Project Title	**Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Expansion for six new districts**
Country	Bangladesh
Submitting Organization	United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and World Health Organization (WHO)
Technical Implementing Agencies	United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and World Health Organization (WHO)
Funding Requirement	Total Estimated Cost of the Project for Five Years: CAD 19,798,993.00 (UN conversion rate: 1 CAD = 1.027 USD)

ANNEX A. EIGHT KEY RECOMMENDATIONS TO BE MET BEFORE EXPANSION

1. A package of evidence based interventions which save the lives of mothers and newborns be defined and adopted
2. Quality standards to support implementation of the basic package of interventions be defined (Benchmark 3)
3. A system of continuous quality improvement be put in place
4. The monitoring and evaluation position which is now vacant and a new position to support quality management is filled
5. There is strong medium term technical assistance support
6. The recent human resource report recommendations are acted upon and supported by international technical assistance
7. The emergency MNH drug inventory is undertaken
8. The selection and monitoring of facilities in the new districts be according to the latest UN guidelines and standards.

Annex B: October 2010 Review Final Presentation to Key Stakeholders (EC, DfID, MoHFW, UN-MNHI)

GoB UN Maternal and Neonatal Morbidity Reduction Initiative (MNHI)

Accelerating Progress towards
Maternal and Neonatal Mortality and Morbidity Reduction Initiative

Joint EC-DFID Review & Evaluation

End of Phase 1 (16th October –2nd November)

UKaid

European Union

Overview

1. Introduction and Progress
2. Issues
3. Management Recommendations
4. Recommendations for Improvement
5. Project's Future Course
6. Donor Recommendations

INTRODUCTION and PROGRESS

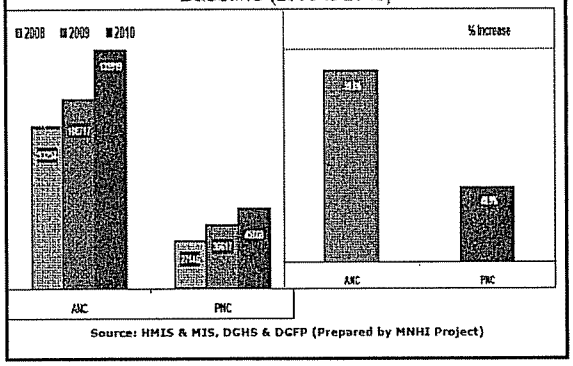
Introduction

- Now completed 19 months of actual implementation
- In the donors eyes MNHI has past 42 months duration
- Last review reported a significant improvement after a slow start
- Following this review donors will agree whether to commit to the scale up of activities in additional districts

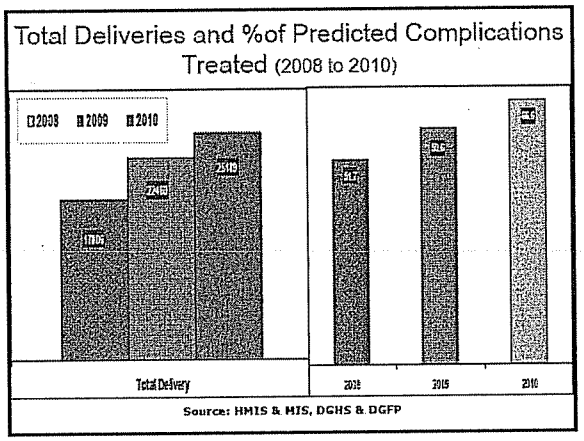
Progress

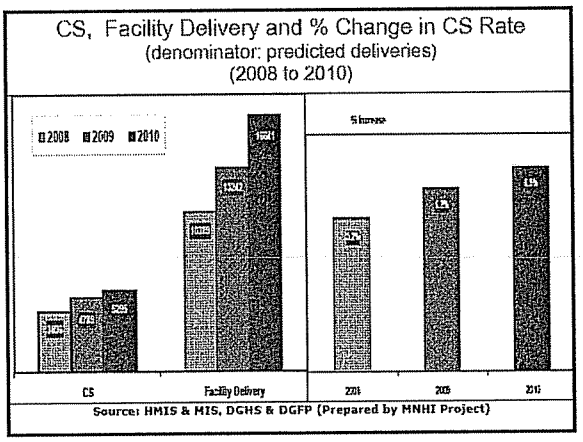
- Significant improvement across the board
- 2009 recommendations largely achieved (response to quality amazing)
- Most benchmarks have been met (staff positions to be filled)
- All 4 outputs broadly achieved (difficult to determine if activities under some outputs have been completed)
- Progress against log-frame indicators look convincing (large numbers, improvement in proxy indicators, but.. disaggregated data and qualitative evidence needed)

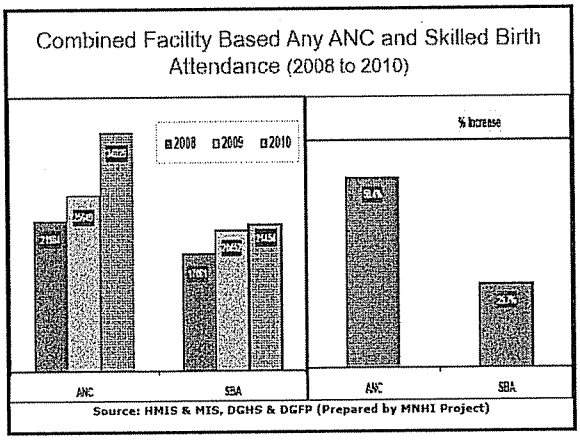
Any ANC and PNC Coverage and % Change from Baseline (2008 to 2010)

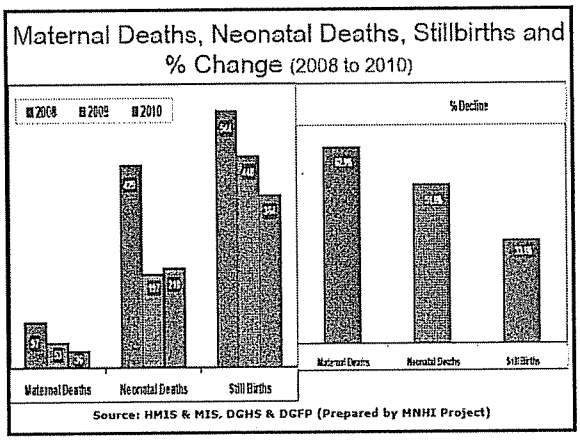


Source: HMIS & MIS, DGHS & DGFP (Prepared by MNHI Project)









Examples of Progress: Supply Side

- Sub-contracting of staff at district and Upzilla level (2 doctors, nurses, cleaners, guards)
- QA framework and standards linked to training, supervision and monitoring with professional association support
- Accreditation of WF District Hospitals (A further 2 in process)
- Monitoring of EmOC signal functions, AMSTL and infection monitoring introduced
- District Case Investment Analysis completed in 2 districts

Examples of Progress: Demand Side

- ComSS and initiatives like engagement in the Tea Gardens and establishment and renovation of estates clinics are to be applauded
- Voice and accountability: public forums, schools debates, district hospital information desks, comments box and exit interviews
- Development of a new cadre of community health volunteers – MoH FW is going to regionalise (issues with payment, FP needed in training)

Other Progress

- Evidence based interventions nearly ready for scale up:
  - Basic Health Worker Care
  - Neonatal Care
  - Emergency Triage and Treatment
  - Counselling in Antenatal Care and Post Natal Care
  - Essential Newborn Care counselling
- District Team Problem Solving (will add value to the district planning)
- Paid for Performance (nearing final evaluation)
- Maternal Perinatal Death Reviews (MPDR)

