USAID's MaMoni Maternal and Newborn Care Strengthening Project

(MaMoni MNCSP)

(USAID Cooperative Agreement # 720388-18-CA00002)

Midterm Review Report

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Acronyms

AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
BCC	Behavioral Change Communication
BDT	Bangladeshi Taka
BSMMU	Bangabandhu Sheikh Mujib Medical University
CDCS	Country Development Cooperation Strategy
CHCP	Community Health Care Provider
CHW	Community Health Workers
CNCP	Comprehensive Newborn Care Package
COHSASA	Council for Health Services Accreditation for Southern Africa
CRP	Child Rights Programming
CSG	Community Support Group
CYP	Couple-Years of Protection
DAC	Development Assistance Committee
DASCOH	Development Association for Self-reliance, Communication and Health
DDFP	Deputy Director Family Planning
DDLG	Deputy Director Local Government
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DGNM	Directorate General of Nursing and Midwifery
DH	District Hospital
DHIS	District Health Information System-2
EMT	Emergency Management Teams
ENC	Essential Newborn Care
EOC	Emergency Obstetric Care
EOP	End of Program
EPI	Expanded Program on Immunization
ERC	Ethical Review Committee
FGD	Focus Group Discussion
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
GYN	Gynecologist
HA	Health Assistant
HEU	Health Economics Unit
HH	Household

HMIS	Health Management Information System
HPNSP	Health Population and Nutrition Sector Program
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSS	Health System Strengthening
HTR	Hard to Reach
IDI	In-depth Interviews
IHI	Institute for Healthcare Improvement
IPC	Infection Prevention and Control
IR	Intermediate Results
ISIA	Improvement Science in Action
IUCD	Intrauterine Contraceptive Devices
KMC	Kangaroo Mother Care
LG	Local Government
LGI	Local Government Institution
LMS	Learning Management System
MCH	Maternal and Child Health
MCRAH	Maternal Child Reproductive and Adolescent Health
MCWC	Mother & Child Welfare Centre
MEL	Monitoring, Evaluation and Learning
MIS	Management Information System
MNC	Maternal and Newborn Care
MNCAH	Maternal, Newborn, Child and Adolescent Health
MNCH	Maternal, Newborn and Child Health
MNCSP	Maternal and Newborn Care Strengthening Project
MNH	Maternal and Newborn Health
MO	Medical Officer
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
NNHP	National Newborn Health Program
NVD	Normal Vaginal Delivery
OBGYN	Obstetrics and Gynecology
PDCA	Plan-Do-Check-Act
PHD	Partners in Health Development
PMIS	Personal Management Information System
PNC	Postnatal Care
PNGO	Partner NGO
PPFP	Post-partum Family Planning

PPH	Post-partum Hemorrhage
PSKS	Palashipara Samaj Kalyan Samity
QI	Quality Improvement
QIC	Quality Improvement Committee
QIS	Quality Improvement Secretariat
QOC	Quality of Care
RIC	Resource Integration Center
RMO	Resident Medical Officer
RRT	Regional Roaming Team
SCANU	Special Care Newborn Unit
SCI	Save the Children International
SSN	Senior Staff Nurse
UFPO	Upazilla Family Planning Officer
UHC	Upazilla Health Complex
UHFPO	Upazilla Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Center
UP	Union Parishad
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
WHO	World Health Organization

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Executive Summary

MaMoni MNCSP is a five-Year (2018-2023) project, funded by the USAID, which is implemented by Save the Children (i.e., the primary implementing organization) and other international and local consortium partners. The project supports the Government of Bangladesh to strengthen its health system to offer quality maternal and newborn care with equity and sustainability in mind. MaMoni was designed to contribute to the Bangladesh Health Population Nutrition Sector Program (HPNSP: 2017-22) goals to reduce maternal and neonatal deaths by increasing equitable utilization of quality maternal and newborn care services in Bangladesh and improving the health system.

The midterm evaluation of the MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP) examines the project's progress towards meeting its objectives and associated target indicators over the three years of the implementation based on both quantitative and qualitative data in 10 districts. The review identifies the project's status, challenges, lessons learned and key opportunities to catalyze the last two years of project activities to achieve its goal and four defined intermediate results (IRs) by the end of the project in 2023. This study has also reviewed the status of the planned scale-down districts in terms of sustainability and identified the challenges that the health facilities would face after the withdrawal of intervention.

The midterm evaluation of MaMoni MNCSP undertaken used a mix of qualitative and quantitative methods: (i) analyzing data & information from project background documents and reports, the project's monitoring and evaluation (M&E) plan and surveys; (ii) in-depth interviews and focus group discussions (FGDs) with partners, stakeholders and beneficiaries; and (iii) field visits to project sites to gain in-depth understandings of achievements, challenges and scope of need-based interventions. Evaluation limitations included the selection of districts where healthcare facilities were identified and visited, possible positive response bias among beneficiaries who participated in the interviews and absence of responses from the service takers and the data discrepancy due to COVID-19. The midterm survey had some limitations, as it covered only the geographic areas and health facilities that this project had focused on during the first two and half years.

Despite the effects of COVID-19, midterm evaluation of MaMoni MNCSP has managed to successfully deliver most of its measurable performance indicators and targets. However, there is a scope for further improvements in project management, staffing, maternal and newborn service delivery, and quality of maternal and newborn care. The performance of the quantitative indicators is assessed by comparing the results between midline (Year 3, end of September 2020) and the baseline (Year 1 of 2018) data on HMI and PMIS data. Moreover, few indicators are assessed based on the survey data that was collected during January-April 2021. Qualitative findings from in-depth interviews and field visits at 3 sample districts conducted in the mid-2021 are used to complement the quantitative findings. The project's findings are summarized in response to each of midterm evaluation objectives, as noted below.

- **What have been the progress and shortcomings (lessons learned) in enhancing equitable utilization of quality MNC services**

MaMoni considers seven indicators, including neonatal and maternal facility mortality rate, institutional deliveries, the disparity in institutional delivery between rich and poor, and utilization of quality ANC

and essential newborn care for enhancing equitable utilization of quality MNC services in the sample 10 districts for enhancing equitable utilization of quality MNC services.

Quantitative analysis reveals that two out of the five indicators are on track. These indicators are maternal facility mortality rate in public sector facility (per 1000 women admitted for delivery or obstetric management in the facility) and % of deliveries in public sector health facilities. Qualitative findings reveal that the project took several measures to address the challenges from COVID-19 pandemic, including supporting service providers to communicate and follow up with patients through phone calls, virtual training, virtual monitoring, and capacity building.

Targets that are lagging include percentage of women receiving quality ANC, and the ratio of coverage for facility delivery between the richest and the poorest wealth quintiles. Despite different measures undertaken by MaMoni, COVID-19 pandemic had a visible adverse impact on quality of MNC due to intermittent lockdowns and mobility restrictions declared by the government. The rise in disparity of facility delivery resulted from the COVID-19 pandemic as it led to a rise in new poor due to the loss of their purchasing power. Moreover, many poor people are unlikely to afford the associated costs related to institutional delivery. In addition, poor people prefer delivering at home in the absence of any complications. Lack of demand creation and awareness building regarding MNH services among the poorest segment of the population contributes to such rise in disparity of facility delivery.

One indicator, i.e., neonatal facility mortality rate, remains unchanged. Based on the observation and IDIs, it is expected that MaMoni's contribution to prompt and effective care of newborn babies admitted to the SCANU and Kangaroo Mother Care (KMC) through organized and coordinated work of the medical and nursing staffs would help reducing the neonatal mortality rate. The indicator, population based neonatal mortality indicator was not measured in the midterm assessment as it is planned to be measured only at the end line.

- **What have been the progresses and shortcomings (lessons learned) in improving responsiveness of district health system to deliver patient-centered MNC services**

This first intermediate result (IR) is comprised of 10 indicators, which are associated with the improvement in responsiveness of district health system to deliver patient-centered MNC services.

Quantitative findings reveal that the program is on track for six out of the remaining seven indicators, which include:

- Percentage of facilities meeting service provision readiness for 24/7 MNC according to the applicable criteria
- Number (%) of USG-assisted service delivery sites providing family planning (FP) counseling and/or services
- % of health offices conducting data-based performance reviews at least once a quarter, amount of USD equivalent funds mobilized from local government institutions for MNC service strengthening

- % of health facilities having essential medicines for delivery services and percentage of health facilities with functional community accountability mechanisms, are on track.

Only for the indicator 'Percentage of UHFWCs providing 24/7 normal delivery services', the midline value (28%) is less than the baseline (29%). Findings from observation and in-depth interviews reveal that BEmONC and CEmONC had relatively low improvements due to COVID-19 and lack of adequately-trained service providers. However, strong advocacy to fill up the positions of neonatologist and anesthetists, hire specialists at local level, hire support staff (ward boy, maids and cleaners), ensure availability of doctors in public facilities, ensure two pairs of specialists (Obs-Gyn and Anesthesia) and trainings for nurses for Obs-Gyn and neonatal care, initiate blood-bank in the DHs, ensure regular supply of oxytocin and bilirubin meter among others would help improve responsiveness of the district health system to deliver patient-centered MNC services.

- **What have been the progresses and shortcomings (lessons learned) in improving quality of MNC services and governance of quality of care**

The second intermediate result (IR 2) comprises nine indicators measured through coordination for QoC between different MoHFW agencies and other stakeholders, scalable models for MNC QoC and the learning systems for monitoring and measurement of MNC QoC. Findings reveal that all remaining indicators[1] has shown positive signs of improvement. However, percentage of scheduled meetings held by QI committees at district and Upazilla upazilla level has shown slow progress over the Years due several factors including the COVID-19 pandemic, the government-imposed countrywide lockdown, and budgetary challenges. It is to be noted that some program changes were made at the start of Year 3 including the scaling back of QIS activities in Year 5 and learning sessions. However, MaMoni initiated engagements with private sector and re-prioritized national activities due to COVID-19. The strategy changes in project QI approaches in the later part of year 3 necessitated the changes in performance indicators under the result area. For example, the indicator "*Percentage of health facilities that had participated in MNH QOC Learning Network that have improved on at least 50% of Core MNC QOC Indicators applicable to the level of facility*" is not measured in midline QoC survey as the indicator was changed.

- **What have been the progresses and shortcomings (lessons learned) in sustaining improvement in access and demand for MNH services and HH practices**

The IR 3 aims to capture three results including increased timely and appropriate care-seeking for MNC, improved client's perception and trust of public sector MNH services and improved access to and availability of MNH services to all population including hard to reach (HTR) areas. Analysis also reveals that 5 out of 10 indicators including a sub-indicator had made improvements at the time of the midterm assessment. One indicator such as couple-Years of protection (CYP) in USG-supported programs is also on track as 91% of the target has been achieved despite the fallout from the COVID-19. However, the value of the indicator "*Percentage of women initiating modern method of FP in the*

[1] (i) Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs, (ii) percentage of women with severe pre-eclampsia/ eclampsia received appropriate management in health facilities that had participated in QOC Learning Network for Manikganj district, (iii) number of newborns not breathing spontaneously at birth who were successfully resuscitated through USG-supported programs in the country, (iv) percentage of scheduled meetings held by QI committees at national, division, district and upazila level, (v) percentage of health facility participating in MNH QOC learning network, and (vi) percentage of health facilities participating in MNH QOC learning network monitoring Core QED indicators.

post-partum period (PPFP)" remains same as the baseline (i.e., 40%). On the other hand, the value of the indicator, "*percentage of women who delivered at home and who consumed misoprostol tablets for PPH prevention*", lags marginally behind the baseline value. The progress of this indicator was disrupted due to the COVID-19 pandemic, lack of smooth supply of misoprostol tablets in the health facilities and lack of home visits and satellite clinics arranged visits due to lock down.

COVID-19 also adversely impacted the indicator assessing the percentage of infants who were put on the breasts within the first hour after birth, as during the pandemic, number of home deliveries increased. Therefore, it requires providing more efforts to improve service utilization at the facility level. Findings reveal that COVID-19 had affected delivery of FP services. Additionally, there is also a reluctance among community people in taking FP methods. In addition, the countrywide restrictions due to COVID-19 on movement along with safety concerns had a negative impact on the availability of service providers, which likely had affected misoprostol distribution and consumption and the prevalence of women initiating modern PPFP.

- **What have been the progresses and shortcomings (lessons learned) in improving national capacity to deliver MNH services at scale**

The IR 4 employs a holistic approach to strengthen national health systems support for quality MNH services at scale and national systems for certification and accreditation of public and private facilities established and demonstrated and select proven interventions and tools/approaches implemented at scale. The performance is measured through six indicators. Analysis reveals that "Number of union level health facilities in the country using e-MIS" has progressed well in achieving the annual targets. National statistics on the percentage of UHFWC providing 24/7 normal delivery services in the country is not assessed as Bangladesh Health Facility Survey (BHFS) report has not yet been published., The human resources such as pediatricians, anesthesiologists and gynecologists, lab technicians, night guards and the inadequate budget have also emerged as key barriers in improving national capacity to deliver MNH services at scale. There are different reasons for the low coverage of CNCP implementation. For example, COVID-19 pandemic reduced the uptake of health services across all facilities. Moreover, findings from visits to three districts reveal that SCANU and KMC services are affected due to lack of trained human resources in sample DHs.

