**Annual Programme Review (APR) 2018 of 4th HPNSP**

**Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH)**

Draft report

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1. **Executive Summary**

This Annual Programme Review, APR, was carried out to review the first 18 months (January 2017 to June 2018) of the fourth health sector program of the Government of Bangladesh - Health Population Nutrition Sector Programme( HPNSP: 2017-2022). APR 2018 was carried out by a team of 12 Consultants between January 20-February 20,2019. Each consultant carried out the review of a specific thematic area of HPNSP with assigned OPs. The review findings are based on documents review, field visits and key informant interviews.

Five OPs were reviewed in the RMNCAH area- NMES, MNCAH, MCRAH, CBHC and HSM. The overall pace of implementation of HPNSP during the review period was slow, as much time was lost in approval of the PIP and individual OPs, and subsequent fund release. The challenge of managing the Rohingya crisis detracted attention of policy makers and a section of health managers during the later half of the review period. However, a number of preparatory activities took place during this period including training, procurement, development of tools and strategies and recruitment. In terms of specific OPs, NMES and CBHC OPs showed relatively good progress. Although NMES OP had a slow start, by the time the review was undertaken, the OP had been able to recover lost grounds and was back on track. The OP had by the end of the review period already achieved one of its programme-end indicators (number of midwives produced). The MNCAH OP showed mixed progress . It was able to achieve two of the three DLIs; however progress in four other indicators either was not reported or the reporting was unreliable. The MCRAH OP’s progress was limited. The annual target setting was weak (four indicators had no annual target, one was overambitious which later had to be reduced ) therefore it was difficult to comment on progress. The HSM OP showed mixed progress having met two of the five indicators, with no progress in two and underachievement in one.

BDHS 2017 and BHFS 2017 reports were used to gauge achievements in the Results Framework indicators of HPNSP. Although these reports have not been officially released, the data from the reports were helpful to give a sense of the extent of improvement (or not) in RMNCAH area. Three indicators in the area of‘public health services strengthened’ and five indicators in‘equitable coverage of ESP’ showed improvement on the basis of BDHS 2017; the two quality related indicators also showed improvement, though for one, a consolidated figure could not be obtained.

Financial progress was also positive with most OPs receiving 96 percent or more of their annual allocation and spending 92 percent or more of the allocated amount.

The review identified a number of challenges in implementing the RMNCAH component of HPNSP:

* Formulation of OPs and OP indicators: Some of the indicators in the OPs are not clear or specific/hard to measure/have no clear baseline. The annual target is set on the basis of annual work plan; the mid terms targets are a different measurement. It thus becomesdifficult to assess if the progress is in the right direction or to the right extent to enable achievement of the mid-term or end-of-programme target. Gaps were observed between OP narratives and budget; some interventions span across several OPs and there is no mechanism in place for coordinating those. Significant number of training have been built into the OPs; given that training is not the mainstay of these OPs, it is not clear how good quality training will be ensured.
* Systems related challenges include a fragmented approach to implementing interventions as a result of the OPs being stand-alone, and lack of clear mechanisms to coordinate/harmonise similar activities across OPs; silo’d approach to service delivery (e.g. many different corners in the same health facility), inappropriate disposal of hospital waste post-outhouse; need for mentoring and supportive supervision for both service providers and field staff and the challenge of providing oversight functions to the burgeoning number of field level health providers and workers, especially CSBAs. Apparent lack of ownership of some of the OP by its leadership could potentially hinder robust implementation of OP activities.
* In RMNCAH, plateauing of maternal mortality ratio is a concern which needs to be addressed with priority. Lack of public facilities to provide effective 24/7 care, increasing deliveries in the private sector with three fourth taking place through C-section, dubious quality of care in a large section of private providers and lack of effective referral system are considered to beother challenges which need to be mitigated to improve maternal health. Important challenges are evolving in reproductive health with introduction of MRM (increased haemorrhage and incomplete abortion); the STI scenario also needs to be revisited to adapt strategies so that STI interventions are more effective. Slowdown in implementation of IMCI was a cause of concern for neonatal health.

In view of the above challenges, the *immediate* priority recommendations areto:

* Revise the OPs to make the indicators more specific and well defined, prioritise activities and ensure accurate budgeting, develop consolidated action plans and coordination mechanism for interventions which cut through more than one OP
* Implement the PPH-eclampsia action plan to address the two major causes of maternal deaths
* Establish quality improvement cell/ unit within MNCAH and MRCAH to accelerate rolling out of QI guidelines.
* Review the ‘corner’ approach recommended for a number of interventions and mainstream services to be provided through ‘corners’, while providing opportunity for meeting the special needs of target groups
* Improve hospital waste management in cooperation with local government ministry and institutes.

The *longer term* recommendations are to :

* Design and implement innovative strategies to attract and retain service providers 24/7 (e.g. through institution based practice or contracting in services)

Accelerate implementation of accreditation guidelines of facilities to bring improvements in quality of care and put basic regulations in place.

1. **Introduction**

Since inception, Bangladesh has prioritised making public health services available and accessible to all its citizens through various interventions, including Health for All (HFA), Primary Health Care (PHC), Expanded Programme of Immunisation (EPI). For the first three decades of its life, the interventions were implemented through ‘project approach’ which led to a proliferation of projects under the Ministry of Health and Family Welfare (MOHFW) and resulted in inadequate efficiency and effectiveness, and fragmentation of services. MOHFW therefore embraced in 1998, a sector wide approach (SWAp), through a five years’ Health and Population Sector Programme (HPSP).

The current programme, Health, Population, Nutrition Sector Programme (HPNSP) is the fourth in the series of SWApsand covers the period of January 2017-June 2022. HPNSP is consistent with Government of Bangladesh (GoB)’s 7thFive Year Plan (2016-20). Coinciding with Bangladesh’s adoption of the Sustainable Development Goals (SDGs),HPNSP is designed to build upon the achievements of the previous three SWAps, and pave the way for realising the health targets of the SDGs through Universal Health Coverage (UHC). Equity, efficiency and access to high quality serviceshave been identified as the three principles for achieving UHC.

This Annual programme Review (APR) is a management instrument designed for both GoB and Development Partners (DPs) to monitor progress in implementation of HPNSP and monitor if the objectives of HPNSP are being met through the programme. There are 29 Operational Plans (OPs) in HPNSP’s Programme Implementation Plan (PIP), which have been clustered under four themes. This section of the APR report deals with the RMNCAH area under the third theme- Quality of Health-Care Services, along with the fourth theme on Cross Cutting Issues- which includes public-private partnership, urban health, gender, equity, voice and accountability (GEVA), as relevant toRMNCAH.

1. **The Context**

Bangladesh has made remarkable progress in improving the health status of its citizens over the last few decades. In fact, this exceptional achievement of improving health status despite economic poverty has led it to being termed as ‘the Bangladesh paradox’ (Chowdhury AMR et al, The Lancet, Volume 382, Issue 9906). This is particularly true of the RMNCAH sector, where there has been remarkable improvement in reducing mortalities and improving health seeking behaviours.