Integration in Next Health Sector Program

Too soon to say if MNHI has been integrated into the next sector program (under development). However;

- H4 Mission Report, draft sector strategy paper and pre-appraisal mission for next sector plan incorporates lessons from MNHI (district level plan with resource allocation, local HR recruitment, and focus on quality of care with equity)
- H4 has been officially requested to review and make inputs in the RH-MNCH component of the next sector program

Huge Potential

- Three strong UN institutions working together to influence policy and advocate for change
- A project that has been struggling to deliver is showing "real results"
- Results which could be scaled up rapidly

ISSUES

Issues

- There are serious concerns about the management
- Coordination between the three UN agencies and Project Office
- Results and evidence of the project need to be documented and widely disseminated.
- Donor visibility needs to be raised at the national level
- Parallel activities need to be absorbed into the health system

Issues

- Government system needs to be engaged more effectively to overcome bottlenecks e.g. approval of district plans
- Supervision and monitoring requires strengthening at all levels of service delivery
- A system needs to be in place to verify project results and data.
- The problem of long delays in implementing district plans will need to be addressed
- A sharper focus on the poor and marginalised is required

RECOMMENDATIONS FOR MANAGEMENT

Recommendations for Management

The lead agency (UNFPA) is moving the MNHI office to a new location with it's own identity.

- That the MNHI office be a central hub for technical assistance and supporting the coordination of project inputs and results.
- The project should work under one operational plan and the rules of the lead agency should apply for all levels of management (standardized management systems)

Recommendations for Management

- A project coordinator be appointed and a specialist consultant be engaged to provide regular backup. One of these persons should be a specialist in health systems strengthening and have a "track record" of working successfully with governments.
- The project team strengthened by having TA in at least the following areas QI, HR, FP and M&E/Research (? MNH). Positions should be internationally advertised and be open to national and international specialists. TAs will report directly to the project coordinator.

Recommendations for Management

- Full-time TAs should sit in the project office 100% of the time with a link to a specific agency and be supported by adequate operation staff
- Field officers are an extended arm of the MNHI office so will come under the rules of the lead management agency (with further expansion withdraw to regional level before phase out)
- Defer engagement of the DSF specialist until a firm decision is made about the implementation of DSF

RECOMMENDATIONS for IMPROVEMENT

Recommendations for Improvement

- Engage a private provider to support supervision, monitoring and development of clinical skills at a district level.
- Build accountability into the system; engage a private research or academic institution to verify results of the project and core data
- Undertake a high profile communication campaign to raise the visibility of MNHI at a national level

Recommendations for Improvement (continued)

- Instigate regular monitoring and evaluation visits to districts which involve the three UN agencies and (MoH&FW).
- To help address the delays in the planning cycle introduce a 2 or 3 year rolling plan
- When selecting communities to work with; target the poorest and hardest to reach
- ~~Clear guidelines need to be developed for identification of the poor.~~ (? Waiting for clarification)

Project's Future Course

Project's Future Course: Scale-Up

- The case for expansion is compelling
- Expansion implies **extension** and **TA support**
- Expansion will be faster than inception and should adapt a rolling model
- Phase 1 "MNHI" districts will be assets to new districts
- There is potential for significant management savings
- Will fit well with the duration of the next sector program

Recommendations: Scale-Up

The project has already considered 4 options for scale-up.

- Option 1: adjacent districts of existing 4 districts;
- Option 2: is based on indicators
- Option 3: coastal or hard to hard-to-reach districts.
- Option 4: 17 UNDAF districts (Geographical Targeting)

Wave 1

- To allow the sharing of assets between districts the review team proposes a scale-up to a minimum of 6 adjacent districts (option 1)

Recommendations: Scale-Up

- When agreeing on adjacent districts with the MoH & FW give priority to UNDAF Ranked Districts (Geographical Targeting)

Wave2

- Wave 2 consider having a minimum of 10 districts
- Future waves could follow and there could be an overlap between waves

Before Scale-Up

Agree on a package of high impact cost effective evidence based strategies and interventions that have been shown to work in a relatively short period of time. Consider where appropriate:

- Adequate number of skilled maternity and newborn health care providers available 24/7
- Improvement of infrastructure and maternity facilities
- Adequate and sustained supplies of maternal and newborn health commodities
- Improving management and monitoring including institutionalizing maternal and perinatal deaths review
- Reduction of barriers in accessing the services

Before Scale-Up

- Review the existing design, operational plan, structure and log-frame and come up with realistic and effective alternatives.
- Align with the existing health system to ensure institutionalisation of the interventions. Advocate for support through the MNH forum.
- Rationalise project management for cost effectiveness and efficiency; e.g. share resources between districts, consider contracting one NGO per district or one NGO to cover two districts, streamline baseline data collection and other studies through a single institution.

Before Scale-Up

- When selecting facilities consider geographical distribution of facilities according the MoH & FW EmOC coverage plan and the catchment areas around CHCs.
- Target the poorest and hardest to reach areas and the referral facilities from those areas.
- Consider developing a succinct acceleration toward MDGs 4 and 5 roadmap for Bangladesh which includes a table of interventions and evidence and implementation plan then have a high profile launch of the roadmap

RECOMMENDATIONS FOR DONOR SUPPORT

Donor Support

The review team believes that the project is on the verge of success. Technical assistance is needed to make it work. If existing donors wish to disengage with their current commitment:

- They should allow a reasonable time to phase out; allowing time for documenting of the lessons learned and best practices as a contribution to global knowledge. To have an optimum value for investment allow time for the implementation of the existing interventions under development.

Donor Support

- However; if a donor does disengage they will not capitalise on their investment which will be realised with the increased coverage of services ; i.e.
  - 885 additional mothers lives saved
  - 11,921 additional newborn lives saved

(Reference: Project Design Document)

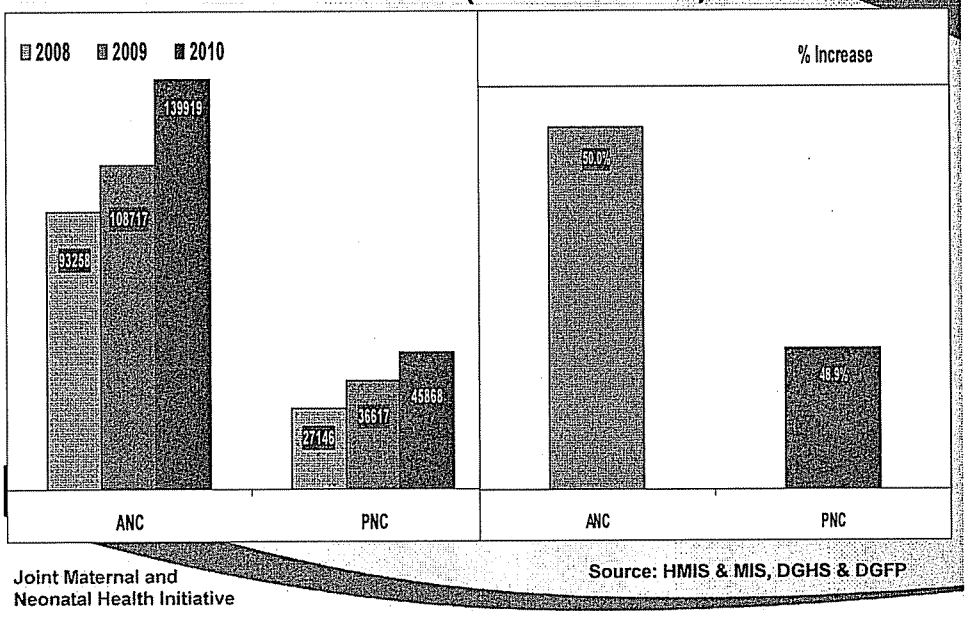
Thank-You

Jenny Middleton Dr Setara Rahman and Dr M.A Sabur

(EC/DFID Review Team 2010)