- **What have been the progresses and shortcomings (lessons learned) in assessing the engagement and satisfaction of the MOH&FW, the District Health Offices, and other partners**

Overall, the respondents (Hospital Superintendent, Consultants, Medical officers, MO/MCWC, MO,-MCH-FP, Nurses, Midwives, and FWVs) have collectively recognized the contribution of MaMoni towards strengthening the quality of maternal and newborn health care services at the public facilities. This has been made possible by supporting the capacity building of local health managers and service providers through training, mentoring, planning, leadership, facility readiness, service management, data usage and e-MIS training, data quality assurance, decision making, strengthening procurement and supply of logistics. Furthermore, MaMoni MNCSP has supported establishing and operating newborn care interventions like special care newborn units (SCANU) and kangaroo mother care (KMC).

MaMoni MNCSP has established a good relationship with the local government. This has enabled the mobilization of budget, support for manpower recruitment including guards and midwives, and

renovation of facilities. Based on the discussion, all the respondents exhibited high levels of satisfaction. On a scale of 10, MaMoni MNCSP's engagement received approximately 70% or higher satisfaction rate with an average score of eight.

Moreover, despite some improvements in human resource issues following MaMoni MNCSP's intervention, shortages of human resources such as gynecologists, anesthetists, pediatric consultants, midwives and supporting staffs remain the impediments in improving national capacity to quality MNH services, which are necessary to get intense engagement and higher level of satisfaction of the MoHFW, DH offices and other partners. In addition, the provisions of key logistics including delivery table, weight machine, curtains, and syringe have been essential in expanding 24/7 UHFWC services. Ensuring all quality bundles at health facilities and strengthening the monitoring process would improve the performance monitoring indicators and ensure quality of care (QoC).

1. Introduction

1.1. Background of MaMoni MNCSP

MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP) is a five-Year long project, funded by the USAID, which is currently being implemented by Save the Children (i.e., the primary implementing organization) along with a number of technical and implementing partners/stakeholders. The activity is awarded by USAID Bangladesh for the period of April 26, 2018 to April 25, 2023. Four local NGO partners such as DASCOH Foundation, Palashipara Samaj Kallyan Samiti (PSKS), Resource Integration Centre (RIC) and Shimantik are supporting and implementing the activities in 44 Upazilla s of 10 initial districts including Brahmanbaria, Chandpur, Lakshmipur, Feni, Noakhali, Faridpur, Manikganj, Madaripur, Kushtia, and Habiganj.

The activities of the project are designed to contribute to the Bangladesh Health Population Nutrition Sector Program (HPNSP: 2017-22) goals to reduce maternal and neonatal deaths by increasing equitable utilization of quality maternal and newborn care services in Bangladesh. MaMoni Project's primary objectives are to strengthen public sector facilities management and quality of care, and leverage support of local government institutions to ensure quality health care for all. This is expected to contribute to improved health care utilization of public sector facilities and eventually reduce maternal and neonatal mortality.

The project is expected to scale down from 4 districts (i.e., Habiganj, Noakhali, Lakshmipur, and Kushtia) and expand furtherto 7 new districts (i.e. Cox's Bazar, Netrakona, Sunamganj, Sylhet, Bandarban, Mymensingh, Shariatpur) and Sandwip Island. Finally, the project's support at the national level is assumed to scale up proven maternal and newborn health (MNH) interventions nationwide. MaMoni MNCSP works through 4 Intermediate Results (IRs) and 13 sub-IRs (Annex 4) that help improve equity in the utilization of quality MNC services through improving the district health system, quality of care, demand and access to health care and the national capacity to deliver MNC care. This will eventually contribute to the Bangladesh Health Population Nutrition Sector Program (HPNSP, 2017-22) goals to reduce maternal and neonatal deaths.

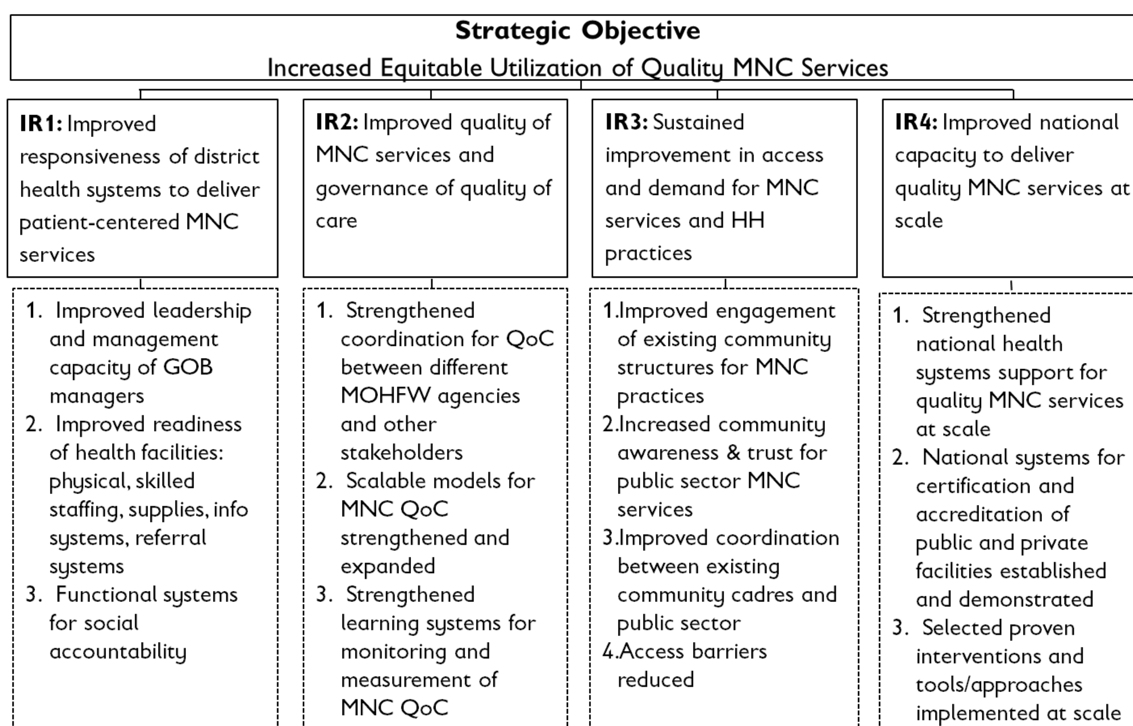


Figure 1: Strategic objective of MaMoni MNCSP

With this rationale, USAID's MaMoni MNCSP's Midterm Review in 10 initial districts assessed the progress to-date comparing the achievements of the project to its targets set forth in the project performance monitoring plan and the benchmark indicators at the baseline as well. This Midterm Review offers an analysis of the overall programmatic achievements against the project objectives and intermediate results (IRs) and sub-IRs. In addition, programmatic performance at each tier of health facilities is explored from policy imperatives. Moreover, Midterm Review aims to address the implementation challenges, to achieve the targets of output performance indicators and come up with an innovative plan to way out while providing a special focus on the COVID-19 context.

1.2. Objectives of Midterm Review of MaMoni MNCSP

The specific objectives of the assignment are stated below:

1. Assess progress to-date of the MaMoni MNCSP towards the achievement of the project's four intermediate results (IRs) areas and in achieving the targets of the performance monitoring indicators;
2. Assess the engagement and satisfaction of the MOHFW, the District Health Offices, and other partners with the progress of the project;
3. Assess the experience of providers at public sector facilities with MaMoni support;
4. Assess how effectively the project is using data and learning to drive project implementation and adjustment;
5. Review the implementation strengths, result and challenges/issues for key project implementation strategies:
    a. MNH quality improvement approach with focus on health facility readiness, quality management and clinical quality
    b. Local government mobilization for health facility improvement

   c. Expansion and improvement of 24/7 UHFWC
   d. Digital health information supports for MNH care
   e. MaMoni MNCSP support to national level in delivering MNC at scale
6. Review MaMoni MNCSP activities to scale down from 4 districts (Habiganj, Noakhali, Lakshmipur, Kushtia) that will ensure sustained improvement in MNH quality and coverage.

1.3. Overview of MaMoni MNCSP evolution and implementation

MaMoni MNCSP evolved from several set of activities that were implemented by USAID in Bangladesh. During 2009-2013, the MaMoni Integrated Safe Motherhood, Newborn Care, and Family Planning Project was implemented. Taking a district-level approach, the project was implemented only in Habiganj to deliver MNCH services, and ensure effective utilization of existing health system. Between 2013 and 2017, maternal and child health systems strengthening was ensured through MaMoni Health Systems Strengthening (HSS) project to support MOHFW in strengthening the health facilities in six districts. The major activities were implemented by community workers and there were public community health workers and project-hired community health workers. MaMoni focused on health system strengthening, both at the district level and national level. But the district level component was intensive because there were community microplanning mechanisms through community action groups, which is no longer used in the current iteration of MaMoni (2019-2023).

The next phase started from 2018 as MaMoni Maternal and Newborn Care Strengthening Project. During the same period, GoB's 4th Health Sector Program was launched. This was the first time that the health sector talked about quality and equity. This provided an auspicious opportunity for USAID to propose a project that influences equitable utilization through a project that USAID is supporting and also focusing on improving quality of services.

MaMoni-MNCSP intervention takes a holistic approach in enhancing the capacity of government managers through competency-based training based on national MNH standards, on-site post-training, follow up and clinical mentoring, counselling and communication skills support for management of complications, planning, leadership, data literacy and use, budgeting, and procurement. This also facilitates in improving health facility readiness. In addition, through advocacy support at the national, district, upazilla and union levels, MaMoni MNCSP contributes towards enhancing health facility readiness through the provision of skilled providers, commodities, medical supplies and equipment. The overall supervision, quality improvement and planning for quality healthcare is also being supported through the expansion of e-MIS services and effective utilization of data. The advocacy support extended by MaMoni MNCSP has provided a platform for interaction of local government institutions and health facilities across the project districts. Such collaborations enable mobilization of funds which contributes significantly in ensuring health facility readiness.

MaMoni MNCSP works with the government to build a responsive health system that provides evidence-based, patient-centered MNC care from conception through pregnancy, delivery and postpartum periods of mothers. The efforts include increasing government managers' leadership and managerial capability, health facility preparedness, and social accountability mechanisms. The interventions are distributed across Mother and Child Welfare Centers (MCWCs) and District Hospitals (DH), Upazilla Health Complexes (UHCs), and Union Health and Family Welfare Centers (UHFWCs) to ensure quality and equitable maternal and newborn health care.

In the first Year, MaMoni MNCSP focused primarily on preparatory activities. During that time, its predecessor, the MaMoni Health System Strengthening (MaMoni HSS) project, was in its preparatory phase. The major activities of the MaMoni MNCSP during this phase include national level advocacy and staff recruitment. The major activities in Year 2 were increase in coverage of additional districts which was facilitated through setting up of local offices, rapport building with government counterparts, staff orientation, upgradation to 24/7 facilities, facility assessment, gap analysis, facility readiness, initiation of learning network in Manikganj district, local government engagement in selected areas, and onboarding of implementing partners June 2019.

Mitigating complexities around partner onboarding was a major issue of Year 2. In Year 3, the program expanded its activities to the remaining 27 Upazilla upazilla of the seven districts, implying that program coverage reached to 71 Upazilla upazilla in later part of Year 3 (i.e., September, 2020). The three major activities of Year 3 include implementation of full package of intervention in selected areas, initiation of several new learnings and introduction of MNHQI bundles in selected districts. Geographical coverage was extended to seven new districts in Year 4, including an island Upazilla upazilla, comprising a total of 124 Upazilla upazilla.

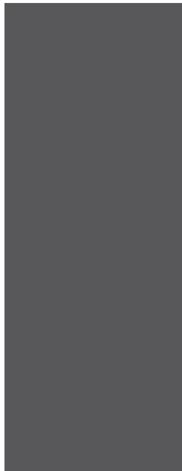
The implementation process was affected by insufficient funds and delayed disbursement during Year 3. Additional challenges arose from the economic fallout from COVID-19 pandemic and lock-down declared by the government. It should be noted that the direction from USAID for expansion of geography further delayed full district expansion in original 10 districts as there were uncertainty about the number of intervention support to be decided.

Delayed approval of modifications and COVID-19 pandemic adversely impacted the outcomes of the MaMoni MNCSP, which is described in later part of the report. The modifications that have so far been applied to the program approach and the geographic coverage include:

- Expansion of geographic locations
- Scale down in 4 out of the old 10 districts
- Repackaging of MNH interventions that includes strengthening counseling on nutrition during ANC, PNC and ENC, community-based interventions and strengthen FP service delivery for all eligible couples focusing on facilities in project districts.
- Revisions of the priorities included in the demonstration and learning agenda
- Working with MOHFW progress the finalization of Accreditation Act and the development of the Body in Year 4.