The maternal mortality ratio (MMR) has decreased from 322 in 2001 to about 196/100,000 live births (NIPORT et al, Bangladesh Maternal Mortality Survey Reports 2001, and Preliminary Report 2016)-an almost 40 percent decrease; the UNestimated MMR is 176 per 1000 live births (2015). Utilisation of services for maternal, neonatal and child health has shown significant increase over the years. Ante-natal care from a qualified provider was accessed by 82 percent of women and all four visits are completed by 47 percent; 53 percent of women were attended by skilled providers at delivery, of whom 50 percent delivered in facilities. A little more than half the women and their babies received post natal care. At the same time, the rich:poor and urban:rural differentials also showed gradual decrease. Areal discrepancies in this measure still persists with Sylhet division having the highest MMR (425 per 100,000 live births) and Khulna the lowest (64 per 100,000 live births (BMMS 2014). Private sector emerged as a major actor in providing delivery care with about a third of all deliveries taking place in private facilities compared to only 14 percent in public ones. Increase in Caesaren section deliveries though continues unabated with one third of all births taking place through C-section; 84 percent of deliveries in the private sector were through C-section (BDHS 2017). This entails a huge financial burden on poorer households as C-Section in a private facility has been estimated to cost about Tk 20,000 compared to Tk 12,000 in public facilities (Bangladesh Health Facilities Survey 2017).

Significant decline has taken place in infant and under-five deaths in about the last ten years with (from 52 to 38 per 1000 live births and 65 to 45 per 1000 live births)(BDHS 2017) though the reduction in neonatal mortality has been slower (37 to 30 per 1000 live births): Bangaldesh was successful in achieving MDG 4. Majority of the neonatal deaths were from preventable causes (birth asphyxia, prematurity, severe infection and acute respiratory infection which together account for almost 75 percent of neonatal deaths). About 80 percent of these deaths occur during the first week of life, 50 percent within the first 24 hours. Estimated number of still births is similar to neonatal deaths and are largely unrecorded.

Bangladesh has a successful immunisation (EPI) programme on the ground, which has played important role in averting childhood deaths. According to BDHS 2017, 86 percent of children have received the full range of vaccinations by their first birthday. Diarrhoea prevalence has decreased to the extent that only 5 percent of under-5 children had diarrhoea and use of oral ORS (oral rehydration salt)for treatment of diarrhoea stood at 83 percent. Pneumonia, neonatal causes and drowning are the major causes of death among under-five, with pneumonia being the single most important cause (21 percent). Death from drowning has increased from 26 to 42 percent from 2007 to 2011 in this group.

These improvements in the maternal, neonatal and child health situation in the country can be attributed to fertility decline, better care seeking practices, improved access to services, with concomitant improvements in women’s education, employment and perhaps decision making capacity as a result of access to information through, particularly, availability of mobile phones (2 out of 3 households own a mobile phone) (BDHS 2017).However, the improvements in the first part of the millennium has started to stall particularly in case of MMR and neonatal deaths.The distribution of main causes of maternal mortality over the years has not shown much change either; haemorrhage (31 percent) and eclampsia (24 percent) continue to account for more than half of maternal deaths (BDHS 2017). The proportion of deaths due to obstructed labour has halved and those due to indirect causes have decreased by more than 40 percent between BDHS 2014 and 2017.

Reproductive health of women has been a cornerstone of interventions for improving the health status of Bangladeshi women. The Bangladesh government has, since its very inception, supported the provision of menstrual regulation (MR) services which are available in most public health facilities and a number of , NGO and private clinics/hospitals. In 2014, access to termination of pregnancy services further increased when GoB approved introduction of MRM (MR with medication) using misoprostol. By now, misoprostol is widely available in drug shops/pharmacies and service delivery outlets. A Guttmacher study in 2014 reported 430,000 MR procedures that year- a 34 percent decline since 2010. Additionally1.2 million terminations were performed, many of them using MRM, and some likely in unsafe conditions or by untrained providers. Performance of MR has decreased at all level of public facilities especially in GoB’s union health centres with only half of them (instead of two-thirds in 2010) providing the service. The proportion of patients with haemorrhage increased from 27 to 48 percent between 2010 and 2014, perhaps related to incorrect use of misoprostol (Hossain A et al, Access to and Quality of Menstrual Regulation Services and Post Abortion Care in Bangladesh, 2014, Guttmacher Institute 2017). More recently, cervical cancer and breast cancer have become important issues of reproductive health as these are the two most common cancers among reproductive aged women, responsible for a significant proportion of the 24 percent cancer deaths of reproductive aged women.

Adolescents comprise more than one fifth of the country’s population. Given the special vulnerability of this group, there have been efforts by the government to undertake initiatives to support their growth and development. The Bangladesh Population Policy of 2012, National Health Policy of 2011, the Bangladesh National Children Policy of 2013 all support adolescent health through promotion of awareness and knowledge, provision of good quality services and adolescents’ development. Early marriage is a norm in the country, with 59 percent of adolescent girls being married by age 18 and21 percent by age 15 (MOHFW, 2006). Adolescent childbearing entail a high risk of maternal death and higher level of mortality (UN World Population Monitoring 2002- Reproductive Rights and Reproductive Health: Selected Aspects). Almost twice as many newborn deaths occur among women less than 20 years old compared to older ones (BDHS 2011).

In order to lend vision and direction and accelerate improvements, GoB has also, over the last three years worked to develop a number of strategies including the National Maternal Health Strategy, the National Strategy for Adolescent Health and the National Child Health Strategy. Operationalising these strategies fall within the purview of HPNSP. However, the ecosystem within which HPNSP and the strategies are being implemented is also evolving. Some of the more important elements of this evolving ecosystem are:

* The bifurcation of MOHFW into two divisions: This bifurcation had existed at the field level before, but with the establishment of two divisions at the Ministry level (Health Services Division and Medical Education & Family Planning Division), even central level planning, implementation and monitoring are under two different wings with no apparent mechanism for coordination and harmony.
* The changing socio-economic situation: The economic gains of the last decade or so during which the GDP grew annually by an average of 6-7 percent and the per-capita income rose to USD 1,466 in 2018 (Daily Star, Sep 25 2018), massive expansion of use of internet with internet penetration of about 50 percent (Daily Star, Sep 20, 2018) and two in three households possessing a mobile phone, has enabled MOHFW to harness digital based technology to strengthen its programme implementation (e.g. use of MIS, e-tenders) and disseminate health education messages.With increased affordability, the private sector is gradually become a bigger actor in service delivery, with the risk of putting poor households under economic crises. Expectations of communities from health care facilities is increasing, and in few cases dissatisfaction with service quality is being expressed through violence at health care centres, creating a sense of insecurity among health care providers and managers.
* Diminishing Role of Developing Partners (DPs) post 2021: Bangladesh is set to transition into a middle income country in 2021, which would perhaps see a further reduction in DP contribution to the future sector programmes and off-budget projects leaving GoB with no option but to find ways to increase efficiency.
* The Rohingya crisis: Between 2017-2018, a huge population of 750,000 Rohingyas- the FDMNs (Forcibly Displaced Myanmar Nationals) took refuge in Bangladesh. The huge new exodus strained the local health system in 2 districts of Chittagong Division where the FDMNs had settled down. The health status of this population was precarious on arrival, and there were threats of outbreak of major epidemics which were successfully managed. Although GoB has responded effectively to the challenge of setting up services for this group, meeting continued health needs of this population will impose an additional burden on health financing and local health infrastructure, which will implications for the entire health sector, including implementation of RMNCAH activities through competition for financial and programme management resources.