ANNEX-C: PROXY AND ACTUAL MNH OUTCOME INDICATORS

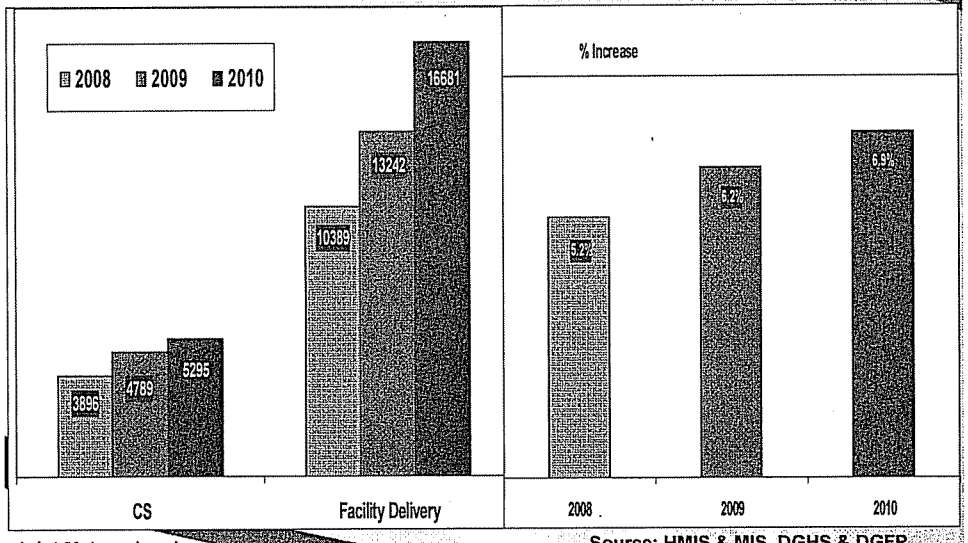
Any ANC and PNC coverage and Percent Change from Baseline (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

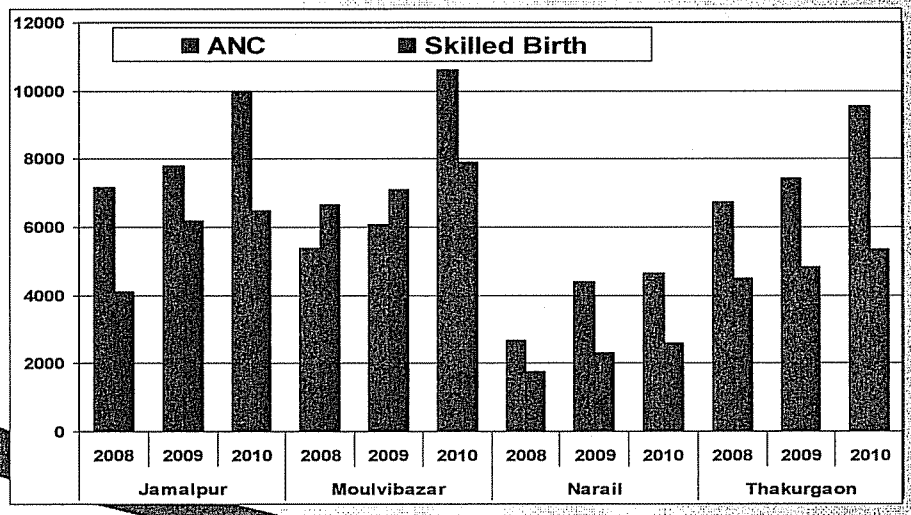
CS, Facility Delivery and Percentage Change in CS Rate (denominator: predicted deliveries) (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

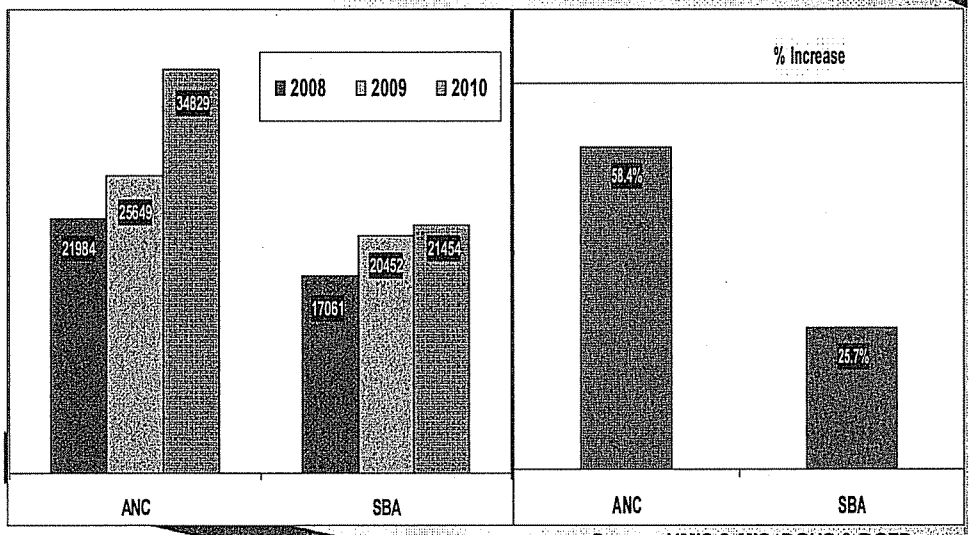
Facility Based Any ANC and Skilled Birth Attendance (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

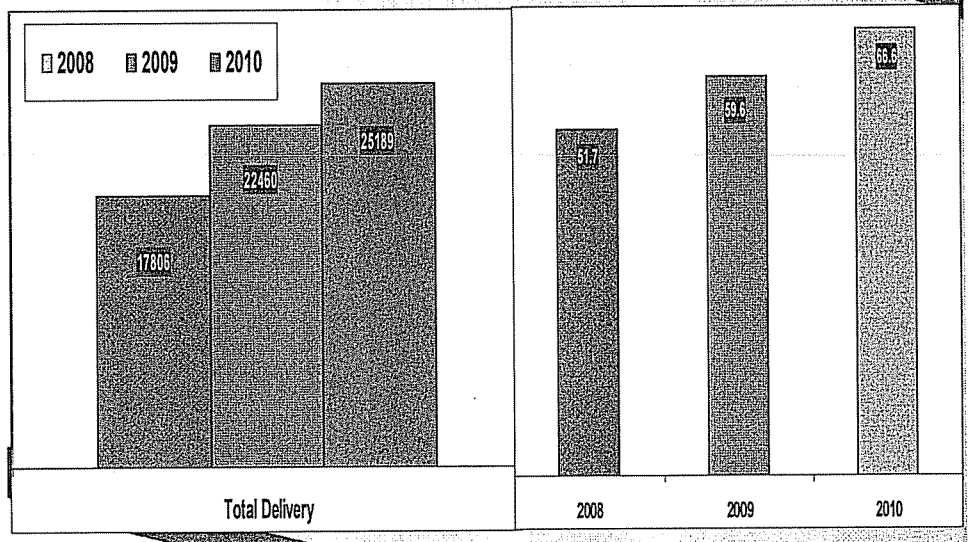
Combined Facility Based Any ANC and Skilled Birth Attendance (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