The MaMoni MNCSP has dropped the following components from the implementation activities in Y4:

- Learning Network model for quality improvement not being expanded into any other district
- Support for health systems strengthening beyond MNH (HRIS - dropped in the Year 4)
- QI support to divisions (Dhaka, Chattogram, Sylhet, Khulna) and all project seconded QI Divisional Coordinators were withdrawn



DATA & METHODOLOGY

2. Methodology and Approach

2.1. Research Design

Process evaluations are vital for interpreting and understanding the result of interventions.[2] It is also important to analyze the delivery of each component of the intervention as well as the procedures, or underlying mechanisms.[3] Thus, for the purpose of this assignment, process evaluation is used as it enables researchers to analyze the obstacles and facilitators that affect the delivery of the intervention in various situations, and investigate the extent of success or failure of such interventions.[4] To evaluate the activities of the program, a mixed-method design is utilized. Within the evaluation literature, mixed-methods have been found to be useful for assessing and understanding multiple criteria including acceptability, fidelity of delivery, feasibility, processes, reach and uptake, client satisfaction, experiences of beneficiaries and stakeholders, and equity-focused approaches.[5,6,7,8] In this regard, the review team applied formative evaluation design to answer the questions using criteria from the USAID, DAC, Save the Children's 'Theory of Change' and Child Rights Programming (CRP) framework[9] and other internationally recognized guideline to carry out the midterm evaluation.

As per the ToR, the study is primarily based on the qualitative interviews and review of secondary data and program documents. In this regard, both quantitative and qualitative data are used to carry out the evaluation. This allows the triangulation of data collected from different sources as well as substantiate the gaps in secondary information. More specifically, the sources for the quantitative secondary data includes the following, but not limited to:

- MaMoni MNCSP Performance Indicators
- MaMoni MNCSP Baseline Health Facility Survey
- MaMoni MNCSP Midline Health Facility Survey
- MaMoni MNCSP Baseline HH Survey
- MaMoni MNCSP Midline HH Survey
- MaMoni MNCSP Rapid Assessment of Quality of Care (QoC)
- MaMoni MNCSP Annual Report 2019
- MaMoni MNCSP Annual Report 2020
- Quarterly Report of HMIS
- Quarterly Report of PMIS
- Data from the routine health management information system of the Ministry of Health and Family Welfare (MOH&FW) and

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[2] Century, J., Rudnick, M., & Freeman, C. (2010). A framework for measuring fidelity of implementation: A foundation for shared language and accumulation of knowledge. *American Journal of Evaluation*, *31*(2), 199-218.

[3] Grant, A., Treweek, S., Dreischulte, T., Foy, R., & Guthrie, B. (2013). Process evaluations for cluster-randomised trials of complex interventions: a proposed framework for design and reporting. *Trials*, *14*(1), 1-10.

[4] van de Glind, I., Bunn, C., Gray, C. M., Hunt, K., Andersen, E., Jelsma, J., ... & Wyke, S. (2017). The intervention process in the European Fans in Training (EuroFIT) trial: a mixed method protocol for evaluation. *Trials*, *18*(1), 1-14.

[5] Toomey, E., Matthews, J., & Hurley, D. A. (2017). Using mixed methods to assess fidelity of delivery and its influencing factors in a complex self-management intervention for people with osteoarthritis and low back pain. *BMJ open*, *7*(8), e015452.

[6] Rosas, L. G., Lv, N., Xiao, L., Lewis, M. A., Zavella, P., Kramer, M. K., ... & Ma, J. (2016). Evaluation of a culturally-adapted lifestyle intervention to treat elevated cardiometabolic risk of Latino adults in primary care (Vida Sana): a randomized controlled trial. *Contemporary clinical trials*, *48*, 30-40.

[7] Wisdom, J., & Creswell, J. W. (2013). Mixed methods: integrating quantitative and qualitative data collection and analysis while studying patient-centered medical home models. *Rockville: Agency for Healthcare Research and Quality*.

[8] Bamberger, M., & Segone, M. (2011). *How to design and manage equity-focused evaluations*. UNICEF Evaluation Office.

[9] Save the Children. (n.d.). *Evaluation Handbook*. Retrieved from https://resourcecenter.savethechildren.net/sites/default/files/documents/5459.pdf

- Project supplementary health information.

Assessment of baseline, quarterly, annual, midterm secondary data help assess the performance of the project. A complete excel dataset has been constructed for analytical purposes. For example, 42 performance indicators prescribed under the MaMoni MNCSP Monitoring, Evaluation and Learning (MEL) plan is divided into two categories. The first group comprises the indicators that are reported annually while the remaining indicators are measured at baseline and midterm. All the indicators are assessed from dynamic and comparative perspectives. Comparisons are made between the baseline and the targets. Moreover, the dynamic analysis identifies the impact of the COVID-19 pandemic on the performance indicators. Additional information from the qualitative (QUAL) data supplement the measures undertaken during the time. Findings from quantitative data highlight the following aspects:

- Some key achievements to-date relative to baseline and project performance indicators
- Achievements related to maternal, neonatal health and family planning coverage
- Programmatic achievement in regards to maternal and newborn health and family planning at the healthcare facilities at the different tiers.
- QoC related programmatic achievements
- Engagement of local government
- e-MIS activities
- Effect of COVID-19 on performance indicators

Information was collated from both primary and secondary sources. Primary qualitative data are collected from different stakeholders using semi-structured and open-ended questionnaires, and the secondary information are gathered through reviewing the available project documents mentioned above. The study team collected qualitative primary data through field observation and interviews with health managers and service providers from health facility staff, and other project stakeholders and implementing partners. Additionally, documents pertinent to the project such as project description, work plans, MEL plan, project annual and quarterly performance reports, performance indicators, program strategy papers and other documents were also examined for our analytical purpose, which highlighted the answers concerning the objectives of study. The list of stakeholders for collecting primary qualitative data using IDIs and FGDs include the following:

- Civil Surgeon
- Government stakeholders at National level MCRAH, MNCAH, QIS, DGHS and DGFP MIS
- Implementing partner NGOs – regional coordinator or focal person
- Local government institutions
- District Family Planning Officers such as DDFP
- Primary implementing organization such as Officials of Save the Children, MaMoni Project – 1 region staff and 1 district staff and one national
- MCWC- MO-CLINIC
- UHFWC -FWV
- DH – Civil Surgeon, Superintendent, Pediatrician, Obs/Gyn
- UHC – UHFP0; Pediatrician, Obs/Gyn, Midwives, Nurse
- UHC-FP- UFPO, MOMCH

Formative research design is used to address the objectives of the study. For this purpose, in-depth interviews were conducted among the stakeholders involved in the implementation process of the MaMoni MNCSP and relevant for midline evaluation (Table 1).

Table 1: Stakeholders for Qualitative Discussion

Stakeholder	Further information
Primary implementing organization	Save the Children and consortium partner of MaMoni MNCSP
Implementing partners	DASCOH Foundation, Palashipara Samaj Kalyan Samiti (PSKS), Resource Integration Centre (RIC) and Shimantik
Government stakeholders	MCRAH, MNCAH, PMMU, QIS, MIS, Hospital Services, MOHFW at district and Upazilla upazillaupazilla level
Local government institutions	Union Parishad, Upazilla Upazilla Parishad, Zilla Parishad, DDLG
Beneficiaries	Health care providers in the MaMoni MNCSP supported health facilities

2.2. Sampling Framework for Qualitative Survey

While statistically significant and/or representative sample size is important in quantitative research, qualitative investigation requires both rich and thick data.[10] Thick data indicate a lot of information and by 'rich data' we mean many-layered, intricate, detailed information. Therefore, the sample size in qualitative study does not require to be statistically significant and/or representative. Rather researchers attempt to ensure data saturation, where saturation means "unavailability of additional data by continuing interviews with the other respondents".[11]

Geographical diversity as well as the extent of various thematic areas were covered while selecting sample size. For the study, one IDI was carried out with one representative from each of the institutions such as implementing partners, government stakeholders, local government institutions, and other partners. In this case, the representative, particularly someone who is well acquainted with the MaMoni MNCSP was purposively selected as they could provide better insights.

Additionally, to conduct the IDI with beneficiaries, the review team selected the three districts based on the five program performance criteria which include:

- Percentage of pregnant women who received at least one antenatal care (ANC) visit from public healthcare facilities in MaMoni MNCSP districts.
- Percentage of pregnant women who received misoprostol tablets from a public healthcare provider in MaMoni MNCSP districts.
- Percentage of women who delivered at public facilities in MaMoni MNCSP districts.
- Percentage of newborns that received 7.1% chlorhexidine onto their umbilical cords immediately after birth at public facilities in MaMoni MNCSP districts

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[10] Dibley, L. (2011). Analysing narrative data using McCormack's Lenses. *Nurse researcher*, *18*(3).
[11] Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., ... & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity*, *52*(4), 1893-1907.

- Number of eligible women who received PPIUCD in MaMoni MNCSP districts

For measuring the performance, we used the baseline and the Year 3 data for the above-mentioned indicators. We then ranked the district as per performance where rank-1 signified the highest performing district and 10 was the lowest performing district. Based on the ranked value of these five indicators, total score was computed for each district. In our case, the lowest and the highest total score would identify the best and worst performing districts among the sample considered. For the six full scale operating districts, we selected the second from the top performer (i.e., Madaripur district) and second from the bottom performer (i.e., Brahmanbaria). Similarly, we have selected the second from the bottom performer (i.e., Noakhali district) as a sample from the scale down district. Therefore, the team visited Brahmanbaria, Madaripur, Noakhali and Lakshmipur districts for observation checklists and interviews. Table 2 provides the details of district rank for all the ten sample districts together.

Table 2: District ranking based on criteria

District	RANK_ ANC	RANK_ MT	RANK_ DPF	RANK Chlorh exidine	RANK_ PPIUC D	Overall Score	Overall Rank
Lakshmipur	1	9	1	1	6	18	1
Chandpur	3	5	2	7	2	19	2
Madaripur	**2**	**1**	**7**	**4**	**7**	**21**	**3**
Feni	8	3	7	1	5	24	4
Faridpur	6	4	5	9	3	27	5
Khushtia	9	5	7	6	1	28	6
Brahmanbaria	**5**	**8**	**6**	**5**	**4**	**28**	**6**
Noakhali	**7**	**7**	**2**	**3**	**10**	**29**	**7**
Habiganj	4	10	2	10	8	34	9
Manikganj	10	1	7	8	9	35	10

Note: ANC for antenatal care; MT for Misoprostol Tablets; DPF for delivered at public facilities;

In line with the selection of the districts and requirements of the study, the team conducted 51 IDIs and 3 FGDs with various stakeholders from national, district, Upazilla upazillaupazilla and union levels (Table 3). The stakeholders were purposively selected with the support for MaMoni project's staff. The various stakeholders and their geographic distribution are provided in Table 4 and Table 5.

Table 3: Sampling framework for IDIs and FGDs

Stakeholder	Type	Total
Beneficiaries	IDI	17
Health Stakeholder	IDI	17
Local government	IDI	7
National Government Stakeholders	IDI	6
PNGOS	IDI	4
Primary Implementing Organizations	FGD	3

Table 4: Number of IDIs completed

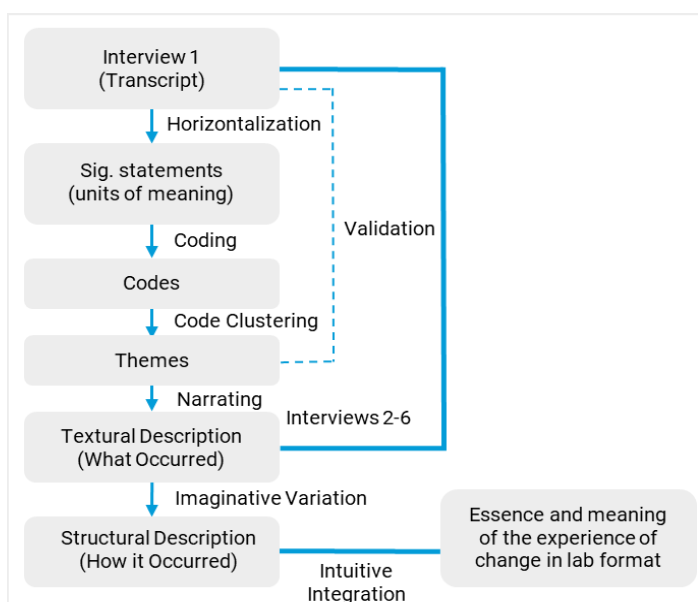
Details			Level/District				Total
Layer	**Category**	**Respondent**	**National**	**Madaripur**	**Brahmanbaria**	**Noakhali**	
District Level	Health Stakeholders	Civil Surgeon	N/A	1	1	1	3
		Superintendent		1	1	1	3
		DDFP		1	1	1	3
	Beneficiaries	Pediatrician		1	1	1	3
		Obs-gyn		1	1	1	3
		Senior Staff Nurse			1 (PDCA)		
	Local government	Zila Parishad		1			1
Upazilla	Health Stakeholders	UHFPO	N/A	1		1	2
		UFPO		1	1	1	3
		MOMCH		1	1	1	3
	Beneficiaries	MO(Clinic)		1 (PDCA)	1		2
		Midwives		1	1	1	3
		Nurses		1	1		3
	Local government	Upazilla Parishad		1	1	1	3
Union	Beneficiaries	FWV	N/A	1	1	1	3
	Local government	Union Parishad		1	1	1	3
National	Government stakeholders	MCRAH	1	N/A			1
		MNCAH	1				1
		QIS	1				1
		MIS	2				2
		BSMMU	1				1
Partner NGOs	PNGOs	DASCOH Foundation	1	N/A			4
		Palashipara Samaj Kalyan Samiti (PSKS)	1				
		Resource Integration Centre (RIC)	1				
		Shimantik	1				
Total							51

Table 5: Number of FGDs completed

Layer	Respondent	Total
Implementing Organisation	Consortium partner of MaMoni MNCSP	1
	MaMoni Technical Team	1
	MaMoni Field Team	1
Total		3

2.3. Data Analysis Plan

The indicators of the program are assessed based on both primary qualitative data and secondary quantitative data. The quantitative analysis includes mean, percentage change, change in percentage points, proportion etc. over the different points in time to understand the performance of the variables of interest from dynamic and comparative perspectives.