1. **Methodology**

APR 2018 was conducted during January 20-February 20 2019. The RMNCAH component involved five OPs- NMES, MNCAH, MRCAH, CBHC and HSM.Progress wasassessed and challenges identified on the basis of the APIR report prepared by Project Management and Monitoring Unit, an independent arm of the MOHFW. The IRT (Independent Review Team) Consultant also reviewed a wide range of documents and websites, andconducted key informant interviews. A field visit was to Sylhet and Sunamganj district was undertaken to observe various levels of government and NGO service delivery facilities first hand and interact with providers beneficiaries. The preliminary findings were shared in a GoB-DPs’ Task Group meeting initially. A Policy Dialogue was held towards the end of the assignment to collect feedback from a wider range of stakeholders including MOHFW, DGHS and DGFP officials and DP representatives and finalised with incorporation of comments and suggestions from the audience. The entire exercise was carried out between January 20-February 20, 2019.

1. **Progress**

Five OPs were included under the RMNCAH thematic area: Nursing and Midwifery Education Services (NMES), Maternal, Neonatal, Child and Adolescent Health (MNCAH), Maternal, Child, Reproductive and Adolescent Health (MCRAH), Community based Health Care (CBHC) and Hospital Services management (HSM). All of these OPs, except MCRAH are within the purview of DGHS/HSD; MCRAH is within the purview of DGFP/ME&FW Division.

* 1. ***Progress in general***

This APR covers the initial 18 months of a five and half years programme (January 2017-June 2018). There were two streams of activities in this phase-

* closing the erstwhile Health, Population, Nutrition Sector Development Programme (HPNSDP)and , prepare for launching of HPNSP
* preparation for, and in some cases introduction of new initiatives under HPNSP

The first six months of HPNSP focussed on closing HPNSDP and getting the ground ready for implementation of HPNSP. Although HPNSP began in January 2017, the Strategic Implementation Plan (SIP) was approved in March 2016 and the OPs in May 2016. This paved the way for release of the first tranche of funds for the programme in May 2017. The next tranche of funds for various OPs were released in July/August and implementation of HPNSP began *in earnest*. Between July 2017 to June 2018, several important initiatives were undertaken in the RMNCAH area which formed the foundation forimplementingspecific interventions later. These included:

* A range of technical and management training/orientations/workshops
* Procurement of a range of clinical and non-clinical equipment and supplies
* Developing/finalisation of guidelines (e.g. facility readiness, geriatric care, standard laboratory services)
* Development/design of systems (e.g. referral system between from CCs to UHCs, adolescent friendly services)
* Development of Maternal Health Strategy, Adolescent Health Strategy
* Recruitment and licensing of first and second batches of direct entry midwives (who however could not be deployed immediately due to long process of obtaining police clearance, necessary before deployment).

The Rohingya crisis which started to unfold from late August created additional management challenge for concerned officials across the sector as services had to be set up almost overnight to respond to their urgent RMNCAH and other health needs. It was apparent that GoB’s health workforce, infrastructure and resources were inadequate to meet the challenges of the sudden and massive influx.

GoB’s response to the crisis quickly evolved from an adhoc, reactive one to a more organised response. An early warning and surveillance system was set up and extensive vaccination programmes were carried out including dispensing 900,000 doses of Oral Cholera Vaccine, 136,000 measles-rubella vaccines255,000 diphtheria vaccines which helped avert major outbreaks of communicable diseases. During August 2017 to July 2018, 3000 babies were delivered, over 800 obstetrics and newborn emergencies were handled 14,000 gender based violence cases received facility based care. Alongside intensive health education and other preventive interventions were implanted.

Managing this crisis stretched the health management structure both centrally as well as locally. The crisis unfolded at a critical time when HPNSP evolving. Subsequently the speed of implementation of activities was somewhat hindered also by the bifurcation of MOHFW. Many of the DP supported projects also came to an end during this time and new programmes were yet to be started (World Bank’s IDA funding could only be disbursed in Decemebr 2017.

***5.2 Progress against indicators of Results Framework (RFW)***

The RMNCAH thematic area is relevant to a number of indicators under Component 3, Results 3.2 (5 indicators) and 3.4 (2 indicators) of the RFW. Progress in these indicators #3.2.3-3.2.6 (antenatal care coverage, delivery by SBAs, postnatal care for non-institutional deliveries, births in health facilities by wealth quintiles) can be derived from 2017 BDHS data. The following table shows the status of these indicators based upon BDHS 2017 (to be published).

**Table 1: Progress in RFW indicators in RMNCAH area**

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| **Result** | **Indicator** | **Baseline- %**  **(BDHS 2014)** | **Progress %**  **(BDHS 2017)** |
| 3.1.PH services strengthened | 3.1.1- % newborn received ENC | 6.1 | 7.4 |
| 3.1.2- 6-23 months fed acceptable diet | 22.8 | 34.0 |
| 3.1.3- % 15-19 yr old started childbearing | 30.8 | 28.0 |
| 3.2.Equitable coverage of ESP | 3.2.3 -ANC four visits | 31.2 | 47.0 |
| 3.2.4 -% delivery by SBA | 42.1 | 53.1 |
| 3.2.5- % non-institutional deliveries receiving PNC | 5.4 | 7.0 |
| 3.2.6- Facility births-poorest:richest | 1:4.7 | 1:1.9 |
| 3.2.9 -MR immunization among children under 12 months | 86.6% (CES) | 88.0 |
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| 3.3.Quality of care improved | Public health facilities with at least one staff trained in pregnancy and childbirth | 9.9 (BHFS 2014) | Data not available exclusively for PH hospitals; Nationally, 64% ANC;45% delivery care (BHFS 2017) |
| % public facilities implement and monitor quality improvement activities | 2 – 1 MCH, 1 DH(APIR 2015) | 110 UHCs |

***5.3 Progress against OP specific indicators***

The progress against individual indicators of each of the five OPs is presented below:Key

80 percent or more achievement No information/unreliable data

50-80% achievement 50% or less achievement

**OP 12 NMES**

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| Indicator | Unit of measurement | Baseline | June 2018  Target | Available data  To date | Mid Term Target | EOP target | Comment | Score: |
| # newly recruited nurses and MWs received orientation training | # nurses/MWs (APIR)  # training (OP- MoH) | 370 trainings | 4000 | 1230 | 4000 | 3000 | .Progress during review period was inadequate but is now back on track |  |
| # nurses received specialized education and training | # nurses trained | 2200 | 6000 | 42 | 6000 | 9000 | New cycle of training has started; back on track |  |
| # newsletter/HR report published | 2/yr | NA | 2 | 2 | 4 | 6 | Indicator not aspirational; needs to be reviewed to relate to OP objectives |  |
| # training manual developed/updated | # manual | ? (DGNM/BNMC) | 4 | 2 | 4 | 5 | Limited progress during review period but now back on track |  |
| # MWs produced | # MW | 975 | 2925 | 2925 | 1950 | 2925 | Programme end target already reached |  |