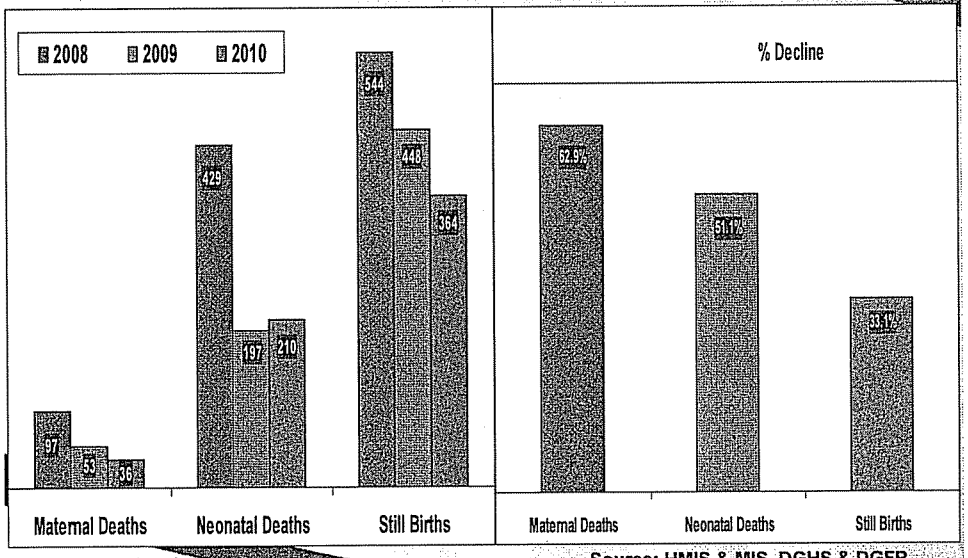
Total Deliveries and Percentage of Predicted Complications Treated (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

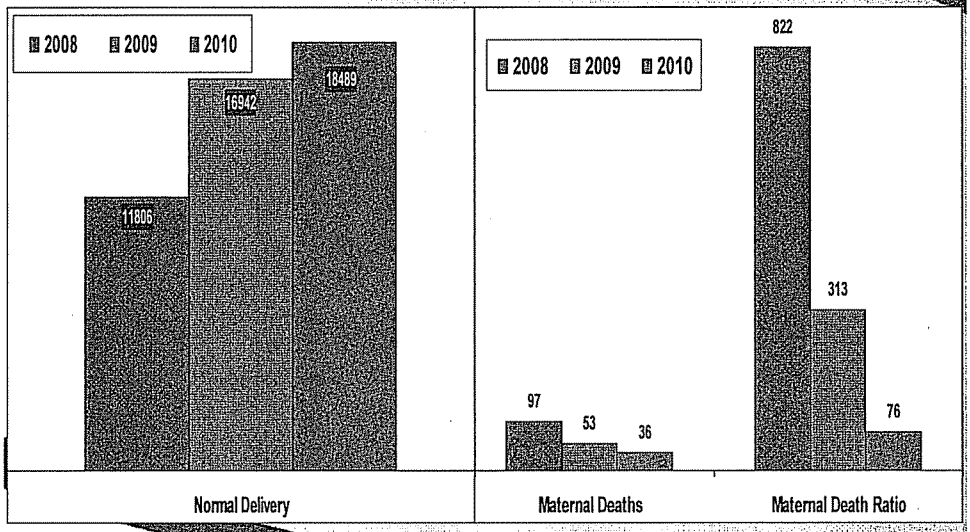
Maternal Deaths, Neonatal Deaths, Stillbirths and Percentage Change (2008 to 2010)



Joint Maternal and Neonatal Health Initiative

Source: HMIS & MIS, DGHS & DGFP

Normal Deliveries, Maternal Deaths and Maternal Death Ratio in MNHI Districts (2008 to 2010)



Source: HMIS & MIS, DGHS & DGFP

Joint Maternal and Neonatal Health Initiative

ANNEXURE D: ORIGINAL MNHI LOGFRAME

LOGICAL FRAMEWORK

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
GOAL: **The reduction of maternal and neonatal mortality and morbidity in Bangladesh, with an emphasis on equity issues to achieve MDGs 4 and 5.**	1. MMR reduced from 320 to 275 2. TFR reduced from 3.0 to 2.8 3. IMR reduced from 65 to 48 4. NMR reduced from 44 to 32	1. HDS, DHS, Sample vital registration	**Assumptions:** • Government continues commitment to MNH Programme • Political stability • Donors commitment to support MNH initiative continues • Wider health and social systems improvement • Govt. remains supportive of parallel funding rather than pooled HNPSP funding. **Risks:** • Resource flows driven by district demands undermines Line Directors' control of resources • Sub optimal coordination between DGFP and DGHS at various levels. • Natural disasters
PURPOSE: **Improve community MNH practices and utilization of quality MNH care and services particularly among the poor and excluded.**	1. Forum to support and facilitate learning on effective MNH approaches formed and functional throughout project. 2. Proportion of women who have attended ANC at least three times increased by 20% from baseline by EOP with a greater proportion of increase among the poor and excluded. 3. Proportion of women delivered by Skilled Health Personnel including CSBA increased by 30% by EOP, with a greater proportion of increase among the poor and excluded. 4. Proportion of mothers who received postnatal care increased from baseline by	1. Household surveys disaggregated by poverty quintile. 2. DHS 3. Implementing agencies' and Government reports research papers, policy papers, 4. Facility clinical records.	**Assumptions:** • Knowledge of danger signs etc will lead to better decisions. • Utilization of services will increase with improved availability, quality and affordability of services • LPP process remains functional • Agencies are available and able to conduct quality BCC activities and willing to be contracted. • Social and Human Development programs run parallel **Risks:** • Long-standing human resource management constraints are not effectively addressed

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
	12% by EoP[1] with a greater proportion of increase among the poor and excluded. 5. Met need for EmOC: Proportion of complicated pregnancies predicted in the community that are appropriately managed at a functional facility increased from baseline by 15% by EOP[2].		• Social barriers to seeking care are not weakened by BCC activities, or are less weakened in poorer sections of the community.
OUTPUT 1: **District and sub-district health MNH plans developed, implemented and monitored by Health and Family Planning Management Teams with the participation of communities.**	1. 4 district plans being implemented by month 18 and 20 district plans being implemented by month 30 with participation of civil society 2. Proportion of districts that have utilized >80% of the funds allocated per plan cycle 3. Minimum 30% of annual district funds support demand side activities (predominantly) implemented by non government agencies	Project records. District planning team meeting minutes. Minutes of ComSS. District planning team monitoring and financial reports	**Assumptions:** • The District planning team will have the capacity and facilitation support of sufficient quality to produce MNH plans that pass technical appraisal committee. • Funds are used for MNH plan implementation. **Risks:** • The plans may be biased by political pressure. • Demand side activities may be out of step with supply side activities; damaging long term. • Central approval processes may cause delays.
OUTPUT 2: **Increased availability and access of a quality continuum of MNH care and services.**	1. At least one CEmOC and 4 BEmOC facilities (accredited and offering the defined services 24 hours a day, 7 days a week[3]) per 500,000 people by EOP. 2. Recorded delays in receiving treatment after arriving at CEmONC and BEmONC facility <45 minutes. 3. CS rate at project supported CEmOC facilities for appropriate indications rises from X% at baseline to 100% 4. Case fatality rate at project supported facilities for complications falls from X% at	DHS records HFPMT records. Project records User surveys Facility clinical records. Specifically established "time from arrival to treatment" registers. User surveys.	**Assumptions:** • The facilities have an equitable geographical spread. • Providers consent to keep required records, do so honestly and allow them to be scrutinized. • Clients are sufficiently aware of their rights to care and services that their "satisfaction" genuinely reflects quality of care. **Risks:** • Unnecessary CS are performed so as to reach required rates. • EmOC procedures attract under the table payments

[1] Based on an increase from national average baseline of 18% to 30%, with local baseline to be determined.
[2] Based on an increase from national average baseline of 35% to 50%, with local baseline to be determined.
[3] CEmOC and BEmOC are defined in paragraph 3.11.3 of the Joint UN Project Proposal and this indicator implies full staffing.