Qualitative data are used to understand the operational efficiency and effectiveness of the project's interventions on several areas including IRs and sub-IRs, satisfaction of the government stakeholders, MNH quality such as readiness, quality management and clinical quality, local government mobilization, improvement of 24/7 UH&FWC, scale up at national level, digital health information etc.

Besides, triangulation of the findings is performed. Information on lessons learned are also captured. Qualitative data are used to understand the views, opinions and perspectives of various stakeholders including health workers, government institutions, community leaders, local government, project team and partners, and beneficiaries.

Data were collected through taking note and scripting the responses in the IDIs. Qualitative data are coded and then analyzed. The figure above to the right illustrates the pathways of data analysis.

2.4. Data Quality Control

Innovision has rigorous quality control measures at each level of the data collection process to ensure valued quality. The high quality of ultimate output is ensured if right measures are taken from design to writing reports through the preparation of tools, close guidance, and supervision at all stages by the lead consultant, and in-depth data analysis. Innovision has paid attention to the questionnaire's

quality (schedule) and editing of the filled-in questionnaire at field level. The quality control mechanisms include:

- Data were collected by the research team members for ensuring valued quality data.
- Open-ended questions in the interviews were noted in detail.
- The interviewer also kept notes for any observation during the interview as these notes play a vital role in taking decision related to the fieldwork.
- Cell phone number of the respondent is stored for verification.

2.5. Data Storage and Management

As stated, primary data are in qualitative form, collected through notes, scripts/transcripts and digital recording. Secondary data are primarily the project document and M&E reports. For safety, the hard copy data are stored in Innovision office while the soft-copy digital data on offline storage in Innovision's dedicated cloud server. The data will be deleted 3 Years after the completion of the study. Innovision ensures that any data that were not approved by an ethics committee will not be published or disseminated beyond the participants from whom it was collected.

2.6. Caveats and Limitations of Review

At this stage the Review Team finds no limitations to have the access to the secondary data. However, the major challenge arose from the extent of spread of the COVID-19, which delayed the collection of primary data from the field level, and probing observation check list. The evaluation team used a purposive sample, not a random sample, for collecting qualitative primary data from beneficiaries and other stakeholders, implying that qualitative data collected through interviews and FGDs are not representative.

2.7. Ethical Consideration

2.7.1. Ethical Review Board

Ethical Review Committee (ERC) of Save the Children US provided ethical clearance (Annex-2).

2.7.2. Consent Protocol

Innovision Consulting holds good reputation for showing zero tolerance to any breaches of confidentiality. We will maintain very transparent and established ethical procedures and protocols for data collection through interviews. All participants (including health service providers, community and local government representative and other stakeholders) were informed about the core purpose of the survey for the end line evaluation and their roles in the data collection. They were asked to provide consent prior to initiating the interview. The interviewer read the consent form and if anyone declines to participate, no pressure will be given upon their decisions. The consent form has been attached to the Annex in this document. The consent form included:

- Purpose of the data collection for the Midterm Review
- Participant roles in data collection for the Midterm Review
- Risks and benefits of participating (if any)

- Voluntary withdrawal from the provision of data for the end-line evaluation; participants will be able to withdraw their consent at any point during the interview
- Terms of confidentiality
- Contact information of researchers involved in data collection for the end-line evaluation

2.7.3. Confidentiality

Quantitative Secondary Data: We ensure that all data collected from Save the Children is stored and used with authorized persons. Only the study team and Innovision higher management is allowed to use the data.

Qualitative Data Collection: The proposed core team is responsible for qualitative data collection. For in-depth-interviews, we ensured confidentiality of the use of data. All information collected, including signed consent forms, from study participants are handled with confidentiality. No interviewers are allowed to share any information they receive from the respondents. We ensure that no data will be disclosed from our side after the session. All signed consent forms are centrally filed in safe place with access to only designated personnel. Moreover, we have experienced study team onboarded who are able to conduct data collection in such way where they can collect necessary information without generating any sensitive data.

As noted earlier, Innovision also ensured that any data that were not approved by an ethics committee will not be published or disseminated beyond the participants from whom it was collected.

2.7.4. Safety for Interviewers

Innovision acknowledges that the survey contains such queries which might make the participants feel uncomfortable and emotionally upset in some cases. We were deeply concerned about this issue and ensured that all the data collectors would appear very friendly to the respondents and they'll make the respondents feel comfortable to discuss any topic even if that is sensitive. However, participants were given full right to decline to respond or to skip any question if they did not wish to answer. Also, they were allowed to terminate their involvement at any moment of the survey.

2.7.5. Child Safeguarding

Innovision team members supported and abide by *Save the Children's Child Safeguarding Policy.* This was ensured and followed as a guideline throughout the implementation of the study. All the review team members working with children and young people adhered to the understanding of safeguarding issues and responded to a concern where necessary, being familiar with this guidance. For this study, no children were interviewed.

3. Key Project Implementation Strategies: Strengths, Results and Challenges

This section reviews the implementation strengths, results and challenges/issues of the MaMoni MNCSP related to MNH quality improvement, local government mobilization, expansion and improvement of 24/7 UHFWC and digital health information supports for MNH care.

> The **decrease in mortality** of children proves that the **quality of care has improved**. It proves that the treatment quality is top-notch. Our mortality rate is low.
>
> -District Healthcare Provider, Male, Noakhali

3.1. MNH Quality Improvement Approach

MaMoni MNCSP started with the National QI interventions to ensure effective governance, and build uniformity across the systems. Implementation plans and approaches were developed in line with the approach in program description. Through introduction of science in action, QILM, and improvement coach, the project encouraged enhancement of QI capacity, capability and scale up. The project also espouses QI measurement & monitoring, which aims to ensure effective and functioning systems are in place. MaMoni MNCSP also supports enabling system wide improvements includes developing policies, procedures and guidelines for an effective accreditation system. At the beginning of the 4th Year, program has modified the following activities:

- Introduction of MNH certification
- Work with other MOHFW entities
- Expansion and scale up of an integrated MNHQI program – Clinical and Operational Bundles
- No Bundles in scale down Districts – expansion of 7 new Districts – total scope 13 Districts
- QMIS Introduction

At the district level, MaMoni is contributing towards strengthening the quality of maternal and newborn health care services at the facilities, supporting in capacity building of local health managers and service providers, training, mentoring, planning, leadership, facility readiness, service management, data usage, decision making and procurement. Furthermore, the project supports in establishing and operating newborn care interventions like special care newborn units (SCANU) and kangaroo mother care (KMC). More specifically, MNHQI approach includes the facility readiness, clinical capacity development, emergency/complication management, strengthening monitoring system, and improvement in the supervision.

Overall, the respondents (Hospital Superintendent, Consultants, Medical officers, MO/ MCWC, MO,-MCH-FP, Nurses, Midwives, and FWVs) collectively recognized that MaMoni is contributing towards strengthening the quality of maternal and newborn health care services at the public facilities through supporting in capacity building of local health managers and service providers, training, mentoring, planning, leadership, facility readiness, service management, data usage, data quality assurance, decision making, procurement and supply of logistics. Furthermore, MaMoni supports in establishing and operating newborn care interventions like special care newborn units (SCANU) and kangaroo mother care (KMC).

> They got the air condition in our OT repaired by mechanics, supplied instruments, and provided 7.1% chlorhexidine. They **support us in every way necessary**.

-District Healthcare Provider, Female, Madaripur

The respondents felt that support for facility readiness coupled with additional quality improvement interventions have facilitated in enhancing the quality of care. They noted that QIC committees have been formed for their respective facilities which conducts regular periodic meetings to discuss and resolve issues. The introduction of quality bundles has provided a set of tools to ensure that specific standard tasks are performed including checking the patients' blood pressure, weight, urine etc.

> As part of PPH management we give the patients **misoprostol, oxytocin, injections** if the blood pressure is too low, **massage their uterus**, try to get any detached part of placenta out of the patient's body.

-Healthcare Provider, Female, Brahmanbaria

These activities were further supplemented through training on how to provide quality ANC service, provision of partograph boards and how to read partograph on every patient. MaMoni also supported them with waste management (3 color bins), hand wash system for infection prevention, and standard instrument sterilization. Other support has, nameplates on walls of washroom, ward, OT, rearrangement of the store etc.

> Unlike before, we are reporting partograph, ANC, PNC data daily now. We write it manually. MaMoni supervises to ensure data accuracy.

-District Healthcare Provider, Female, Brahmanbaria

3.1.1. Key achievements

The midline assessment reveals that MaMoni MNCSP has many key achievements against plan. Until Year 3, major achievements of MaMoni includes:

- National QI Steering Committee held
- Learning Network established
- Patient Safety and IPC Packages developed
- MaMoni MNCSP scaled up MNH-QI bundles and until Year 3, 95 facilities in 6 districts have been connected under 'Learning & Sharing Scale Up MNH-QI Model.'
- Clinical Bundles development commenced
- Continued monitoring activities through online coaching and mentoring
- District scale up to Madaripur
- Improvement Science in Action and IC W2 held in Q1
- Introduction of emergency management system

- Establishment of monitoring system
- Introduction of MNHP checklist & automation of the checklist
- Achievements in MNH service readiness
- Decentralized planning
- Support to SCANUs.

The key achievements of the program under the theme 'MNH Quality Improvement Approach' in project districts are highlighted below

- Around 47% of women who delivered in public sector health facility in Manikganj that has participated in MNH QoC learning network reported positive experience of care at the baseline. It reached around 51% in the midline, implying 4 percentage points improvements over the period.
- Baseline finding show that 67,206 women giving birth had received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs. Program reached to 104,691 women in the midline, which exceeded the target of 78,478 women.
- There is an improvement in case of percentage of women with severe pre-eclampsia/ eclampsia received appropriate management in health. For example, baseline estimate was 65% whereas it is 80% for the midline in Manikganj.
- Overall, the number of newborns not breathing spontaneously at birth who were successfully resuscitated through USG-supported programs in the country increased to 34,764 at the midline from 27,190 at the baseline. The achievement in case of QI committee meetings was 18% against the target of 25%. The shortfall is due to COVID-19 situation.
- Percentage of health facility participating in MNH QOC learning network increased to 11% in the midline and the achievement has exceeded the program target of 10%.
- Number of people trained in QI increased to 644 persons in the midline. It is noteworthy to mention here that program has achieved 42% of the target due to interruptions caused by COVID-19.
- The achievement of the program is also evident in the case of health facilities participating in MNH QOC learning network monitoring Core MNC QOC indicators. Findings reveal that 96% of health facilities participated in MNH QOC learning network monitoring Core MNC QOC indicators.
- Achievement in improved national capacity to deliver quality MNH services at scale is found for the performance measuring indicators such as national scale up plan for MNH QI strategy rolled out, number of MNC providers position fulfilled as per sanctioned positions by level of facility, percentage of MNC providers position fulfilled as per sanctioned positions by level of facility, and number of union level health facilities in the country using e-MIS.
- The usage of MNH-QI Bundle by facilities is scaling up under learning and sharing model over the time period. For example, it started with only 12 facilities at the baseline and now, it has reached 86 facilities.
- MNHQI Bundle Coaching has also ensured logistics and improved documentation.
- Evidence from 23 sample facilities in 6 districts shows that MNH-QI Bundle contributes to the improvements in correct usage of partograph. However, ensuring trained HR is important to have further improvement and the sustainable impact as well.

- Implementation of MNH-QI Bundle has improved quality vaginal delivery care on admission, labor and delivery & after delivery. However, proper documentation and ensuring compliance might improve the quality further.