**OP 16 MNCAH**

| Indicator | Unit of measurement | Baseline | June 2018  Target | Available data  To date | Mid Term Target | EOP target | Comment | Score |
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| Utilisation of Maternal health services is increased in Sylhet and Chittagong divisions | # normal deliveries in public facilites | 40,172 | 42,500 | 66,905 | 12% over baseline | 18% over baseline |  |  |
| Immunisation and equity both are enhanced in Sylhet and Chittagong (children immunized for measles and rubella immunisation coverage ) | % of children immunised | 70% in 4 districts in Sylhet; 80% in 11 districts in Chittagong | 71% in Sylhet and 81% in Chittagong | 98% in Sylhet, 95% in Chittagong | 73% in Sylhet; 83% in Chittagong | 75% in Sylhet;  85% in Chittagong | Should specify ‘fully immunised’ and as above |  |
| School based adolescent and nutrition services are developed in Sylhet and Chittagong | Percentage of public secondary school a) 4 districts in Sylhet and b) 5 districts in Chittagong division | 35 public secondary school of 5 district from Sylhet & Chittagong division(Sunmganj, Chandpur, Chittagong, Moulvibazar and Habiganj) selected | 26 public secondary school of 5 district from Sylhet & Chittagong division(sunmganj, Chandpur, Chittagong, Moulvibazar and Habiganj) selected | 74% | 30% | 40% | The scale of effort planned for Y1 appears far less than what would be needed to achieve mid-term/ programme end target. |  |
| % newborn received essential care | Percentage | 6.1% | 9% | - | 15% | 25% | 7.4% in BDHS 2017. Not possible to delineate DGHS’ contribution |  |
| ANC coverage (at least 4 visits) | Percentage | 31.2% (BDHS 2014) | 35% | 37% | 40% | 50% | Unclear source of progress data; BDHS 2017 showed 47% achievement |  |
| Percentage of delivery by skilled birth attendants (SBA) | Percentage BDHS every 3 years/UESD, every non-DHS years | 42.1% (BDHS 2014) | 45% | 45% | 55% | 65% | Reported progress data’s source is unclear;53.1% births attended by SBAs according to BDHS 2017 |  |
| Percentage mothers with non-institutional delivery receiving postnatal care from a medically trained provider within two days of delivery | Percentage BDHS every 3 years/UESD, every non-DHS years | 5.4% | 5.5% | - | 7% | 10% | 7.1 % in BDHS 2017 |  |
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**OP 17 MCRAH**

| **Indicator** | **Unit of measurement** | **Baseline** | **June 2018**  **Target** | **Available data**  **To date** | **Mid Term Target** | **EOP target** | **Comment** | **Score:** |
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| Utilisation of maternal health services is increased in Sylhet and Chittagong divisions | Percentage normal deliveries in public facilites | 71,132 | 71,844  (49,000 revised target) | 47,417 | 12% over baseline | 18% over baseline | June 2018 target was revised downwards to 49,000 |  |
| Percentage of new born received essential new born care | Percentage | 6.1 (BDHS 2014) | - | - | 15 | 25 | No target set; BDHS 2017 reported 7.4% as the national aggregate. Not possible to delineate contribution of DGFP separately |  |
| ANC coverage (at least 4 visit) | Percentage | 31.2 (BDHS 2014) | - | 410,626 | 40 | 50 | No target set; Units of measurement of annual target and achievement don’t match baseline/midterm/EOP targets; BDHS 2017 reports 47% |  |
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| Percentage of delivery by skilled birth attendant (SBA) | Percentage BDHS, every 3 years/UESD, every non-DHS years | 42.1% (BDHS 2014) | - | 634,373 | 55% | 65% | No target set; Units of measurement don’t match; BDHS 2017 reports 53% |  |
| Percentage mothers with non-institutional delivery receiving post natal care from a medically trained provider within two days of delivery | Percentage BDHS, every 3 years/UESD, every non-DHS years | 5.4 (BDHS 2014) | - | 492,230 | 7 | 10 | No target set; Progress reported by June is incorrect (from key Informant Interview) |  |
| Number of health facilities (MCWC/UH&FWC) made functional adolescent friendly health services | Number | 93 (MCH-S unit report, DGFP) | 200 | 200 | 600 | 979 |  |  |
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**OP 23 CBHC**

| Indicator | Unit of measurement | Baseline | June 2018  Target | Available data  To date | Mid Term Target | EOP target | Comment | Score: |
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| Number of CC functioning at Upazila Health Complex | Number of CCs at Upazila Health Complex | 0 (CBHC 2016) | 64 | 64 | 200 | 400 |  |  |
| Number of CC having population based data | Number of CCs (HIS/CC Monitoring Report) | 0 (CBHC 2016) | 1000 | 200 | 1000 | 5000 | The system is still paper-based |  |
| Functional referral system | Referral system functioning in UHC (facilities records) | No functional referral system exist | Initiatives taken for establishment of referral system | 8 Upazilas | Initiatives undertaken for establishment of referral | Referral system functioning in 200 UHCs | Effectiveness of the referral system needs to be assessed |  |
| Medical waste management operating at all levels of Upazila health system | Different levels of facilities practicing medical waste management (Observance) | Very limited medical waste management at UZHC only | Medical waste management process initiated at all level of facilities | - | Medical waste management process initiated at all levels of facilities | Medical waste management operating at 100 UHCs | The term ‘initiation’ is not defined; it is not clear how much has been achieved |  |
| Institutional mechanisms developed in 3 CHT districts and respective plain land Upazilas for delivering tribal health services | Number of CHT districts and plain land Upazilas (monitoring /Admin report) | Number of CHT districts and plainland upazilas (monitoring/admin report) | 2 CHT and 5 plainland Upazilas | 2 CHT districts partly (Bandarban 4 and Khagrachari 2 Upazilas | 3 CHT and 10 plainland Uapzilas | All 3 CHT districts and all required plainland Upazilas | Limited progress mainly due to difficulty in mobilizing local service providers |  |

**OP 24 HSM**

| Indicator | Unit of measurement | Baseline | June 2018  Target | Available data  To date | Mid Term Target | EOP target | Comment | Score: |
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| Number of hospitals (DH and above) introduced standard in-house medical waste management | Number of hospitals (Admin report) | MCH-06 Special. H-10, DH-04 (APIR 2016) | Total:36  MCH:10  Spcl: 12  DH: 14 | Total: 38  MCH: 10  Spl.H: 14  DH: 14 | MCH-18  Special. H-14 DH-28 | MCH-28  Special. H-22 DH-48 | Waste management is in place only upto the level of outhouse. |  |
| Number of public and non-public facilities accredited | Number of hospitals (Admin/status report) | 0 | 0 | 0 | Accreditation mechanism established | MCH-12  DH-19  Non-public hospitals-30 | Guidelines developed; legal and other processes needed to implement need to be developed |  |
| Number of district hospitals connected to structure referral system | Number of hospitals (Admin/status report) | 02 | 4 | 3 | 30 | 50 | Initial draft of the guidelines produced; Referral system introduced in 3 hospitals ; Effectiveness needs to be assessed |  |
| Number of districts with a public hospital having five essential specialities (Medicine, Surgery, Pediatrics, Obs& Gynae and Anasthologist) | Number of districts | Under 10 districts with a public hospital with 5 essential specialities |  |  | 25 | 45 | The indicator is not tracked. Needs to be reflected in HRD |  |
| Number of district hospitals providing CEmONC services in Sylhet and Chittagong divisions | Number of district hospitals | 00 | 6 | 7 | 09 | 13 |  |  |

***5.4 Progress on priority activities***

A number of priority areas were listed in the IRT Consultant’s terms of reference, for assessing progress. The following table summarises the progress in those areas.

