage HIV (selected DH & all MCH)<br>• Induction of labour for prolonged pregnancy<br>• Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction; breech presentation, repair of genital tears, manual removal of placenta) | • Management of severe postpartum infections<br>• Management of severe postpartum depression<br>• Tubal ligation and vasectomy<br>• Contraceptive implants | • Presumptive antibiotic therapy for newborns at risk of bacterial infection<br>• Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies<br>• Continuous positive airway pressure (CPAP) for babies with respiratory distress syndrome (medical college hospitals)<br>• Case management of neonatal sepsis, meningitis and pneumonia |

# Annex 2

## Staffing standards by type of facility and service provided

| Type of Facility | Service Provided | Type and Minimum number of provider/ support staff | | |
|---|---|---|---|---|
| Community Clinic | Pregnancy registration ANC, PNC | CHCP | SBA trained worker | Regular supply of strips for basic blood & urine tests, to be performed |
| UH&FWC | 24/7 Maternity, Basic lab facility | Medical Officer-1 | FWV-1<br>Midwife-2 | Regular supply of strips for basic blood & urine tests, to be performed by FWV/MW |
| UHC | 24/7 Maternity & BEmONC | Jr. Consultant OG-1<br>Jr. Consultant Anest-1 | Midwife-8 | MT (Lab)-1 |
| UHC | 24/7 Maternity & CEmONC | 2 Pairs:<br>Jr. Consultant OG-1,<br>Jr. Consultant Anest.-1, or:<br>MO (OG)-1,<br>MO (Anest)-1 | Midwife-8<br>OT Nurse-2 | MT (Lab)-1 |
| MCWC (Upazila and below ) | 24/7 Maternity & BEmONC | MO-Clinic | FWV/<br>Midwife-6 | MT (Lab)-1 |
| MCWC (District level) | 24/7 Maternity & CEmONC | MO- Clinic-2<br>MO ( Anest.)-2 | Midwife-8 | MT (Lab)-1 |
| DH | 24/7 Maternity & CEmONC | 3 Pairs: Consultant OG, Consultant Anest. or MO (OG) , MO (Anest.)<br>Paediatrician-1<br>MO (Neonat.)-1 | Midwife-16<br>OT Nurse-4 | MT (Lab)-2 |

# Annex 3

## LIST OF CONTRIBUTORS

The National Maternal Health Strategy 2017-2030, which includes the main strategy document and the related SOP, was developed thanks to the work of five Technical Sub-Committees (TSC) which were formed by the National Technical Committee (NTC). Members of NSC, NTC and TSCs are listed below. Overall, more than 100 technical experts and professionals have contributed to produce these two documents.

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## The process of Reviewing and updating of National Maternal Health Strategy and development of Maternal Health SOPs received also contributions by:

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