3.1.2. Implementation challenges

- QI was integrated with the improvement in MNH care delivery, but it is not reflected in the IR system.
- Multiple changes were brought into the process of implementation of activities, which made the things difficult to measure its impacts and sustainability.
- Such changes also posed challenges for the communication with International, National and Local Stakeholders.
- Learning Network cancellation has impacted on learning and sharing model for MNHQI Activities
- Capability Development cancellation impacted on ability to developing professional QI leadership and coaching capability.
- Budgetary challenges posed the challenges in scaling up activities
- Challenges arising from the advent of COVID-19.
- Ensuring compliance at all facility level, more specifically for the implementation of clinical and operational bundles, would require skilled personnel. Shortage of skills pose a serious challenge to ensure quality.
- Cancellation of posts in four divisions and three districts would pose a serious challenge at the field level implementation and monitoring. MaMoni MNCSP staff acts as functional a intermediary between health facilities and government agencies to provide various such as mobilizing stakeholders, arranging meetings and trainings, and reducing delays in providing logistical supports. Making the posts redundant would create gaps in interaction between the health facilities and government stakeholders, which likely impair MNC activities.

3.2. Local Government Engagement

MaMoni MNCSP works with local government institutions such as Union Parishad, Upazilla Parishad, and Zilla Parishad to engage the latter in planning, implementation and monitoring of project-supported MNH activities. The project leverages active engagement of community representatives and local champions on facility management teams (CSCs, MNC committees). Through advocacy, MaMoni MNCSP also facilitates mobilization of funds or resources from MOHFW and from local government to implement plans in an integrated fashion. The earmarked funds collected through local government institutions (LGIs) are tapped to support health service delivery through CSCs, MNC committees and local government representation.

> MaMoni MNCSP is closely involved in MNH of our area. **Together we monitor the delivery service and other MNH services**. We have already activated 12 facilities and deliveries are being done at satisfactory rate there. We have initiated caesarean deliveries, hired doctors, anesthetists, medicine consultants, pediatric

> consultants, decorated delivery rooms etc. in order to make 12 facilities fully functional.

-Upazilla Chairman, Male, Brahmanbaria

The midterm review revealed that the coordinated and joint activities have led to solutions for identified problems. Community and local government engagement has ensured service promotion through mobilizing substantial funds for maternal and newborn care (MNC) by Local Government Institutions (LGIs). For example, LGI's resource allocation and utilization was surprisingly high – USD 567,709 (454%)) against the targeted amount of USD 125,000 were utilized for MNC in FY20, a great successful case of MaMoni MNCSP. Findings also unveil the facts that local government also addressed the issue of stock out by providing refrigerators to ensure proper storage of oxytocin. The project also engaged the local people.

Moreover, awareness raising and community mobilization was found among many other activities. The major activities undertaken by LGIs until the midline assessment included renovation, repair and utility services of the facilities, construction of placenta dumping pits, construction of approach roads, and local level procurement of logistics such as furniture and emergency medicines, such as injection oxytocin and magnesium sulfate. LGIs also contributed in improving the facilities by deploying human resources such a midwife, maid and night guard, and supplying community ambulances for the union level facilities in Madaripur and Lakshmipur. Several facilities also received furniture, solar panels, tube-wells and hand washing spaces were made available by the LGIs. Joint local problem solving through engaging local stakeholders, like LGIs and other NGOs is found in the sample districts.

LGIs also supported MNH services during COVID-19 pandemic by establishing handwashing stations in health facilities, providing PPE for FWV and SSN of the UHCs, providing infection prevention logistics, hand sanitizer and liquid soap, and transport support for emergency cases. LGIs provided gift boxes to the pregnant women and families to inspire them for institutional delivery. LGIs distributed relief among the poor pregnant women and milk powder for children over 6 months old.

Several healthcare workers who had been working in the districts before the MaMoni MNCSP had imitated, found a drastic improvement in the levels of motivation and engagement of the local government. They noted that local government had become more active and are providing increasing support to ensure MNH in the MaMoni districts.

MaMoni did motivational work to create liaison with the local government. This has enabled in the mobilization of budget, support for manpower recruitment including guards and midwives, and renovation of facilities.

> When I told him that I needed the support of the local govt for renovating the health facilities, he instructed a UP chairman who helped me present my plan to the UP. As a result, **I got BDT 1.68 million budget** for the renovation purpose of UHFWC this Year. I'm grateful to MaMoni for the idea of getting the local govt involved in this regard.

-Healthcare provider, Male, Brahmanbaria

Based on the qualitative findings, it is found that motivating and engaging the local government institutions would help improvement ownership and regular meetings with the local governments help keep them in the loop. The results that are obtained include mobilization of funds to spend for MNH, recruitment of midwives, maids and other support staff for facilities with a shortage of such human resources and renovation and reopening of various facilities previously closed and the supports during the covid-19 pandemic.

> Previously there was no health budget from union parishad. As a result of MaMoni MNCSP's advocacy, a **portion of union budget** is now being allotted for health sector per month.
>
> -Zila Parishad Member, Female, Brahmanbaria

However, assistance from the LGIs for MNH services is not same for the sample districts, implying that not all UP Chairman are equally supportive. This issue was raised by one of the healthcare providers during the qualitative discussions. This particularly refers to lack of effort and tendency to shirk responsibility among some of the local government representatives.

3.3. Expansion and Improvement of 24/7 UH&FWC

MaMoni MNCSP identified UHFWCs, which are strategically located union level facilities, to provide 24/7 normal delivery services at a minimum cost and time as upgradation of UHFWCs as 24/7 facilities is also a national level priority of DGFP. MaMoni defined UHFWCs as 24/7 UHFWCs with having a resident skilled delivery provider or a skilled provider available within 15 minutes of call and performing at least 60 deliveries in a Year.

MaMoni MNCSP advocates and facilitates the tool kit 'How To' guidelines for strengthening UHFWCs readiness, supporting meeting planning and facilitation with local stakeholders at district level, assuring their ownership and commitment for continued support beyond the program period for sustainability. Moreover, the inclusion of a National Newborn Health Program demonstrates a positive policy environment and emphasis on improving access to 24/7 services at UHFWCs. It also assists the DGFP MCRAH OP's costed plan and strengthens UHFWCs to provide 24/7 MNH services in coordination with local government institutions. The existing Stakeholders Forum for UHFWCs helps to review and update MNC guidelines and standards and monitor the implementation progress of MOHFW commitment to accelerate efforts to strengthen UHFWCs, especially QoC, and support UHFWCs to function as 24/7 MNC facilities. National level technical assistance to DGFP to implement a plan for the phased implementation of UHFWC help district and Upazilla upazilla managers in using data from UHFWCs. Systems for accreditation are re-energized at the beginning of the 4th Year. The strengths of MaMoni identified in this regard while collecting qualitative information include engagement of local government to oversee and visit UHFWCs, need-based provisioning of logistics to ensure facility readiness, capacity building of FWVs and midwives, engagement of MaMoni with national level and community engagement.

Findings reveal that 18% (176) of the UHFWCs in MaMoni MNCSP districts has qualified personnel to provide 24/7 MNC and who had performed at least 60 deliveries annually, in Year 3. This indicates toward a rising trend over the Years. However, inequality in this regard exists across the MaMoni districts. Most importantly, the number of UHFWCs providing 24/7 MNC depends on the presence

or absence of FWVs. The highest percentage of deliveries was conducted in the UHFWCs (43%) compared to other facilities including DHs, UHCs and MCWCs and the performance of this indicator increased by 6 percentage points in Year 3 compared to Year 2. Moreover, 176 designated 24/7 UHFWCs conducted 33,633 (82%) out of 41,059 deliveries in Year 3, implying that the interventions are contributing towards increasing coverage of facility delivery.

The coordinated efforts of MaMoni MNCSP with other stakeholders also helped to mobilize local government funds for purchasing essential medicine. For example, 885 units of Inj. Oxytocin were purchased and supplied to UHFWCs by the union parishads. Another success case is evident for UHFWCs located in Lakshmipur and Madaripur where Upazilla Nirbahi Officer provided 50 units of Inj. MgSO4 IM. Moreover, 335 doses of misoprostol tablets were procured with LG funds in Habiganj district. These findings along with many others highlight the importance of introducing such efforts at scale for strengthening UHFWCs to provide 24/7 MNC care, and turn the UHFWCs into model of 24/7 normal delivery centers. Utilization of MNCH and normal delivery services are increasing and patients can visit even at night in case of emergencies. Availability of key items (spotlight, curtains, chairs, racks, weight machines, kit boxes for PPH, eclampsia management, etc.) has made the 24/7 UHFWCs as more patient-centric. Despite such key achievement, 24/7 UHFWCs are facing the challenges from the followings, which include:

- In several facilities, there is a lack of FWVs and other support staff (maid, cleaners, etc.)
- Lack of ambulance to send the patients to distant facilities.
- Despite high coverage of deliveries by the 24/7 UHFWCs in Year 3, practice of institutional delivery, on an average, is low among the population.

3.4. Digital Health Information Supports for MNH Care

The recent e-MIS expansion is reaching closer to the HPNSP result framework target. Beginning with Tangail and Habiganj, the paperless operation has been extended to Noakhali, Lakshmipur, Natore, and Jhenaidah districts in Year 4. The project was supposed to complete the expansion of e-MIS in remaining 71 Upazilla upazilla. in 10 districts in Year 3. However, due to delayed funding and COVID-19, expansion of e-MIS had been stalled in Year 3, which led to a lower achievement rate. However, at the end of Year 4, MaMoni project completed the expansion to 718 facilities in MaMoni area. In total 2190 facilities across 25 districts are using the e-MIS facility system with MaMoni's technical support.

The digital health information interventions also include mHealth notification, which has been making positive contributions towards the project's progress. The mHealth notification includes ANC, delivery, PNC, and PPFP reminders. Due to integration with the e-MIS, the system now can generate and delivers over 90% of expected individually customized SMS. It is expected that digital health information supports for MNH care will be scaled up.

As part of the Hospital Automation initiative DGHS introduced OpenMRS, which is an open-source enterprise electronic medical record system platform for manage the clinical data. MaMoni MNCSP supported DGHS and implemented the patient registration system, ANC-PNC and IMCI register in Manikganj DH and Daulatpur UHC in the same district. But, the implementation of laboratory, pharmacy, admission and labor and delivery were delayed due to COVID-19. However, it is under

consideration to implement in the hospital shortly. The program coverage stood at 87,027 patients/clients in Manikganj DH and 48,824 in Daulatpur UHC respectively in Year 3. The slow inflow of the patients in those facilities was evident due to the COVID-19 outbreak. However, 3,671 and 1,907 patients, on an average, were found at the DH and UHC per month respectively and the numbers trended up in the recent months.

Digital clients' feedback prototype contributes to capturing the clients' experience of ANC, PNC and delivery care related to QoC indicators recommended by WHO. A dashboard displaying collated data from the kiosk was also developed. As part of the digital communication strategy, MaMoni MNCSP Facebook page played role in increasing mass awareness, enhancing knowledge on basic maternal and neonatal care stages and preventive measures in the last Year of COVID-19. MaMoni also hosts a Facebook Live Q&A Session on 'Experiencing Motherhood During COVID-19' for Safe Motherhood Day and it had a great impact.

DGFP has launched a distance learning management system (LMS) using the Moodle application with having operational and technical support from MaMoni MNCSP. The support of digital health information of the MaMoni for MNH care include capacity building of health facility staff to use digital tools, troubleshooting support, regular monitoring and analysis of data, automatic data synchronization and integrating data with the national database. As a result, every client/patient's information (name, spouse name, age, address, phone number etc.) are available from the archived, critical issues are identified and discussed and last but not least, corrective measures are undertaken through periodic review meetings.

The respondents from during the IDIs noted that MaMoni's support for e-MIS has mostly come in the form of technical support in handling e-MIS, capacity building of staff to use digital tablets, monitoring and supervision of data inputs in digital and physical form, and analysis of data. They put particular emphasis on the role of MaMoni in supervising data every month. During the discussions, many respondents also mentioned that e-MIS support is enabling district health stakeholders to understand gaps in data such as missing data, interruptions in service intake, poor ANC and PNC performance. As part of the activity, MaMoni ensures that reporting is being done accurately. Furthermore, MaMoni also support to present data in monthly/quarterly meetings as part of performance review to take corrective measures and facilitate informed decision-making.

> MaMoni MNCSP also play a big role in MIS support and reporting. We **get regular updates** on the number of registered pregnant women, ANC & PNC, clinical deliveries at performance review programs. Sometimes there are huge data entry gaps between our MIS and e-MIS MaMoni helps us **identify the gaps between our MIS and e-MIS**. They present these gaps in our monthly meetings and we take mitigation decisions.