**Table 2: Progress in Priority Activities**

|  |  |
| --- | --- |
| **Priority activity** | **Progress** |
| Implementation of National Strategy for Maternal Health | The revised National Maternal Health Strategywas submitted to MOHFW and is being translated into Bangla. It is expected to be approved soon. Implementation plan and costing needs to be developed. |
| Maternal and Perinatal Death Surveillance | MPDSR had been introduced in 22 districts under the previous sector programme, HPNSDP. Work has continued during the current review period and 32 districts were brought under the cover of this initiative. National MPDSR guidelines, TOT guidelines, and a pocketbook guideline have developed to support the initiative. TOT has been completed in all 32 districts and orientation training in respective upazilas. Upazila, district and divisional level MPDSR committees have been put into place to review the deaths and suggest remedial measures. Maternal and neonatal deaths are both notifiable. Since MRDSR has only been introduced in about half of all districts, the proportion of deaths covered by MPDSR and uploaded into DHIS 2 is small; in the earlier 22 districts where MPDSR was introduced before HPNSP, higher (about 48 percent) deaths are reported (KI interview, UNICEF). And SOP has been developed to support the initiative. Training of Trainers has been completed in these districts and orientation training in related upazilas. Both maternal and neonatal deaths are notifiable and all cases of such deaths need to be covered by MPDSR and information uploaded in DHIS 2. However, information on only 2-28 percent of notified maternal deaths and 2-14 percent of notified neonatal deaths had been updated in DGHS’ Dashboard in 2018. Once reviewed, the review findings are discussed in district level MPDSR committees and at facility level, in case of facility deaths. |
| PPH and Eclampsia Action Plan | The PPH/Eclampsia Action Plan was developed under the leadership of the EOC Technical Committee under DGHS, with facilitation from MNCAH. An implementation plan was also developed during this period. |
| MNH SOPs | A total of 34 MNH related SOPs have been developed over a period of about five years, and published through the technical assistance of OGSB, in two volumes. SOPs have been developed by QIS, they are more on processes related to facility-based service delivery than on thematic areas and include SOPs on Operation theatre, OPD, IPD, Radiology, Pathology, MPDSR. |
| 24/7 deliveries at UZ and union levels | No specific progress during this period |
| Strengthening of strategically located facilities for BEmONC and CEmONC | No progress on the EmONC assessment during this period. Critical HR gap- non availability of service provider pair- does not allow putting in place signal functions in the designated facility. |
| Addressing indirect causes of maternal death, malnutrition and chronic diseases | Progress on maternal malnutrition causes is narrated in the related IRT report. MPDSR data also captures causes of indirect deaths. |
| Implementation of the National Newborn Health Programme | The Plan has been developed however there was no progress in actual implementation. Costed implementation plan to be developed early 2019 |
| IMCI | Good progress in 3rd sector plan; progress has stalled somewhat due to introduction of NNHP which has subsumed IMCI |
| EPI | Overall coverage has improved. Since vaccines are now being procured with GoB funds by UNICEF following a procurement process prescribed by Ministry of Finance, this resulted in delay in few initial procurements. This problem has been temporarily solved through a bridge funding to tide over procedural delays. |
| Adolescent Health Programme | A national Adolescent Health Strategy (2017-2030) has been completed during this period, along with Action Plan, and is awaiting approval of MOHFW. Preparatory activities for introducing school based adolescent health and nutrition service initiated (please see IRT report on nutrition also); adolescent health services introduced in 200 DGFP facilities through adolescent corners (Please see Anneex 1, Indicator 3 under MNCAH, Indicator 6 under MCRAH OPs for details). School health programme under MNCAH is yet to start services. An SOP on adolescent health, teachers and basic health workers guideline to train targeted service providers have also been developed. |

***5.5 Progress in quality of care***

There is a long history of investments and inputs in improving quality of care. Work in this area was first undertaken as a pilot project during 1994-98, and then incorporated as dedicated OP in the next two sector programmes, HPSP and HPNSP. Under the last sector programme, HPNSDP, quality was included in the HSM OP and it was decided to adopt the TQM (Total Quality Management) which was piloted in a small number of facilities (32 UHCs, 3 MCWCs, 14 DHs and 3 MCHs). In addition, accreditation process of Women Friendly Hospital was developed and perinatal and newborn death review was introduced in a limited number of centres. Alongside, a dedicated Quality Improvement Secretariat (QIS) was established under the Health Economics Unit (HEU) which undertook various initiatives including development of a national strategy for quality improvement, formation of a Technical Advisory Group for reviewing standards, guidelines etc., development of key performance indicators for monitoring quality, etc. The QIS also worked in parallel with a number of DPs and NGOs to develop guidelines, pilots etc. with direct funding.

This substantial investment of time and money over the years resulted in pockets of improvement, but there has been no systemic impact on quality of care. In the current sector plan, two OPs, HSM and HEF have included quality improvement, though with different scopes. The HSM OP under RMNCAH component initiated a few discrete activities, including development of an action plan for quality improvement, drafting an accreditation protocol and hospital emergency management guidelines, which were awaiting approval of by the end of the review period. There has been no progress in the single OP level indicator (on number of public and non-public facilities accredited) during the review period.

***5.6 GEVA (Gender, Equity, Voice and Accountability)***

The sub-themes of GEVA need to be more strongly embedded in the planning, implementation and reporting of progress of HPNSP. The only gender disaggregated data available in the APIR relates to training where female and male participants have been disaggregated and presented. This however does not enable any conclusion to be drawn, since trainees have been naturally drawn in for various training programmes based upon the role they were engaged in. Reporting disaggregated data at the service level too would help to ensure that the programme has been able to provide equitable access to males and females. WFHI (Women Friendly Hospital Initiative), PMDSR, establishment of breastfeeding corners are some positive steps which have been included in PIP and are being introduced. However, these initiatives need to be strongly embedded in the programme. Maternal and geographical equity has been ensured to a large extent by including the two underperforming divisions in the DLIs; the maternal voucher scheme enables some disadvantaged mothers to access services, but information on this needs to be visible and available in the APIR report. Equity in terms of access to the poor however is being served by the programme as the facilities have been historically providing services mostly to the poor although there is numerous anecdotal evidence of the rich and/or influential getting preferential services. There have been efforts in the past to channel the voice of beneficiaries into the programme through district and divisional committees, which have not worked with the exception of places where inputs from NGOs through off budget projects were provided. The community groups around some of the CCs however have been found to be active good example of community involvement. There has been no visible work on accountability; accountability has many aspects and it is necessary to develop a uniform understanding of the term and build systems to establish and measure accountability.

***5.7 Public-Private Partnership***

Several discrete public-private partnerships have been in place during the review period, mostly having continued from the previous sector programme. Save the Children has been providing technical assistance to MOHFW in ten districts in system strengthening; OGSB has worked closely with MNCAH OP in developing the PPH eclampsia action plan; and an autonomous institute (BSSMU) has been closely involved in extending cervical screening programmes in various GoB health facilities in addition to providing training and referral services. Recently, a forum to stop the escalation of C-section has been established which has been working mainly to generate awareness about the risks and hazards of unnecessary C-sections, and is composed of a range of participants including private and public sector specialists, researchers and thought leaders in the sector.

***5.8 Facility observation and beneficiary feedback***

The tight timeframe of the assignment did not provide the space to carry out structured focus groups with beneficiaries. However , the Consultant had the opportunity to interact with a number of attending patients at the facilities visited. In the ob/gyn unit of the Sylhet Medical College Hospital which the IRT team visited in the evening, severe overcrowding, lack of adequate number of providers, lack of smooth patient flow was observed. It appeared that many of the patients had come from far, enduring 2-5 hours of travel. Some of them had been referred from lower level facilities but majority had come directly to the hospital…’what is the point of going to the hospital near my home when they will send me here anyway’ said one of the attendants. ‘ We came here at 11 am. I was seen soonafter and told to arrange blood; it’s 7 pm now but my husband has still not been able to manage it’- said another woman. Overall there was satisfaction with the services, in spite of the difficult surroundings. The IRT members observed that the providers were under tremendous stress, having to handle the rush of patients with a small team and were often harsh in their behaviour and handling of patients. In the Sunamganj District hospital, there was less rush. About 70 percent of the beds in the ob/gyn unit appeared full. Two patients whom the Consultant talked with appeared satisfied with services, though one mentioned that she had to buy medicines from outside. Both patients lived a long distance from the hospital; one had come to the hospital on the advice of a relative, and the second was referred from a UHC. In interpreting the patient feedback though, one needs to remember that the conversations took place within the hospital premises and so thepatients may not have been totally frank in expressing their views.