Hierarchy of Aims	Objectively Verifiable Indicators	Means of Verification	Risks and Assumptions
	baseline to be <1%.		and so are performed less frequently for poorer women.
OUTPUT 3: Increased demand for MNH care and services particularly by the poor and excluded.	1. Proportion of mothers who seek care from a trained provider for neonatal illness increases from baseline by 15%. 2. 100% of targeted unions with functional community support systems (ComSS) (meeting 6 times in a year and producing minutes) by EOP. 3. Increasing trend of client satisfaction with MN services over project. 4. Proportion of families having a birth preparedness plan including plans for transport in case of an emergency and the appropriate facility to attend.	Baseline and follow up surveys, exit interviews and end line survey.	**Assumptions:** • Knowledge changes women's decision making. • Knowledge among Mothers-in-law and men changes decision making. • "Intention to act" surveys may not reflect actual behaviour. **Risks:** • ComSS do not include or represent the poorest or exclude illiterate people. • Birth preparedness plans may not be followed.
OUTPUT 4: Increased equity, participation and accountability in MNH interventions.	1. All district plans implement specific strategies for reaching the poorest throughout project. 2. At least 2 innovative approaches for increasing financial access of poor and excluded tested by year 3 and depending on outcomes taken to scale. 3. Pilot maternal and neonatal "near miss" and mortality audits in selected CEmOC and BEmOC facilities. 4. 80% of ComSSs (with a gender balance) attend meetings to develop the Upazilla plan.	District MNH plans ComSS minutes and records. Focus group discussions with ComSS members.	**Assumptions:** • Planners are aware of the patterns of poverty and marginalization in their districts/upazilas. • Planners take the ComSS seriously. **Risks:** • Providers may be unwilling to record and discuss case fatality rates or be involved in "near miss" or maternal/neonatal death audits. • ComSS gets hijacked by a political elites, men, or only literate people.

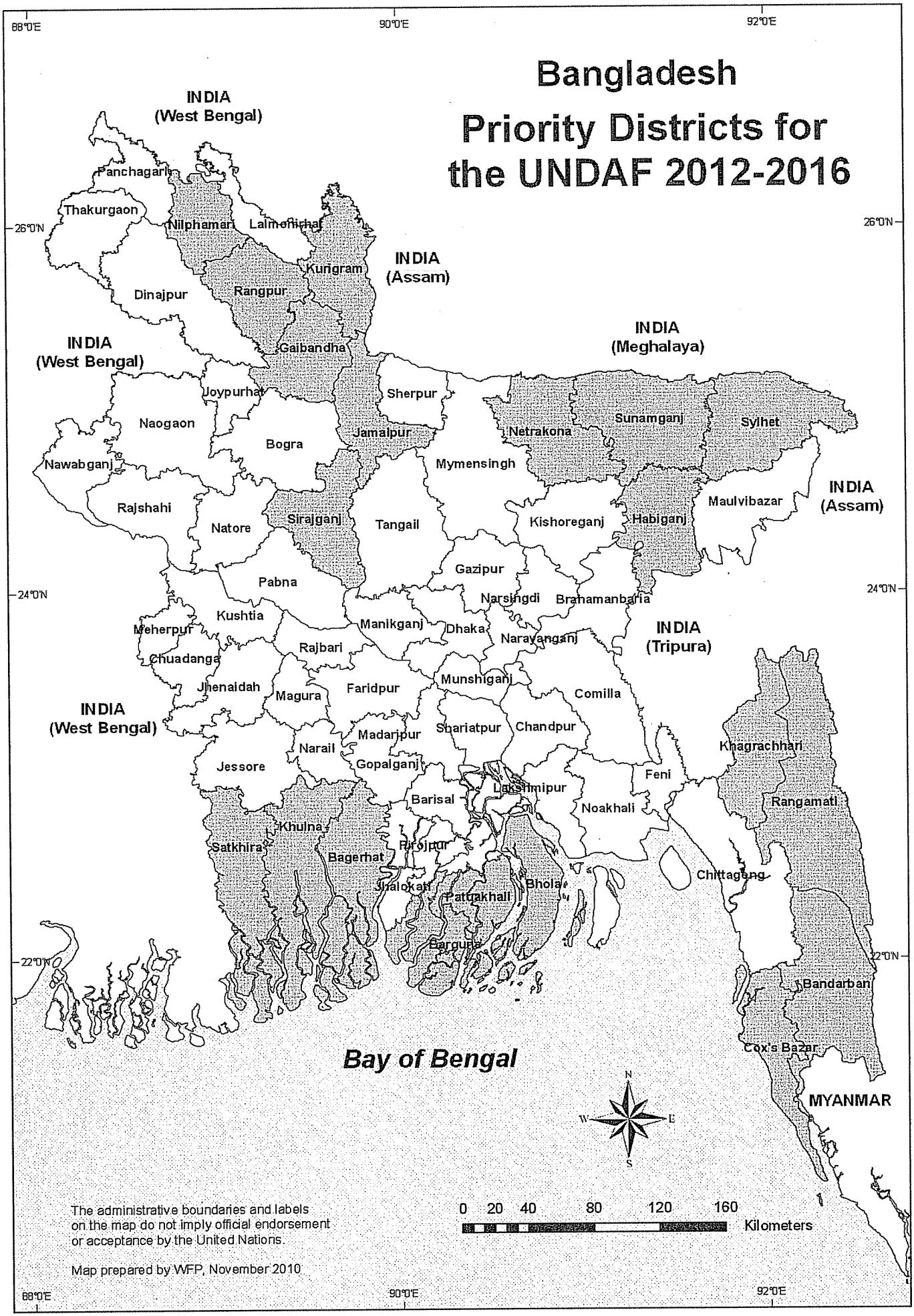
Annex-III

Benchmark/Milestone for Achievement after 18 months of Project Implementation

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
1	Project management in place and functioning efficiently and effectively.	1. Project committees established, meeting regularly and performing as per project documentation 2. All identified staff recruited, contracted, in post and functioning. 3. All UN agencies present in all joint meetings. 4. The progress report is submitted on time.	Minutes of committees. Staff contracts. Minutes of joint UN agency meetings. Progress reports.	Staff with the right skills and experience can be identified.
2	Baseline survey results available, analyzed and contributing to evidence-based district MNH planning	1. Surveys that map all supply and demand side activities by all agencies are available. 2. Surveys delivered in timely manner.	Survey data available.	Surveys are large enough and of good enough quality. Agencies are available to reliably undertake surveys.
3	Guidelines and procedures for prioritization of district MNH fund (eg what is eligible, how) agreed, codified and approved.	1. Guidelines agreed, approved and promote equity 2. LLP toolkit augmented to reflect MNH focus activities. 3. Minimum 30% of funds in each district support demand side activities, predominantly by non government agencies.	Standards identified, or if not available, adapted (or as a last resort) developed for: • Quality of care and clinical standards • Accreditation • Financial and physical asset management Guidelines produced to assist evidence-based, international best-practice-based and local context-based district MNH planning. Reports of technical appraisal of district plans.	DHS and DGFP reach agreement on guidelines and toolkits.