The major challenges found during the collection of qualitative information include the followings:

- Software or server goes down sometimes
- Network-related issues
- Some digital tablets require replacement or servicing, which are not provided on an urgent basis

- Reluctance to use tablets by some health facility staffs, especially among the elderly staff. In addition to other non-tech savvy individuals, these staff prefer the manual entry systems.
- Different MIS system in DGHS and DGFP and interoperability of two systems
  Ensuring quality of data and data validation

3.5. MaMoni MNCSP Supports to National Level

MaMoni MNCSP has provided technical assistance to the MOHFW in developing 'National Guideline for Providing Essential Maternal, Newborn and Child Health Services in the Context of COVID-19 for Bangladesh, Maternal health action plan, MPDSR guidelines, and Adolescent health guidelines, and supported the revision of MCRAH operational plans. It also supported the development of e-training modules on the 'National Guideline for Providing Essential Maternal, Newborn, and Child Health Services in the Context of COVID-19 for Bangladesh' for service providers in collaboration with the MCH Services unit and MIS unit of DGFP. This e-training course was rolled-out in MaMoni MNCSP districts, followed by a short online orientation for the managers and service providers.

The DGFP, with the technical assistance from MaMoni, established a 'National MCH Monitoring Cell' and engaged different stakeholders. MaMoni also supported in developing/revising service registers like SCANU and IMCI registers. The project also provides technical assistance in capturing the newborn health indicators in the DHIS2 and in the reporting system. Therefore, continuous national level advocacy for MNH, close engagement with National Newborn Health Program (NNHP), involvement in the development of strategy, action plan, SOPs, guidelines related to maternal, newborn health, quality assurance and experiences earned from implementation of MaMoni project, demonstration of evidence (MNH care) and advocacy for national scale up based on proven experiences and working very closely with DGNM to get midwife into the facilities are strengths evident in this respect.

The project along with the National Newborn Health Program (NNHP) supported the Comilla Medical College with a view to turning it into a regional training center for offering high-quality, competency-based training to strengthen national capacity to deliver quality maternal and newborn health services at scale. The project established several KMC unit at MaMoni districts. eLearning Modules as per government's national guideline on MNH services were developed and introduced during COVID-19. The project supports to strengthen the health systems in 10 districts and scale up nationwide based on proven maternal and newborn health (MNH) interventions. Some advocacy related activities on accreditation have been done so far. MaMoni MNCSP arranged training on National Newborn Health Program implementation toolkit to guide managers for planning, implementation and monitoring of newborn health interventions. MaMoni developed draft QI curriculum, which requires extensive consultation with all development partners. MaMoni provided necessary technical support to MoHFW in order to address the Governance and Stewardship and Human Resources for Health (HRH) issues.

Also these result in passing the second stage of quality improvement strategy at national level, establishing regional training center at Comilla Medical College & Hospital, adapting and translating the SOP into Bengali for Union based service providers, replication of MaMoni's MH and NH checklists at national and district levels, scaling up of e-MIS in a number of districts and strengthening partnership with government, professional bodies, academia, and BSMMU at national and subnational level.

IDI findings show that MaMoni's MNCSP supports to national level are often disrupted by frequent changes of the directors, line managers and project managers (Key government officials), lack of coordination between DGHS and DGFP and the COVID-19 pandemic

4. Progress and Performance of MaMoni MNCSP: Intermediate Results and Monitoring Indicators

This section provides an assessment of the progress of the indicators associated with maternal and newborn care. Qualitative judgements are added with the places where it seems appropriate. In this regard, the section has been divided into the following 5 sub-sections:

- **Increased Equitable Utilization of Quality MNC Services**
- **IR 1: Improved responsiveness of district health systems to deliver patient-centered MNC services**
- **IR 2: Improved quality of MNC services and governance of quality of care**
- **IR 3: Sustained improvement in access and demand for MNC services and HH practices**
- **IR 4: Improved national capacity to deliver quality MNH services at scale**

Under each sub-section, each indicator and sub-indicator if any has been assessed to determine their progress and performance until the midline assessment. The analysis has been supported through a review of project documents and qualitative discussions with various stakeholders.

4.1. State of Increased Equitable Utilization of Quality MNC Services

The overall goal of the MaMoni MNCSP is to enhance equitable utilization of quality MNC Services. This component has been measured through 7 indicators including neonatal and maternal mortality rate, institutional deliveries, the disparity in institutional delivery between rich and poor, and utilization of quality ANC and essential newborn care.

Maternal and Neonatal Facility Mortality

MaMoni MNCSP activities are designed to contribute to the HPNSP 2017-22 goals to reducing maternal and neonatal deaths by increasing equitable utilization of quality MNC services in sample districts and it also supports at national level to scale up proven maternal and newborn health (MNH) interventions nationwide. Maternal and neonatal mortality rates are considered to be useful indicators for understanding maternal and neonatal health and quality of care. The indicator 'neonatal facility mortality rate in public sector facility (per 1000 live birth in facility)' reveals no change over the time. The level of neonatal facility mortality rate is already low, so further reduction in such is likely to be slow. More importantly, the baseline value of neonatal facility mortality per 1,000 live births in facility were 11 and the MaMoni's 2020 target and achievement was also the same, implying that neonatal facility mortality remained unchanged during the baseline and midline periods. Although neonatal death is dependent on a host of factors, qualitative assessment has revealed poor newborn handling practice during home deliveries and a lack of essential equipment such as infection control life-support machines at the health facilities that result in neonatal death. During the IDI, a healthcare provider noted the following:

> "10 out of 20 newborns admitted in the facility suffer from **perinatal asphyxia** due to **poor handling** of **home deliveries** by non-trained midwives at the rural level. As a result, we receive

cases where the babies **were born with head injuries**, babies did not cry after being born. Many newborns also suffer from **low birth weight** and **sepsis/septicemia**."

-Healthcare Provider, Male, Brahmanbaria

The maternal facility mortality rate (per 1,000 women admitted for delivery or obstetric management in the facility) in public sector facilities improved dramatically. It was found in the baseline that it was 30 per 1,000 women were admitted for delivery or obstetric management in public facility. Program set the 2020 target to 14.5/1,000. The midline value stood at 1/1,000, which seems surprisingly low compared to the baseline and the target as well. This may be explained by the type of quality ANC and PNC services received by the mothers from public health facilities. In addition, the better practice of referral system in case of critical delivery cases contributed to such dramatic improvement in maternal facility mortality rate. Moreover, the critical COVID-19 time period needs to be considered while analyzing or commenting on such improvements. Findings discussed below and Figure 2 reveal that the low number deliveries at health facilities during the lockdown might contribute to low maternal facility mortality rate to some extent.

Deliveries in Public Sector Health Facilities

The analysis reveals a marginal improvement in the indicator for deliveries in public sector health facilities between baseline and midline period (0.9 percentage points). More importantly, % of deliveries in public sector facilities including district hospital, Upazilla upazilla health complex, mother and child welfare center and UHFWC is relatively much lower compared to deliveries in private health facilities. It is found that around 19% of the estimated expected number of pregnant women usually deliver at public facilities. Among these deliveries, 43% occurred at UHFWCs, followed by 26% at DHs, 23% at UHCs and 8% at MCWC. 81% of these were normal vaginal deliveries; 18% were C-sections, and only 1% were assisted vaginal deliveries. The proportion of C-section decreased by 5.2 percentage points in Year 3 compared to the baseline, a significant contribution of MaMoni. Active management of the third stage of labor (AMTSL) is provided to all women with having normal and assisted vaginal deliveries at public facilities.

Overall, program had a positive impact on health facility delivery. During the baseline, 47.1% of deliveries conducted in health facilities whereas it increased to 52.1% in the midline. Similar findings are also evident for skilled birth attendants, increased to 55% in the midline from 49.9% in the baseline. Based on field investigation and review of project documents, it was found that the COVID-19 pandemic also had an adverse impact on the number of deliveries made at public facilities. As shown in **Figure 2**, during the lockdown (April-June 2020), the number of deliveries fell at all levels of the institution, with DHs leading the way, followed by UHCs. Although the numbers picked up in the following months, the dip during the lockdown period had affected the overall performance of this indicator.

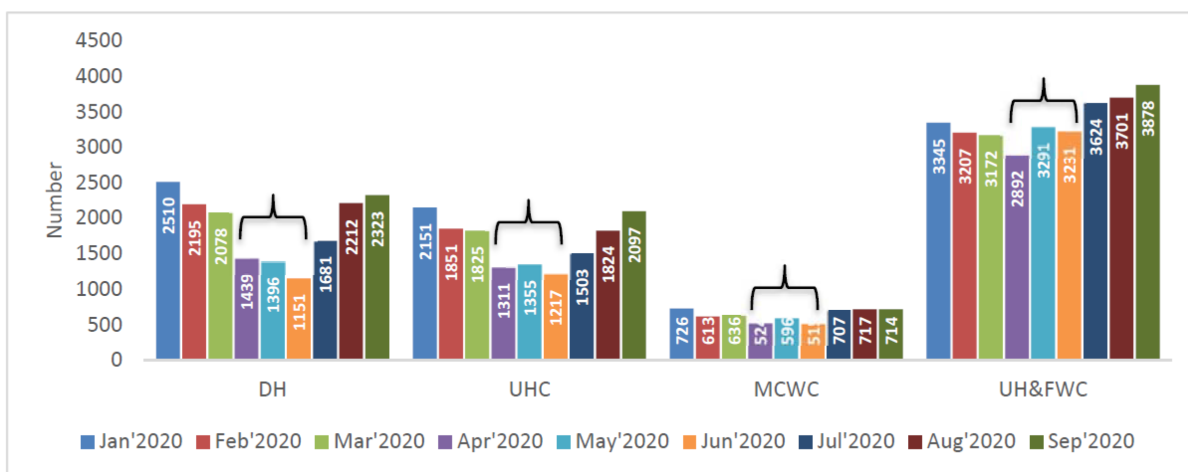


Figure 2: Trends in facility deliveries in MaMoni MNCSP districts

Source: Adapted from MaMoni MNCSP Annual Progress Report (Year 3)

During the IDI, the providers of public sector facilities (Hospital Superintendent, Consultants, Medical officers, MO/ MCWC, MO,-MCH-FP, Nurses, Midwives, and FWVs) collectively recognized that MaMoni is contributing towards strengthening the quality of maternal and newborn health care services at the public facilities, supporting in capacity building of local health managers and service providers, training, mentoring, planning, leadership, facility readiness, service management, data usage, data quality assurance, decision making, procurement and supply of logistics. These interventions provided visible, measurable and remarkable" support in facility readiness for MNH care. MaMoni MNCSP established standard ANC and PNC corners, labor rooms and provided logistics support such as instruments, BCC materials.

> Previously the number of deliveries was around 30-45. Now **it has gone up to 50 because of MaMoni's support**. We have had maximum 90 (monthly) deliveries at my Upazilla upazilla and 30 at Doriya Doulat UHFWC as a model facility.
>
> -Healthcare Provider, Female, Brahmanbaria

Women Receiving Quality ANC

This indicator refers to the percentage of the women receiving quality ANC 4+ visits for the last pregnancy. This visit includes at least one visit from a medically trained provider where her blood pressure is checked, weight taken, blood and urine checked and counselling given to her on danger signs during an ANC visit. It is important to note here that from the perspective of the providers, no or lack of knowledge or operational definition is the strongest barrier to quality ANC provisioning. On-the-job training and coaching for the service providers on the basics of quality ANC would help understand and provide quality ANC. For further clarity, the percentage is provided as quality ANC against the total ANC services utilization. Quality ANC includes recording of four components (weight, blood pressure, Hemoglobin and urine albumin). Findings show that the value of the indicator

‘percentage of the women receiving quality ANC 4+ visits for the last pregnancy’ has fallen by 2.40 percentage points in 2020 compared to the baseline period of 2018. The spread of COVID-19 pandemic and the mobility restriction declared by the government resulted in the lower coverage of women for quality ANC 4+ visits, as mothers feared going for lab tests. Despite such facts, ANC from public health facilities increased by 8 percentage points over the same time period.

The service providers of public health facilities during IDI, felt that support for facility readiness coupled with additional quality improvement interventions have facilitated in enhancing the quality care. They noted that QIC committees have been formed for their respective facilities which conducts regular periodic meetings to discuss and resolve issues. The introduction of quality bundles has provided a set of guiding rules to ensure that specific tasks are performed including checking the patients' blood pressure, weight, urine etc.

> “The **capacity building trainings** provided by MaMoni are crucial in a sense that the midwives be able to handle the ANC & PNC corners, labor rooms independently.”
>
> [District health manager, Noakhali]

The pandemic led to both demand-supply shocks for ANC services. Throughout the qualitative discussions, various stakeholders had mentioned that the pregnant mothers were reluctant to come to the public health facilities due to the fear of contacting covid infection. Additionally, the supply of ANC services was also disrupted due to a lack of personal protective equipment (PPE), and a lack of manpower, prioritization of covid related services and supervision and monitoring.[12] Since adequate PPE were not available, many healthcare providers were reluctant to provide services due to fear of getting infected by the coronavirus. There were also shortages of healthcare providers to provide the usual services. Many facilities had assigned them to COVID-19 units to handle the infected patients.