***5.9 Financial progress***

Total allocation of fund was released for two of the 4OPs; close to the full amount was released for one and 96 percent for another one. The spending rate was healthy (>90 percent) for all the OPs.

**Table 3: Fund allocation and expenditure of the 5 RMNCAH OPs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OP title** | **Total Allocation\*** (in crore Tk.) | **Fund released**  (% of allocation) | **Fund utilisation against release**  (% of fund released) | **Fund utilisation against allocation**  (% of fund allocated) |
| NMES | 913 | 100 | 68 | 68 |
| MNCAH | 703 | 96 | 98 | 94 |
| MRCAH | 182 | 100 | 92 | 92 |
| CBHC | 769 | 100 | 96 | 96 |
| HSM | 913 | 99 | 95 | 94 |

APIR 2017 \*rounded off

***5.10 Direct Project Aid to HPNSP***

During the review period, in addition to HPNSP, a number of projects, directly funded by various DPs also contributed to RMNCAH progress. The major actors in this were USAID, DFID, Global Affairs Canada (GAC), Swedish International Development Cooperation Agency and EKN. A total of 45 projects in the RMNCAH area had been active during the review period, including fiver supporting operations among the Rohingyas. USAID alone had 13 projects with durations ranging from 3-5 years and of total value of about USD 271 million on the ground (discounting projects in non-RMNCAH areas). DFID had 3 projects with a combined value of about GBP 19 million, ranging between 4-5 years. GAC’s projects were of 2-7 years and together amounted to CAD 90 million. SIDCA and EKN had substantial contribution as well (SEK equivalent to USD 7 million and 10 million approximately). These DPA projects are contributing to all the areas of RMNCAH.

*Please see Annex 2 for a listing of the major DPA investments in RMNCAH.*

1. **Challenges**

A number of challenges in RMNCAH area were identified in course of this review.

***6.1 Formulation of OPs and OP indicators***

**6.1.1 Inappropraite indicators:**

Some indicators are not relevant to the OP, not specific or are hard to measure given the data available. In the APIR, progress has been reported against annual workplan targets, which makes it hard to estimate if the activities are actually contributing adequately to achieving midterm or endline targets. Sources of data used in reporting APIR progress are often not specified and questioned even by the OP team members. Importantly, there is no measurement framework for GEVA, equity and efficiency although these constitute important underlying principles for the programme.

**6.1.2 Gaps and overlaps in OPs:**

Gaps have been observed between the OP narratives and budget, with some activities in the narrative not budgeted for, and others budgeted but not reflected in the narrative. Trainings have been included in almost every OP; it is not clear how quality of these training will be ensured. Moreover there are no plans to ensure that trained personnel are retained in their position for at least a minimum duration after training.

**6.1.3 Lack of linkage between OPs:**

There are a number of initiatives which are interdependent on several OPs across both the MOHFW divisions. For example implementation of National Maternal Health Strategy, or Structured Referral System would require several different OPs to work together. Since the OPs work in silos, implementation becomes uncoordinated and synergies have no space to develop, resulting in fragmented implementation and wastage of resources.

***6.2 Systems related issues***

**6.2.1 Fragmented implementation:**

Interventions are sometimes designed and introduced in one part of the programme. Since the OPs are self standing, the learning’s from interventions are not shared across the programme; such sharing is more difficult among the two arms of MOHFW- HSD and DGFP. Pilot interventions are being developed with technical assistance from DPs, and are resulting in pockets of improvement. Previous experience has shown that as DP funded activities end, scaling up of these interventions does not take place and the earlier momentum is lost- e.g. the IMCI intervention.

**6.2.2 Stronger leadership in, and ownsership of OPs :**

The IRT team observed a lack of initiative and interest to take ownership of the OPs among some of the OP leadership teams. This was evidenced by their lack of knowledge on ongoing activities/reports and weak or no forward planning to mitigate difficulties. Many of the initiatives were apparently driven by DPs, the country teams providing limited inputs to planning of interventions.

**6.2.3 Vertical, silo’d interventions:**

The approach of establishing ‘corners’ for carrying out targeted interventions in facilities seems to be taking ground, with several corners being already introduced at UHCs- IMCI corner, adolescents corner, breastfeeding corner, EPI corner, etc. This is not an effective strategy as it segregates the concerned service and moves it away from mainstreaming, stretches the service providers (as the same provider has competing demands on her/his time from several ‘corners’), and in the long run may not be sustainable..

**6.2.4 Waste management:**

Progress has been achieved in waste management at the facilities level where waste segregation and transport to outhouses are in place. Except in those facilities where an NGO is contracted to collect, treat and then dispose the waste, the hospital waste is generally carried from the outhouse by local government authorities to landfills, without being treated, thus posing a public health and environmental hazard.

**6.2.5 Lack of ‘supportive’ supervision and mentoring:**

Inspite of regular monitoring and supervisory visits, the need for a well developed system to provide ‘supportive supervision’ through on the job training, counselling and mentoring is felt by providers. Those who have been in recent mentoring training have benefited greatly in terms of learning and morale boosting. The positive impact of mentoring has been observed in BRACU’s midwifery programme.

**6.2.6 Scaling up quality interventions**

Much work has been done over the last two decades on improving quality of services (please see section 5.5). Although quality has been acknowledged to be a cornerstone for HNPSP, and a number of models/tools have been developed for quality improvement by QIS, none of these have been scaled up to an extent where these could impact

**6.2.7Many different cadres in delivery services:**

Delivery services are now being provided by a range of providers, trained through different programmes. These include the CSBAs trained by GoB and privately, Midwives (direct entry), Certified Midwives, FWVs. The training duration and curriculum of these different cadres vary and it is logical to assume that their skill levels also differ. Mechanism to bring all these cadres under some kind of asupervisory system is essential. Given the increasing number of CSBAs, and several categories of field levelworkers, including MPHVs planned to be recruited shortly, it will be a challenge to find the right level of supervisory support for this large contingent of providers/field-workers.

***6.3 Challenges in RMNCAH area***

**6.3.1 Plateauing of maternal mortality:**

This is perhaps the most serious of challenges. The low hanging fruits in reducing maternal mortality have been reaped, and further reduction will require focussed, concerted efforts. There has been considerable improvement in several maternal health related indicators, though further improvements cannot be achieved without addressing the problem of having adequately skilled providers at all levels of facilities and in the field with a supportive structure around them along with adequate provision of supplies and logistics. The two major contributors to maternal mortality (haemorrhage and eclampsia) proportions remain unchanged over the years, calling for targeted action to treat/prevent these conditions.

**6.3.2 Increasing Caesarean Sections:**

C-sections continue to increase with about a third women delivering through C section; in the private sector this is as high as three quarters of all deliveries. The rate is considerably higher than the universally accepted percentage, and is perhaps driven at least in some cases by the preference of the doctors and/or the patient. Although some measure of quality is ensured in the public facilities, the quality in the private sector varies widely and is unknown to a large measure.