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
4	4 District MNH plans developed, approved, quality assured and being implemented.	District MNH plans being implemented ComSS modalities incorporated in district plan.	District plans Technical appraisal committee reports Project reports	Plans good enough to be approved. Implementation stays in line with plan. There is no political instability or interference.
5	Partnership arrangements defined and agreed.	1. Partners identified, agreed, and nature of relationship defined. 2. Activities incorporated into District plans.	Project reports Partnership agreements Contract documents	Partners of sufficient quality are available and willing to join partnerships and/or be contracted.
6	Monitoring arrangements in place and operational	1. Monitoring framework agreed and operational 2. Indicators post-18 months proposed for review	Monitoring reports	
7	Rights based approach mainstreamed across the project and plans developed to continue mainstreaming throughout to project end.	1. Participation: Civil society stakeholders participate in district MNH, including planning and monitoring. 2. Equity: District planning guidelines demonstrate pro-poor focus. Plans in place to ensure increased equity in service provision 3. Accountability: Project has mechanisms for accountability to citizens within districts, and in particular the poorest.	District MNH planning meetings minutes. Focus group discussions with present and ex-participants from civil society. An external review of all district MNH plans and their implementation to assess the extent to which they were equitable and poverty focused. Records of how accountability has been built into the project. FGDs with communities who have had or sought to had inputs to the plans.	Civil society will be interested in being participating. Participation will not be monopolized by men, elites, other interest groups. District planners want to target the poorest. District planners will agree to be more accountable.

	Benchmarks	Verifiable Indicators	Means of verification	Assumptions
8	Innovations and innovative approaches agreed and planned.	• Demand Side Financing proposal for pilot prepared. • Options to address HR problems in project districts researched and formal proposals developed for review. • Maternal and perinatal death and "near miss" audits and verbal autopsy proposal developed.	A range of models identified.	District MNH planners see demand side financing as important enough to pilot.
9	Forum for MNH operational (exchange and learning) with agreed purpose.	Forum established with agreed purpose and membership.	Minutes of meetings. Records of decisions	Membership will engage and meet regularly
10	Inventory of indicator emergency MNH drugs and monitoring of availability.	Cases of indicator MNH drug supply stockouts investigated, bottlenecks documented and reported to MoHFW decision makers for action.	Inventory Availability data	


Bangladesh
Priority Districts for the UNDAF 2012-2016
INDIA (West Bengal)
INDIA (Assam)
INDIA (Meghalaya)
INDIA (Tripura)
INDIA (West Bengal)
INDIA (West Bengal)
INDIA (Assam)
MYANMAR
Bay of Bengal
88°0'E
90°0'E
92°0'E
26°0'N
24°0'N
22°0'N
Panchagarh
Thakurgaon
Nilphamari
Lalmonirhat
Kurigram
Dinajpur
Rangpur
Gaibandha
Joypurhat
Sherpur
Naogaon
Bogra
Jamalpur
Nawabganj
Mymensingh
Netrakona
Sunamganj
Sylhet
Maulvibazar
Habiganj
Rajshahi
Natore
Sirajganj
Tangail
Kishoreganj
Pabna
Gazipur
Narsingdi
Brahamanbaria
Kushtia
Meherpur
Manikganj
Dhaka
Narayanganj
Rajbari
Chuadanga
Munshiganj
Jhenaidah
Magura
Faridpur
Comilla
Madaripur
Shariatpur
Chandpur
Narail
Khagrachhari
Jessore
Gopalganj
Feni
Lakshmipur
Barisal
Rangamati
Noakhali
Khulna
Satkhira
Pirojpur
Bagerhat
Chittagong
Jhalokati
Patuakhali
Bhola
Barguna
Bandarban
Cox's Bazar
N
W
E
S
0 20 40 80 120 160
Kilometers
The administrative boundaries and labels on the map do not imply official endorsement or acceptance by the United Nations.
Map prepared by WFP, November 2010

ANNEX F. INTERVENTION PACKAGES FOR MATERNAL AND NEWBORN HEALTH

	Universal packages (recommended in all settings)	**Situational packages** (where warranted)
Pre-pregnancy care	**Family planning** Health education to women, men families and the community Information on safe-sex, family planning, birth spacing, the availability of services including for safe abortion Counselling on and distribution of contraceptive methods including emergency contraception Screening and prevention of STIs (including HIV), cancer of the cervix and cancer of the breast.	Prevention of HIV
Safe abortion care	**Safe abortion care** Access to and provision of safe abortion care to the full extent of the law Access to and provision of treatment for complications of spontaneous and unsafe abortion WHO-recommended surgical and medical methods for uterine evacuation Contraceptive information, counselling and methods Screening, treatment and referral for other sexual and reproductive health needs.	
Care during pregnancy	**Antenatal care:** Tetanus toxoid immunization Birth and emergency planning Detection and management of complications Detection and treatment of syphilis Information and counselling on self-care, nutrition, safer sex, breastfeeding, family planning for birth spacing	Intermittent preventive therapy (IPT) for malaria Sleeping under insecticide-treated bednets Prevention of mother-to-child transmission of HIV
Care during labour, birth and 1-2 hours after birth	**Skilled care at birth:** Monitoring progress during labour Social support (companion) during birth Immediate newborn care (resuscitation if required, thermal care, hygienic cord care, early initiation of breastfeeding) **Emergency obstetric and newborn care:** Detection and clinical management of obstetric and newborn complications	Prevention of mother-to-child transmission of HIV
Postnatal/ Newborn care	**Routine postnatal care of mother and newborn:** Family planning/birth spacing information and counselling Counselling on self-care, recognition of danger signs, and key health practices Exclusive breastfeeding Thermal care Hygienic cord care Extra care of LBW infants	Prevention of mother-to-child transmission of HIV

	Prompt care-seeking for illness Immunization Management of newborn illness	

Who Will Deliver Interventions along the Continua of Care

Continua →	Interventions/ packages*	Who will deliver interventions: In the home and community	At first-level health facilities	At referral facilities
Pre-Pregnancy	***Family planning***	*CHWs provide support, information and counselling*	*Midwives, nurses and health assistants provide family planning and refer for complications*	*Nurses and doctors provide family planning provide management of methods of choices and treatment of conditions not provided at first-level facilities*
Abortion	***Safe abortion care***	*CHWs provide support, information and counselling*	*Nurses, midwives and doctors provide uterine evacuation for first-trimester and incomplete abortions, and treat common abortion-related complications*	*Skilled doctors, nurses and midwives conduct uterine evacuation for pregnancies beyond the first-trimester and manage any abortion related complications*
Pregnancy	*ANC*	*CHWs promote ANC- seeking and birth preparedness*	*Nurses and health assistants provide ANC and refer for complications*	*Nurses and doctors provide ANC for high-risk pregnancies and manage complications of pregnancy*
Birth and Immediate postnatal period	***Skilled care at birth*** ***Emergency obstetric and newborn care***	*CHWs promote skilled care at birth*	*Skilled birth attendants assist at delivery, give immediate newborn care, detect obstetric complications and*	*Skilled birth attendants assist deliveries and manage complications of labour and birth*

			refer	
Newborn period	***Routine postnatal care of mother and newborn***	*Skilled birth attendants and/ or CHWs do home visits to provide care, counsel and refer if needed*	*Nurses and health assistants give postnatal care, refer for complications*	*Nurses, doctors manage postpartum complications and severe newborn illness*

ANNEX G. DIFFERENT MNH PROJECTS

1. The Maternal, Newborn and Child Health Project (MNCH)

This is a joint BRAC and UNICEF project. It started in four districts in 2008 and expanded to ten districts in 2010. It is supported by DFID, AusAID and the Royal Dutch Embassy. The main focus of MNCH is to:

- Increase the skill and motivation of human resources to offer quality MNCH services at household and community levels.
- Enhance and strengthen referral linkage with public and private facilities.
- Involve all stakeholders and strengthen their capacities to effectively part icipate in all elements of the project.
- Increase informed demand for services.
- Facilitate the scale-up of successful approaches.