> The hospital environment has improved a lot ever since MaMoni intervened. They arranged trainings. **We have learned new things**. They gave us mobile phones with monthly recharge to follow-up on patients for ANC visits. They arrange weekly meetings where we discuss about the progress of our service.
>
> Healthcare Provider, Female, Brahmanbaria

Women Receiving Essential Newborn Care

MaMoni MNCSP helped to establish newborn management areas in all DHs and MCWCs, 40 UHCs and 127 UHFWCs in the project districts with a view to improving preparedness of health facilities to provide essential newborn care (ENC) delivery services. Essential newborn care (ENC) entails performing five important tasks right after a child is born:

- Cord-cutting with boiled/sterile instrument

[12] MaMoni MNCSP Annual Progress Report October 1, 2019– September 30, 2020

- Application of 7.1% chlorhexidine onto umbilical cord
- Drying and wrapping within 0-4 minutes of birth
- Delayed bathing (at least 72 hours after birth); and
- Initiation of breastfeeding within 1 hour after birth.

The analysis reveals that there has been improvement in the percentage of women delivering at home who had received ENC in the MaMoni project districts. Compared to the baseline period, the indicator's performance has increased by 2.5 percentage points until the midline. More specifically, MaMoni MNCSP as part of essential newborn care (ENC) continued its supports to the application of 7.1% chlorhexidine in the project districts. Findings reveal that overall, 100% of babies born in public facilities in MaMoni MNCSP districts in Year 3 received 7.1% chlorhexidine on their umbilical cords immediately after birth. Due to uninterrupted supply and regular follow up, data of three Years also showed the sustainability and the universal coverage of the application of 7.1% chlorhexidine in public facilities in project districts.

The project assistance for developing the "National Guideline for Providing Essential Maternal, Newborn and Child Health Services in the Context of COVID-19 for Bangladesh" was a great success of MaMoni MNCSP. This facilitated the adaptation of global guidelines. MaMoni also supported translating and designing the guideline in Bangla and preparing the training materials and countrywide orientation of the health managers and service providers through an online training platform for the continuation of the MNH services during the COVID-19 situation.

Disparity in Facility Delivery between Richest and The Poorest Wealth Quintiles

The indicator, 'ratio of coverage for facility delivery between richest and the poorest wealth quintiles', measures the difference in facility delivery coverage among the poorest wealth quintile from the facility delivery among the richest wealth quintile. Compared to the baseline period, the disparity has widened among the richest and the poorest segments in the MaMoni project districts. Ratio of coverage for facility delivery between richest and the poorest wealth quintiles was widened, implying rise in inequality in coverage for facility delivery between the richest and the poorest. For example, during the midterm period, 5.3% of the poor had sought facility delivery compared to 15% of the richest segments.

The rise in disparity could however resulted from the COVID-19 pandemic as many poor were unlikely to afford the associated costs related to institutional delivery. Similarly, during the field investigation, midwives and gynecologists had opined that poor people prefer delivering at home and only visit the hospital if there are complications. This implies that introducing awareness program in this regard may contribute to increase the facility delivery. Moreover, due to COVID-19 movement restriction, many women who would have gone to facility for delivery could not have done so.

4.2. State of IR 1: Improved Responsiveness of District Health Systems to Deliver Patient-Centered MNC Services

The first intermediate result (IR 1) of the MaMoni MNCSP is to ensure Improved Responsiveness of District Health Systems to Deliver Patient-Centered MNC Services. Within this IR, there are 10 indicators and an additional sub-indicator that measures the improved readiness of district, upazilla and union level public sector health facilities through:

- Improved leadership and management capacity of GOB managers. For example, 77% facilities (i.e., 70 facilities) against the annual target conducted data-driven decentralized planning until Year 3. Similarly, 64% of the planned joint supervisory visits were conducted by the first- and second-line supervisors of the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP).
- MaMoni MNCSP supported batches of training on data quality check and management for district and Upazilla upazilla managers and statisticians under DGFP in few sample districts. Participants learned a common method of estimating population, pregnancy, live births and stillbirths. Participants also reviewed the reporting flow chart, scope of data error, and how to minimize the errors. This training aimed at strengthening capacity of district and Upazilla upazilla managers to provide leadership and more efficient management support to the statisticians, developing a positive approach and more proactively engaging them to obtain correct data and timely input in HMIS.
- Improved readiness of health facilities: physical, skilled staffing, supplies, info systems, referral systems
- Functional systems for social accountability

The indicators and their level of progress have been compiled in the Annex Table 4 .

Facilities Meeting Service Provision Readiness for 24/7 MNC

Health facility is considered meeting the service provisioning readiness for MNC services if the facility has the following items/tracer indicators:

- Guidelines on Basic Emergency Obstetric and Newborn Care (BEmONC) or Comprehensive Emergency Obstetric and Newborn Care (CEmONC)
- At least one service provider trained in MH package capturing ANC/PNC/Delivery and FP
- Basic equipment for normal delivery (Examination light, Delivery pack, Suction apparatus, Neonatal bag and mask, Partograph, Gloves)
- Medicines and commodities (Injectable oxytocin, Injectable antibiotic, Magnesium sulphate, Skin disinfectant, Intravenous solution with infusion set)

Findings reveal a 29-percentage point improvement in facilities meeting service provision readiness for 24/7 MNC compared to the baseline. Overall, the service provision readiness has improved largely due to improvement in the availability of contributing items. From the qualitative discussions, many FWVs, midwives, nurses and OBS-GYN expressed that they have now access to various equipment due to MaMoni's support. This finding is also consistent with the reviewers' observations during the health facility visits at Madaripur, Noakhali, Lakshmipur and Brahmanbaria districts. However, items

such as BEmONC and CEmONC have shown relatively low improvements due to COVID-19 and lack of adequately trained manpower. More importantly, it is found that the number of facilities providing EmONC services have grown marginally over the three Years.

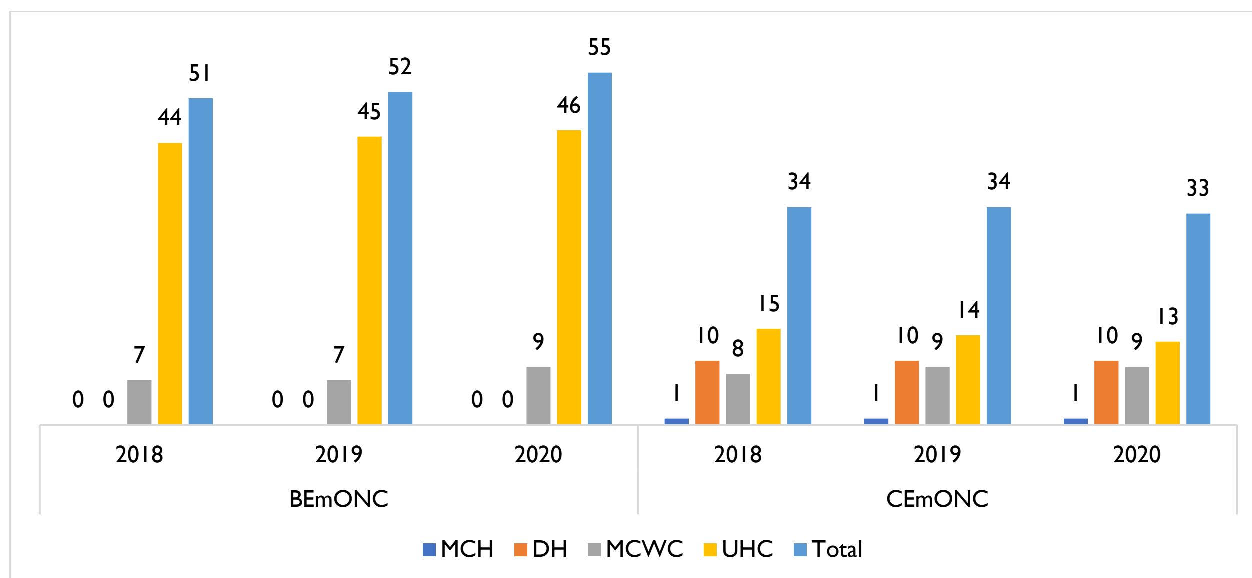


Figure 3: Number of facilities providing EmONC services

Source: Authors' illustrations based on information provided in Annual Progress Report (Year 3)

> They mainly took care of facility readiness for us and provided logistical support. It took us 6-8 months to receive logistics from directorate warehouse. MaMoni **speeded up this process** through constant advocacy.
>
> -UFPO, Male, Brahmanbaria

USG-Assisted Service Delivery Sites Providing Family Planning (FP) Counselling and/or Services

Family planning counselling and/or services include counselling and/or services on short-acting (pill, condom, injectable) and long-acting and permanent methods (IUD, implants, voluntary sterilization). In this regard, the project performance of the **Indicator #9** shows the improvement of 11.5 percentage points. The progress in this indicator was facilitated by the training of healthcare providers in post-partum family planning (PPFP) issues and increase in uptake of FP measures such as Postpartum intrauterine contraceptive devices (PPIUCD) and Implant. For example, the progress and performance of indicators reported in the Annex Table 4 shows that the usage of modern family planning method during postpartum period (PPFP) increased by 11.5 percentage points in public health facilities. This can be attributed to training on PPFP training given to FWVs, nurses and other healthcare providers. The healthcare providers reiterate the importance of family planning during post-partum period to the visiting mothers during their ANC visits. This helps in imparting such knowledge from an early period.

Health Offices Conducting Data-Based Performance Reviews At Least Once A Quarter

97% of the planned quarterly performance review meetings were conducted in the MaMoni project districts. Compared to baseline, the performance increased by 19 percentage points. Throughout the year, the project collaborated closely with local managers to track progress and communicate results at monthly progress reviews and quarterly performance reviews. During the COVID-19 pandemic, MaMoni MNCSP discussed the matter with health and family planning authorities, as well as service providers, to ensure that MNH services are provided at the facility and community level in accordance with national MNH guidelines. For example, through such meetings, neonatal health dashboard, which will assist managers in identifying gaps in recording and reporting was updated. Supporting this progress, one stakeholder from working in the MaMoni project noted:

> "We arrange **half-Yearly** (previously quarterly) SPRM - Quality & Performance Review Meetings where we **present the scenario of MNC components** at Upazilla upazilla health complexes and make decisions accordingly."
>
> -MaMoni MNCSP Project Staff, Male

Mobilization of funds from local government institutions for MNC service strengthening

The performance of **Indicator #11**, 'amount of USD equivalent funds mobilized from local government institutions for MNC service strengthening', has been laudable. The effort started with local advocacy, sensitization, orientation, and interpersonal contacts to mobilize LGIs. As a result, USD 567,709 equivalent funds have been raised for maternity and newborn care, which is a 454 per cent increase against the annual target of USD 125,000.

Several healthcare workers who had been working in the districts before the MaMoni MNCSP had initated, found a drastic improvement in the levels of motivation and engagement of the local government. They noted that local government had become more active and are providing increasing support to ensure MNH in the MaMoni districts. This has enabled in the mobilization of budget, support for manpower recruitment including guards and midwives, and renovation of facilities.

> The chairman of Badar Pasha union has become quite active because of MaMoni's advocacy. He provided lots of support to maintain the delivery service quality at local UHFWC center. **All the credit goes to MaMoni** for pulling efforts and motivating the chairman. Even the local people are appreciative of their activities, especially towards normal delivery service. People pay regular visits to the facilities more than before.
>
> -Healthcare Manager, Male, Rajoir, Madaripur

Persons Trained in MNC By Type and Level with MNCSP Support

Under the indicator #14, 'number of persons trained in MNC by type and level with MNCSP support', it was only 952 individuals who were trained and this implies 18% achievement of the target in Year

3. However, in Year 2, the target achievement was 190%. The annual progress report identified delay in fund disbursement and COVID-19 pandemic for the under-achievement of this indicator in Year 3, especially for the Covid-Year.

Health Facilities with Functional Community Accountability Mechanisms

According to the performance indicator reference sheet, functional community accountability mechanism includes suggestion box, client interview form, official meeting with community leaders, public hearing, social audit, health fairs, informal discussion with clients or the community, email, facility's website, letters from clients/community, and text/SMS messages. In comparison to baseline, the coverage of functional community accountability mechanisms is more than double (71%, which is even higher than the EOP target) of the baseline estimate (35%). It is noted here that 53 out of 59 health facilities has established client's feedback mechanisms where clients could provide their feedbacks in written form upon service receipts. 2 UHFWCs has introduced the Community Score Card (CmSC) and thus, the leaders of the UHFWC management committees could develop action plans and implement as agreed.

Mobilization of local resources has supported the purchase of key equipment and expenditure behind periodical maintenance, which erstwhile was difficult. Highlighting this issue, one stakeholder added:

> In order to engage the local government in MNH, there is a UHFWC committee consisting of existing local government and community components such as Union Parishad, Zila Parishad, Upazilla Parishad. There are also support committee, facility management committee at district hospitals. At initial stage of our work, we had seen that **90% UP Chairman were not aware** that they were the chairperson of UHFWC committee. Therefore, they were also **unaware of their roles in management and service** of that committee. We worked on functioning of this management committee through 1-day orientation programs about the specific responsibilities of all 20 members. Now we **arrange monthly meetings** for this committees at every UH&FWC. Previously, the portion of UP budget meant for health sector was mostly used for Water and Sanitation but after our facilitation, now a major portion of the same budget is allocated for MNH every Year.