**6.3.3 Availability of 24/7 delivery care:**

There has been little progress in this area, mainly due to lack of skilled provider(s) in the facilities. Innovative ways of temporarily hiring such providers in the absence of a regular posted one has been mentioned as a strategy in the PIP document, but is yet to be tried. Most facilities seem to close after 2.00pm, except some tertiary level ones, driving women either to the private sector.

**6.3.4 Quality of care in private sector:**

The largest section of facility deliveries take place in the private sector; and the share of this sector is increasing faster than the public sector with many of the public providers working in the private. Yet, it is known that facilities within private sector differ widely in the standards of care and the fees charged. In the absence of a strong regulatory framework, the risks of women receiving wrong or poor quality services and being financially exploited are high.

**6.3.5 Maintaining emphasis on reproductive health:**

The PIP document has relatively less focus on reproductive health services, as none of the indicators relate to this important component of RMNCAH. The reproductive health scenario is changing rapidly with a countrywide decrease in the number of MR services (especially at the union level where MR services decreased precipitously.) There has been a concomitant increase in induced abortions, possibly as a result of introduction of MRM. Complications such as haemorrhage and incomplete abortions are on the rise (Hossain A et al, Guttmacher Institute 2017). Cervical cancer and breast cancer incidence continue to increase, and while cervical cancer screening and referral is being scaled up, more needs to be done to scale up breast cancer screening and referrals and capacity to manage these morbidities. STIs have been an issue neglected for the last decade or so. The country now needs to move from syndromic to aetiologic diagnoses of STIs and a surveillance mechanism needs to be put in place.

1. **Recommendations**

The recommendations have been developed on the basis of challenges mentioned in Section 6. These have been categorised into two categories- immediate and long term based. The first group of recommendations need immediate attention and are critical to ensure smooth implementation and achievement of results.. The second group are those which would take some time to design and implement; they will support to improve the quality of delivery of results and may require work beyond HPNSP period.

1. **Immediate Priority**

|  |  |  |
| --- | --- | --- |
| 1. ***Revise OPs; identify coordination mechanisms for linked OPs*** | | |
| OP:  MNCAH, MRCAH, NMES, CBHC, HSM with MOHFW | | Responsibility: LD SWMMP with respective OP team |
| Timeline: Now-Sep 2019 | | PAP Recommendation:    Yes |
| The problems with the current OPs are mentioned in Section 5.1. In that context, it is necessary to:   * Review indicators to make them more specific, reflecting the activities and objectives to be achieved, with clear data sources and means of verification. * Ensure that all activities and initiatives are reflected in budget. * Develop consolidated activity plans with budgets for those activities which cut across two or more OPs (e.g. implementation of National Maternal Health Strategy) and identify linked activities across relevant OPs and put in place coordination mechanisms. | | |
|  | | |
|  | | |
| 1. ***Expedite implementation of action plan for eclampsia and PPH*** | | |
| OP:  MNCAH, MRCAH, NMES, CBHC, HSM | | Responsibility: LD MNCAH, working together with LD MCRAH |
| Timeline: Now-Jun2021 | | PAP Recommendation:    Yes |
| Since maternal mortality ratio has stalled in the recent years, and since the two major causes remain unchanged, targeted action to prevent and treat these conditions is required. The PPH- Eclampsia Action Plan has been already developed; which now needs to be rolled out quickly, along with corresponding logistics, HR and other resources. | | |
| 1. ***Review the ‘corner’ approach and mainstream services to be provided through ‘corners’*** | | |
| OP:  MNCAH, MRCAH, HSM | Responsibility: LD MNCAH to lead with a small working group from related OPs | |
| Timeline: Now-Dec 2020 | PAP Recommendation:    Yes | |
| The constraints of a silo’d approach to services has been mentioned in the Challenges section (5.2.3). This approach therefore needs to be revisited and alternate approach whereby services remain in mainstream and also meet specific needs of the target groups needs to be worked out. | | |
| 1. ***Improving waste management*** | | |
| OP:  MNCAH, MRCAH, CBHC, HSM with MOHFW | Responsibility: MNCAH in partnership with Local Government Ministry, with support from Secretary HSD | |
| Timeline: Now-Jun2020 | PAP Recommendation:    Yes | |
| Description:  Inadequate processing of waste in outhouses and dumping of untreated waste in landfills needs to be addressed. Since this is the responsibility of the local government authorities, MOHFW needs to work with the local government institutes at both central and local levels to facilitate proper and safe disposal of this waste. | | |
|  | | |
| 1. **Longer term priority** | | |
|  | | |
| 1. ***Availability of 24/7 delivery care at district and Upazila level*** | | |
| OP:  MNCAH, MRCAH HSM | Responsibility: MOHFW | |
| Timeline: Now-Jun2022 | PAP Recommendation:    No | |
| Description:    There has been little progress in this issue over the years due mainly to lack of availability of skilled providers in adequate numbers to enable 24/7 service provision. New approaches (e.g. contracting in services of specialists like ob/gyn specialists, anesthetists, or allowing institution based private practice) need to be tried to attract and retain skilled providers. The model introduced by DGFP at union levels wherein FWVs have been provided with living quarters and are allowed to practice, is showing good results. This approach needs to be assessed and replicated if considered successful. | | |
| 1. ***Roll out quality improvement initiatives*** | | |
| OP:  MNCAH, MRCAH, HSM, CBHC | | Responsibility: MOHFW |
| Timeline: Now-June 2021 | | PAP Recommendation: Yes |
| Quality related tools and models developed by QIS need to be quickly rolled out; QIS needs to be incorporated within DGHS to allow closer coordination and interaction with th service delivery infrastructure. Quality Improvement Cell should be created within MNCAH and MRCAH OPs to catalyse roll out quality improvement initiatives. | | |
| 1. ***Fast track introduction of accreditation*** | | |
| OP:  MNCAH, MRCAH, HSM, CBHC (with QIS) with DGHS and DGFP | | Responsibility: QIS |
| Timeline: Now-June 2021 | | PAP Recommendation:    No |
| Accreditation would contribute to regulating well as improving quality of service delivery. Implementation of this activity needs to prioritsed within HPNSP, and earlier work under HPNSDP reactivated to prepare for countrywide implementation | | |