2. The Maternal, Neonatal and Child Survival Project (MNCS)

This project is implemented by the Government of Bangladesh and UNICEF with support from AusAID. It started in 2008 with a planned project life of 3.5 years. It aims to provide a package of high- impact, evidence-based interventions targeting over four million children in eight low performing districts. The three principle components of MNCS:

- Integrated Management of Childhood Illness (IMCI including Essential Newborn Care).
- Antenatal Care Plus (ANC and PNC).
- Expanded Program of Immunization Plus (EPI, Vitamin A and de-worming).

Implementation strategies include community and facility-based service delivery and also social mobilization.

3. ACCESS

ACCESS started in 2006 and is supported by USAID. This project is implemented in seven upazilas (sub-districts) of Sylhet district, covering a population of 1.5 million people. ACCESS collaborates with the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) and two national NGOs, Shimantik and Friends in Village Development, Bangladesh. Community and religious leaders, members of women's groups and local officials are mobilized involve community members at local level.

4. MAMONI

MAMONI is also supported by USAID, and is also implemented in Sylhet district. The project aims to address the high death rates among women and infants in the district through:

- Improved outreach by field workers.
- BCC for safer pregnancy and delivery.
- Improved family planning and child spacing.
- Increased awareness and use of proven, low cost methods for saving newborns.
- BCC to promote family planning.
- Strategies to provide emergency transport for pregnant women in labour.

MAMONI works in 15 upazilas coveraging some 3.5 million people.

5. Mayer Hashi

This project is also supported by USAID and the implementing partner is EngenderHealth. The main focus of Mayer Hashi is to build the capacity of government and NGOs to provide quality Family Planning services. The project aims to:

- Improve women's and children's health by increasing awareness of and access to long-acting and permanent methods (LAPM) of family planning.
- Raising awareness among health care workers of obstetric and neonatal emergencies allowing them to identify and treat them at an early stage.
- Extend the coverage of its Misoprostol PPH prevention intervention.

6. Safe Motherhood Promotion Project (SMPP)

SMPP is funded by JICA and implemented in one district (Narshingdi) but is planned to expand to several coastal districts. SMPP works in collaboration with MoHF. The project started in July 2006 covering 2.2 million people. The project focuses on:

- Strengthening health systems and management.
- Ensuring safe delivery services.
- Promoting Community Participation.

ANNEX H: DESCRIPTION OF UNFPA BANGLADESH PROGRAMME

1. UNFPA- GoB collaboration through 7th Country Programme

The current country programme (CP) covers the period 2006-2010 with the extension till 2011. The aid modalities and programme delivery emphasises capacity development, service delivery with particular focus on the poor and vulnerable and added gender dimension in the programme with emphasis on the Gender-Based Violence (GBV). In keeping with the commitments made by the government through MDGs (1, 3, 5, and 6 with a greater thrust on 3 and 5), ICPD '94, and Beijing Platform for Action, and in conformity with UNDAF framework, the 7th CP directly addresses the national priorities in health and population sector. The specific outcomes of the 7th CP are:

- Population and reproductive health related strategies effectively translated into programmes, especially for the poor and vulnerable;
- Young people are given information and services and empowered to protect themselves, specially against STI and HIV/AIDS;
- A policy environment that promotes reproductive health and rights is created; and
- Women and girls are supported and empowered to make decisions about their reproductive health and rights.

To achieve these outcomes, the programme is implemented through three mutually re-enforcing components: ***1) Reproductive Health***; ***2) Gender***; and ***3) Population and Development***. While some interventions are national in scope (e.g., advocacy, contraceptive security and components that are part of HNPSP (SWAp), many of the CP activities are concentrated on two underserved and low performing districts (i.e., Cox's Bazaar and Sylhet). The district level programme interventions are being coordinated and monitored through two field (district) offices.

1) REPRODUCTIVE HEALTH (RH)

The RH component supports and is fully integrated within the health sector SWAp (HNPSP 2003-11) through parallel funding, with a small proportion of funds (US$ 1 million) channeled through World Bank administered pool funding. Programme outputs to be achieved through the RH component include: i) increased access to improved SRH information and services; ii) increased demand especially among poor and vulnerable for SRH services; iii) SRH needs and education of young people addressed; iv) improved awareness and prevention about RTI/STI/HIV/AIDS among young people and high-risk groups.

Main implementing partners:

Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS) of Ministry of Health & Family Welfare; and Urban Primary Health Clinics of Ministry of Local Government, Rural Development & Cooperatives; Ministry of Youth and Sports; Ministry of Education; and NGOs such as Research Training & Management International (RTMI) for interventions in Rohinga Refugee camps, Bandhu Social Welfare Society (BSWS) and HIV/AIDS Allience in Bangladesh (HASAB) for HIV interventions.

Notable achievements to date:

- *FP/RH* - With UNFPA assistance (training, provision of essential drugs, medical, surgical and other equipments, etc.), 70 Maternal Child Welfare Centres (MCWCs), 20 Upazila Health Complexes (UHCs), and 30 urban clinics deliver FP and EmOC services nationwide; a national Communication Strategy for FP/RH developed.
- *Maternal mortality reduction* - Poor vulnerable pregnant women of 3 upazilas of Cox's Bazaar district are receiving financial support under National Pilot Programme of "DSF/Maternal Voucher Scheme" partially supported by UNFPA to get access to EmOC services; About 5,500 community workers trained as Community based Skilled Birth Attendants (CSBAs) to provide services in 60 districts; A strategic direction document enhancing contribution of nurse/midwives for midwifery

services developed in 2009 with emphasis on Policy-Planning, Training-Education, Deployment-Utilization, including certification and regulation by the Government.

- *Fistula* - A National Fistula Centre established along with 9 fistula corners at 9 Medical Colleges Hospitals. Thirty five (35) repaired fistula patients trained as Community Fistula Advocates (CFA) and rehabilitated in their own community for advocating "Campaign to end Obstetric Fistula" in Bangladesh.
- *Peer approach for Adolescent Reproductive health (ARH)* - ARH Strategy developed. 263 Peer educators who work through 50 youth clubs, 80 core trainers and 200 peer educators who work through 40 schools have been trained. About 4000 adolescent and youth from schools and 4500 boy scouts and girls' guides have been trained on ARH/life skills. National Youth Forum established and actively involved in advocacy (2010 theme is "Preventing Early Marriage").
- *Health sector response to VAW* - Establishment of One Stop Crisis Centre (OCC) in Cox's Bazaar District Hospital supported through training of service providers.
- *HIV* – National Partnership Forum formed on the issues of HIV and Sex work. Adolescents are working as advocate through different print and electronic media and at private universities for adolescent supportive national policy and health care system.