**Annex 1: 4TH HPNSP: DPA to RMNCAH services (on budget/ off budget/ parallel)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | PROJECT TITLE | DURATION | | LOCATION | PROJECT VALUE | IMPLEMENTING PARTNER |
| **USAID** | | | | | | | |
| 1 | Marketing Innovations for Sustainable Health Development | | Oct 2016-Sep 2021 | Nationwide | USD 20million | SMC |
| 2 | Advancing Universal Health Coverage (AUHC) | | Oct 2017-Sep 2022 | Nationwide | USD 90 million | Chemonics |
| 3 | MaMoni Maternal and Newborn Care Strengthening Project | | Apr 2018-Apr 2023 | 10 districts | USD 49.5million | Save the Children |
| 4 | Accelerating Universal Access to Family Planning (AUAFP) | | Jul 2018-2023 | Nationwide | USD 40.6million | Pathfinder International/ |
| 5 | Ujjiban Social and Behavioral Change Communication (SBCC) Activity | | Mar 2017-2022 | Nationwide | USD 15 million | John Hopkins Univsity |
| 6 | Advancing Adolescent Health (A2H) Activity | | Jan 2016-2019 |  | USD 6million | Plan USA |
| 7 | Research for Decision Makers | | May 2017-2022 | Nationwide | USD 15million | Icddr,B |
| 8 | Improving Nutrition using Community-Based Approaches (INCA) | | May 2017-2020 | 3 districts | USD 4.5 million | Caritas Bangladesh |
| 9 | Early Childhood Development Mass Media Activity (Sisimpur) | | Dec 2017-Nov 2021 | Nationwide | USD 4million | Sesame Workshop, New York |
| 10 | Fistula Care Plus Project | | Dec 2013-Dec 2018 | Nationwide | USD 5.9million | Engender Health |
| 11 | APS PE/E (Ending Eclampsia) | | Oct 2012-Sep 2019 |  | USD 375,974 | Population Council |
| 12 | Mayer Hashi Family Planning Project in Bangladesh (MH-II) | | Oct 2013-Sep 2018 |  | USD 20 million | Engender Health |
| 13 | Improving Community Health Workers Program Performance through Harmonization & Community Engagement to Sustain Effective Coverage at Scale | | Mar 2016-Mar 2020 |  | USD .25 million | Save the Children |
|  |  | |  |  |  |  |
|  | PROJECT TITLE | DURATION | | LOCATION | PROJECT VALUE | IMPLEMENTING PARTNER |
| **DFID** | | | | | | | |
| 14 | Family Planning in Bangladesh- Improving Quality and Access | | Oct 2016-Sep 2021 | 6 divisions | GBP 4.99 million | Ipas |
| 15 | Saving lives of mothers and babies in Bangladesh: Strengthening the national midwifery programme | | 2016-2021 | Nationwide | GBP 5.34million | UNFPA |
| 16 | Better Health in Bangladesh: TA to Health Systems Strengthening(FP; BEMoNC; STI; Cervical Cancer) | | 2018-2022 | Nationwide | GBP 8.8million | UNFPA, WHO |
| **Global Affairs Canada** | | | | | | | |
| 17 | Improving maternal, sexual and reproductive health and rights in Bangladesh | | 2017-2022 | 5 | CAD 12 million | UNFPA |
| 18 | Improving Maternal, Sexual and Reproductive Health and Rights on budget | | Apr 2017-Jun 2022 | Nationwide | CAD 35 million | UNICEF AND UNFPA |
| 19 | Strengthening Health Outcome of Children | | 2018 4yrs |  | CAD 12 million | PLAN |
| 21 | Strengthening HR for Health | | April2012-April 2019 |  | CAD 20million | Co-water |
| 22 | Achieving Universal Access to SRHR in Host Communities of Cox’s Bazar  (equitable SRHR care and GBV response to host communities) | | 2018-2020 (3 years) | Cox’s Bazar district (except Ukhiya and Teknaf) | CAD 11 million | UNFPA |
| **Swedish International Development Cooperating Agency** | | | | | | | |
| 23 | Strengthening Midwifery-led Continuum of Care in Bangladesh | | 2017-2021 (4 years) | 5 districts | SEK 61.5 million | UNFPA |
| 24 | Support to MR, PAC services in government medical college hospitals | | 2016-2019 | Nationwide | SEK 50,000 | RH Step |
| **Embassy of the Kingdom of Netherlands** | | | | | | | |
| 25 | |  | | --- | | Generation Breakthrough | | | |  | | --- | | 01 December 2012 till 31 December 2019 | | |  | | --- | | Patuakhali, Barguna, Barisal and Dhaka | | |  | | --- | | -USD 8.036 million | | UNFPA |
| 26 | Shastho, Odhikar o NarirIcchapuron/  Women’s Health, Rights, and Choices | | Dec 2013 - 31 March 2018 | Dhaka city (15 slums) | BDT 278 million | Bangladesh Legal Aid and Services Trust (Lead) |
|  | PROJECT TITLE | DURATION | | LOCATION | PROJECT VALUE | IMPLEMENTING PARTNER |
|  |  | |  |  |  |  |
| 27 | Working with Women: Phase II  Promoting SRHR through Inclusive Business practices within the Ready Made Garment industry in Bangladesh | | Oct 2017–Sep 2021 | 10 Garment factories | Euro 2.4 million | SNV Bangladesh |
| 28 | Ritu: Promoting Menstrual Hygiene Management in Bangladesh | | Nov2015-April 2019 | Netrokona | Euro 3.5 million | Simavi (Lead), Red-Orange, TNO, BNPS& DORP |
| 29 | NIRAPOD 2:  Empowering women on Sexual and Reproductive Health & Rights and Choice of Safe MR and FP | | Dec 2015-Dec 2019 | 6 southern districts; 48 Garment Factories | BDT 250 million | Marie Stopes Bangladesh |
| 30 | UBR 2: Unite for Body Rights 2 | | Dec 2015-Dec 2019 | 12 upazillas | Euro 6 million | RHSTEP (Lead) |
| 31 | ADOHEARTS :Adolescent Health & Rights enhancement through innovation and system strengthening | | Oct 2016-Dec 2020 | 4 districts | USD 5 million | UNICEF |
| 32 | IMAGE-Plus :Initiatives for married adolescent girls’ empowerment | | Dec 2016-Dec2020 | 3 districts | BDT 300 million | Terre des Hommes NL (Lead) |
| 33 | SANGJOG :A program for better SRHR for young people vulnerable to HIV in Bangladesh | | Dec 2016-Nov 2018 | 7 districts | BDT 143 million | RH Step |
| 34 | ASTHA :Strengthening Access to Multi-sectoral Public Services for gender based violence (GBV) Survivors in Bangladesh | | Nov 2017-Dec 2021 | 4 districts | USD 3.6 million | UNFPA |
| 35 | Making Market Work for Women | | Nov 2015-Dec 2019 | 4 districts | BDT 186 million | Action Aid Bangladesh and Partners |
|  | **UNICEF** | |  |  |  |  |
| 36 | GoB-UNICEF joint Country Program | | 2017-2020 | National level; 25 UNDAF districts | USD 4.6 million | UNICEF Core resources (RR) |
| 37 | GAVI Health Systems Strengthening II | | 2016-2019 | 40 districts | USD 20,395,457 | Gavi HSS2/ UNICEF |
| 39 | Improving Effective Coverage of Maternal, Newborn, Child Health | | 2015-2019 | Dhaka Urban, Dhamrai, Savar, Kishoreganj district | 3.4 million USD | Swiss natcom/ UNICEF |
| 40 | City Corporations (LGIs)  MNCAH | | 2018 - 2020 | 8 City Corporations and LGD, MoLDRD&C | USD 8 million | UNICEF support to Urban (various grants, incl RR) |
|  | PROJECT TITLE | DURATION | | LOCATION | PROJECT VALUE | IMPLEMENTING PARTNER |
| **RMNCAH support for Rohingyas** | | | | | | | |
| 41 | Rohingya support through World Bank | |  | Camps | CAD 50m | GAC |
| 42 | Emergency Response for Availability and Accessibility of Quality MR, PAC and FP Services for Rohingya Refugees in Bangladesh | | Sep 2017-Jun 2019 | Cox’s bazar district | USD 1,12m | Funder: DFID  Implementer: UNFPA |
| 43 | Sexual and Reproductive Health Program for Rohingya Refugees  in Bangladesh | | Feb 2018-Mar 2019 | Cox’s bazar district | USD 163,851 | Packard Foundation |
| 44 | Amplify challenge – mobile app for Rohingya refugees | | Nov 2018- May 2019 | Cox’s bazar district | USD 80,000 | Open IDEO/ |
| 45 | Rohingya Response, provide support to FDMN and host communities | | 2017-2018 | Ukhiya and Teknaf 6 other upazilas in Cox’s Bazar | USD 10,393.690 | UNICEF |