2) GENDER

The gender component is focusing primarily on gender equity and equality and women's empowerment, GBV, raising awareness on gender issues and development of local coalitions for promoting women's rights especially through involving men, boys and leaders of influence such as religious leaders and parliamentarians. The expected output of this component is: Rights of women and girls promoted and gender equity enhanced.

Main implementing partners:

Ministry of Women and Children Affairs, Ministry of Information, Ministry of Labour & Employment, Ministry of Religious Affairs, Ministry of Home Affairs, Bangladesh Garment Manufactures & Exports Association (BGMEA).

Notable achievements to date:

- *Support to Women Support Centre* - With UNFPA assistance, 2 Women Support Centres (WSCs) in Sylhet and Cox's Bazaar provides services to the survivors of VAW in the area of legal aid, treatment, psychosocial counseling, shelter, food assistance, adult and child literacy and vocational training for income generating activities. To date 584 women (and 592 children) and 52 women (and 57 children) took shelter in Sylhet and Cox Bazaar WSCs respectively.
- *Engaging Men and Boys to end GBV* - A national network established with the organizations working on engaging men and boys to end GBV. A South Asia Regional consultation on working with boys and men for gender equality and GBV prevention took place in Dhaka in 2009.
- *Community sensitization* - Religious leaders oriented on the issues of RH and rights, gender, and HIV/AIDS, now are instrumental in sensitizing communities through interactive meetings and delivering lectures in the mosques, etc., for changing societal attitude positively towards gender, women and girls' rights and prevention of violence. Messages have also been disseminated to general public through mass media, film show, folk songs, etc., under the project with Information Ministry.
- *Sensitization of marginalized women* - About 4,000 women working in garment and tea plantation sectors oriented and increased knowledge on RH and rights, laws on dowry, early marriage, and gender equality.

3) POPULATION & DEVELOPMENT (P&D)

The P&D component is emphasizing the utilization of gender and poverty disaggregated data for development planning and poverty reduction. It includes, amongst others, capacity development for population research, data collection and training, and advocacy on population, gender, and RH and rights at national and sub-national levels. Programme outputs to be achieved through the component include: i) Population and gender concerns integrated into national and sectoral plans; ii) Improved analysis and utilization of data disaggregated by age, sex, economic status and location.

Main implementing partners:
Population planning wing of Planning Commission, Bangladesh Bureau of Statistics (BBS), Population Science Department of Dhaka University, Bangladesh Parliament Secretariat, National Institute of Population Research and Training (NIPORT) of Ministry of Health & Family Welfare.

Notable achievements to date:

- *Research and Advocacy* – A number of researches conducted by NIPORT with some of the findings utilized for policy advocacy and programme formulation. Parliamentarians oriented on the population issues, now play major roles in advocacy initiatives. Formation of 2 parliamentary sub-committees on Youth and HIV/AIDS is the milestone achievement.
- *Strengthening Department of Population Sciences, Dhaka University* - In order to create pool of Population Scientists in-house, UNFPA facilitated the establishment (in 1998) and strengthening of Department of Population Sciences in the University of Dhaka. To date, over 200 masters and about 100 diplomas awarded in Population Sciences.
- *Digitized EA Mauza Maps* - With UNFPA assistance, BBS is preparing digitized enumeration area (EA) mouza maps towards producing GIS base maps, which will be used for census 2011.

2. UN-GoB joint maternal and neonatal health initiative (MNHI) (2007-2012)

UNFPA leads the joint MNHI where the GoB and 3 UN agencies (UNFPA, UNICEF, and WHO) work collectively to accelerate the progress towards maternal and neonatal mortality and morbidity reduction (MDG 4 & 5) with an emphasis on equity issues. With a view to improving community MNH practices and utilisation of quality MNH care and services particularly among the poor and excluded, the project adopts an innovative rights-based approach that combines supply and demand side interventions based at district level. The project was signed on 7 June 2007 for US$31.2 million, with DFID and EC funding. The first phase of implementation covers 4 districts (Thakurgaon, Narail, Moulvibazarr and Jamalpur) with scope to scale up in the additional districts in phase 2. The project beneficiaries include 47.5 million mothers and newborns.

3. UN-GoB joint programme on Violence Against Women (VAW) (2010-2012)

Three-year UN-GoB joint programme on VAW, funded by Spanish MDG Fund (US$8 million), kick started its implementation. UNFPA is the lead agency of the programme that involves 9 UN agencies (UNFPA, UNIFEM, UNICEF, WHO, ILO, UNESCO, IOM, UNDP and UNAIDS) and 11 GoB implementing partners. The programme will address the issues related to policies and implementation of the adopted laws and conventions, the attitudes and behaviour of men and women, boys and girls themselves, and provide survivors of VAW with immediate relief and rehabilitation.

4. Population and Housing Census (2011 - 2013)

The Government is preparing for the 5th Population and Housing Census in 2011. UNFPA supports the Government, particularly the Bangladesh Bureau of Statistics (BBS) in conducting the census in all three phases (Pre-census, actual census/enumeration, and post census activities). Overall UNFPA assistance is focusing on the development of capacity of BBS for conducting and efficient management of the census as well as procurement of equipment for data capturing and analysis, including printing. UNFPA is also providing technical support in several important areas, such as engendering census, inclusion of maternal mortality and disability, migration and preparation of reports. UNFPA secured funding about €10.4 million from the Delegation of the European Union as well as contributing from its own resources. The project will continue until the end of 2013.

ANNEX I. BUDGET SUMMARY (CIDA CONTRIBUTION) (CAD) *

	Year 1	Year 2	Year 3	Year 4	Year 5	Total (CAD)
Sub Total Human Resources	739,132	1,133,500	1,398,158	647,421	724,446	4,642,656
Sub Total Travel	27,421	-	29,578	32,659	18,281	107,938
Sub Total Equipment & Supplies	160,828	3,697	3,697	3,697	3,697	175,617
Sub Total Local Office	165,552	132,278	132,278	396,833	396,833	1,223,773
Output 1 intervention	403,611	484,898	494,765	494,935	325,549	2,203,758
Output 2 intervention	1,181,862	1,392,351	1,505,824	993,024	385,158	5,458,220
Output 3 & 4 interventions	852,410	919,165	919,165	898,625	25,675	3,615,040
M&E	143,780	82,160	51,350	51,350	205,400	534,040
Documentation, dissemination, and visibility	42,621	69,836	72,147	77,539	95,511	357,653
Sub Total Programme Cost	2,624,284	2,948,410	3,043,251	2,515,473	1,037,293	12,168,711
A. Direct Cost Total	3,717,217	4,217,885	4,606,961	3,596,082	2,180,549	18,318,695
B. Overhead 7% (0.07*A)	260,205	295,252	322,487	251,726	152,638	1,282,309
C. Total (A+B)	3,977,422	4,513,137	4,929,448	3,847,808	2,333,188	19,601,003
D. Administrative Agent's Fee 1% (0.01*E)	40,176	45,587	49,792	38,867	23,568	197,990
E. GRAND TOTAL (C+D)	**4,017,598**	**4,558,724**	**4,979,240**	**3,886,675**	**2,356,755**	**19,798,993**

N.B. Exchange rate: 1 CAD = 1.027 USD

*** Out of $19,798,993 budgeted for the programme, CIDA will contribute $19,750,000**