-MaMoni MNCSP Project Staff, Male, Noakhali

4.3. State of IR 2: Improved quality of MNC services and governance of quality of care

The second intermediate result (IR 2) of the MaMoni MNCSP is to achieve an improved quality of MNC services and governance of quality of care through improved adherence to WHO MNH QoC standards, and developing and expanding scalable model for improving MNH Quality of Care. Within this IR, 8 indicators are collectively measured:

- Strengthened coordination for QoC between different MOHFW agencies and other stakeholders
- Scalable models for MNC QoC strengthened and expanded
- Strengthened learning systems for monitoring and measurement of MNC QoC

Analysis of the indicators revealed that **all indicators have progressed better** compared to the baseline estimates and also in achieving the Yearly target. The indicator 'percentage of health facilities that had participated in MNH QOC Learning Network that have improved at least 50% of Core MNC QOC Indicators applicable to the level of facility' is not measured in midline as it has been revised.

Discussion of the State of IR 2

The indicator 'Percentage of women who delivered in public sector health facility that has participated in MNH QoC learning network reporting positive experience of care' shows an improvement of 4.2 percentage points over the baseline. Similarly, Uterotonic is an important input for active management of the third stage of labor (AMTSL) and to reduce postpartum hemorrhage (PPH). This could include the use of oxytocin or misoprostol. As the progress of Indicator 20 indicates, 104,691 women had received uterotonics from a skilled birth attendant both at the facility and at home. This represents 133% achievement of the target set for 2020.

The program also shows improvement over the baseline for the indicator 'Percentage of women with severe pre-eclampsia/ eclampsia received appropriate management in health facilities that had participated in QOC Learning Network'. For example, women with severe pre-eclampsia/eclampsia received appropriate management in health facilities increased to 80% in Year 3 from 65% in the baseline in Manikganj. This finding has been reflected by the service providers at the qualitative review.

The respondents felt that support for facility readiness coupled with additional quality improvement interventions (eg. training of service providers, availability of PPH & eclampsia kits, monitoring/mentoring etc.) have facilitated in enhancing the quality care. The introduction of quality bundles has to provide a set of guiding rules to ensure that specific tasks are performed.

> "As part of **PPH management** we give the patients misoprostol, oxytocin, injections if the blood pressure is too low, massage their uterus, try to get any detached part of placenta out of the patient's body."
>
> -Healthcare Provider, Female, Brahmanbaria

According to the Performance Indicator Reference Sheet, the resuscitation method can include either (1) stimulation and/or bag and mask provided by a USG-assisted program, and/or (2) a health worker

trained in resuscitation by USG-assisted program. Analysis of this indicator reveals that it has progressed well above the baseline value and its target for 2020. During this midline (2020), 34,764 newborns who did not breathe at birth were resuscitated. This achievement is over 1.5 times higher than the annual target.

> "KMC service has improved. We refer 1-2 patients to KMC daily on average. We have some nurses trained in KMC. **KMC is crucial to low birth rate babies** (below 2kg). This has decreased the newborn mortality rate in my opinion."
>
> -District Healthcare Provider, Male, Brahmanbaria

In terms of quality improvement, the indicators for QI meetings and training showed slow progress. In case of the meetings, findings represent achievement of 71% of the target scheduled meetings in 2020 were held by QI committees at the national, division, district and upazilla level. The Annual Progress Report pointed out that the low performance was due to the COVID-19 pandemic. This issue was also raised during the qualitative discussions.

> The meetings were **regular and fruitful** before the COVID-19. We got good responses then. Now, it has become a bit **irregular due to the pandemic**.
>
> -PNGO Staff, Male[13]

Similarly, 644 people were trained in 2020 on quality improvement issues which are only 42% achievement of the target for the Year. The annual report identified **delay in fund disbursement and the impact of COVID-19** as the factors which caused less-than-satisfactory performance of this indicator.

4.4. State of IR 3: Sustained improvement in access and demand for MNC services and HH practices

Under the third IR, the MaMoni MNCSP project aims to attain three results by the end of the project:

- Increased timely and appropriate care-seeking for MNH
- Improved client's perception and trust of public sector MNC services
- Improved access to and availability of MNCS services to all population including hard to reach (HTR) areas

The results-framework for this result has defined 10 indicators and one sub-indicators to measure progress. Analysis reveals that 7 indicators had made improvements during the midline while another 3 will require more efforts for further improvements.

Discussion of the State of IR 3

[13] Geographic location and name of the PNGO has not been mentioned to protect the anonymity of the respondent

The midline value of the Indicator #27 ‘Percentage of women initiating modern method of FP in the post-partum period (PPFP)’ is found 40%, which is same as in the baseline. More importantly, public health facilities have shown great successes in using any modern family planning method during postpartum period (PPFP) compared with other type of facilities including home deliveries at home. This made the program to achieve 109% of the midline target set for the indicator # 28 ‘Number of deliveries in public sector health facilities’. For example, midline target for the indicator # 28 is 90,206 whereas achievement at the midline is 98,368. Despite the progress, there is a disparity among the districts in terms of delivery at public facilities. Findings reveal that Brahmanbaria (10%), Faridpur (15%), Kushtia (16%), Madaripur (15%) and Manikganj (12%) have a lower percentage for public facility delivery compared to the district total of all the MaMoni MNCSP districts (16%). Moreover, Kushtia, Madaripur and Manikganj experienced a decline in deliveries in public facilities. In the case of CYP[14], the project's Yearly forecast for a CYP was 1,593,206, and it reached 1,385,701, or 87% of its target. During the qualitative discussions, many healthcare providers noted that the COVID-19 pandemic had affected their delivery of FP services. Additionally, there is also a reluctance among community people in taking FP methods, which also contributes to low performance.

> The people here are quite **reluctant and conservative**. We have to motivate them hard to take FP methods. We do counsel each and every patient.
>
> -Healthcare Provider, Female, Brahmanbaria

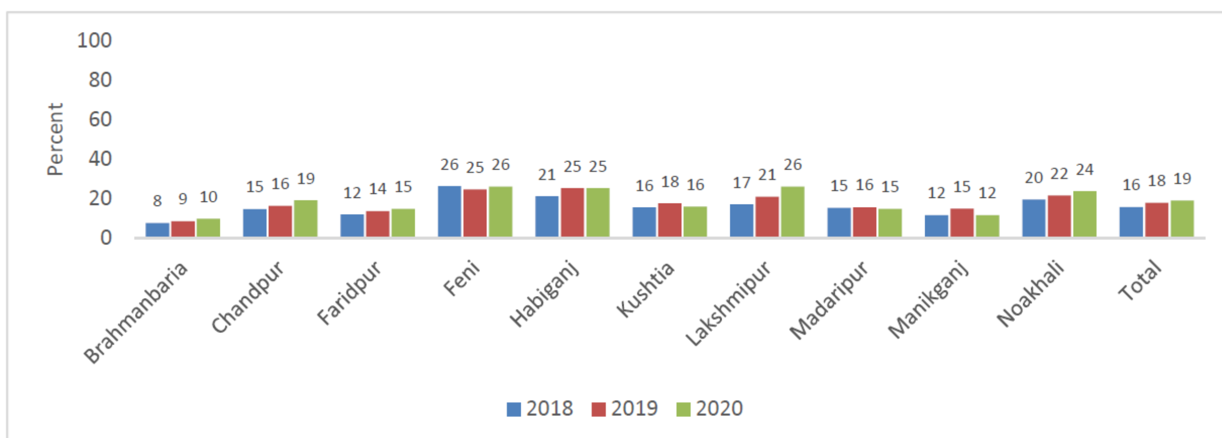


Figure 4: Percentage of women who delivered at public facilities in MaMoni MNCSP districts

Source: Adapted from MaMoni MNCSP Annual Progress Report (Year 3)

According to national health policy, pregnant women at 32 weeks are required to be given two misoprostol tablets to prevent post-partum hemorrhage (PPH) during delivery at home. In the MNCSP districts in 2020, 14.4% of the mothers had consumed misoprostol during delivery at home, which is

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[14] According to the Performance Indicator Reference Sheet, the CYP indicator quantifies the quantity of contraceptive coverage supplied to a certain population in a particular Year, which is linked to contraceptive prevalence and the reduction of unwanted pregnancies. This is based on the projected protection given by family planning (FP) services throughout a one-Year period, based on the total amount of contraceptives sold or distributed completely for free to users in USG-supported programs during that timeframe.

0.6 percentage points lower than the baseline value. Major declines had been observed during the first few months of the COVID-19 pandemic. The annual progress report mentioned that misoprostol tablet distribution to pregnant women dropped from 66% in February to 44% in May, and then to 36% in September. The countrywide restrictions on movement along with safety concerns had a negative impact on the availability of service providers, which has likely affected misoprostol distribution and consumption.

The Performance Indicator Reference Sheet mentioned that a pregnant woman will be counted as reached with nutrition-specific interventions if she receives one or more of iron and folic acid supplementation and counselling on maternal nutrition. In this regard, the project had reached 204,034 pregnant women with its interventions. This accounts for 110% of the annual target for 2020.

In the MaMoni MNCSP districts, 61.4% of infants were put to the breast within the first hour after birth. Compared to the baseline, this is 3.8 percentage points lower. This indicates an overall slack in progress and performance of this indicator for the MNCSP districts.

The primary role of the UHFWC Management Committee's is to maintain the facility's safety and security, as well as the provision and usage of medicine, equipment, and logistics. In this regard, ensuring regular committee meetings is imperative. The project was able to attain 100% of its target for 2020 for this indicator as it fulfilled its target that UHFWC Management Committee meetings were held at least bi-monthly during the midline period.

A microplanning meeting is a regular gathering in a community clinic where FWA, HA, CHCP, CSG, and frontline NGO workers discuss and update information, as well as prepare action plans to address any burning issues. This meeting is planned to be held at least bi-monthly. However, the progress has been slow as 8% out of 10% target of the CCs held a microplanning/CHW coordination meetings in the last three months prior to the surveys.

The MTR finds that nearly 81% of households reported their intention to use the public sector for MNH services.

Against a target of 1,244 individuals, the project was able to reach all the individuals residing in hard-to-reach and underserved areas reached through alternate service provision mechanisms for MNH. Noting their achievement in establishing institutional delivery in Hatiya, one respondent made the following remark:

> Before MaMoni was launched, the institutional delivery rate in Hatiya was very low. The financially solvent clients were able to visit the mainland, Dhaka or Chattogram for institutional delivery purposes. The rest of our population was entirely dependent on home deliveries. Ever since MaMoni started working in Hatiya, the **institutional delivery rate has achieved significant improvements, a big jump indeed**.

-Local Government Stakeholder, Male, Noakhali

4.5. State of IR 4: Improved national capacity to deliver quality MNH services at scale

The fourth IR "Improved national capacity to deliver quality MNH services at scale" employs a holistic approach to establish

- Strengthened national health systems support for quality MNC services at scale
- National systems for certification and accreditation of public and private facilities established and demonstrated
- Selected proven interventions and tools/approaches implemented at scale

The aforementioned efforts are measured through six indicators along with one sub-indicator. Analysis of these indicators reveals that four of them (i.e., National scale up plan for MNH QI strategy rolled out, Number of MNC providers position fulfilled as per sanctioned positions by level of facility, Percentage of MNC providers position fulfilled as per sanctioned positions by level of facility and Number of union level health facilities in the country using e-MIS) have progressed well in achieving the annual targets. One of the indicators such as 'Percentage of health facilities in the country implementing comprehensive newborn care package by level of facility will require further improvement. For indicator #39 'Number of facilities-initiated accreditation process', no data is available as the direction for the accreditation process is currently being discussed with MoHFW and USAID. Furthermore, national statistics on the percentage of UHFWC providing 24/7 normal delivery services in the country (Indicator #42: Percentage of UHFWC providing 24/7 normal delivery services in the country) is also unavailable as the Bangladesh Health Facility Survey has not yet been conducted.

National level stakeholders acknowledged the project engagement in improving national capacity building to deliver quality MNH services at scale. During IDI the responders mentioned that MaMoni engages in the development of strategy, action plan, SOPs, guidelines related to maternal, newborn health, quality assurance and bring experiences from implementation of MaMoni project that can be scale up nationally.

> In national level, **MaMoni provides technical support and develops strategies, manuals, guidelines, etc.** for maternal and newborn care intervention. They also provide technical assistance for policy, advocacy, establishing program monitoring framework, facility readiness, service quality, strengthening the e-MIS, data quality assurance etc.

Director, DGHS, MOHFW

National scale up plan for MNH QI strategy rolled out

MNH-QI bundles were scaled up at 86 facilities across six districts by MaMoni MNCSP. Under the "Learning & Sharing Scale Up MNHQI Model," a total of 95 facilities in six districts have been connected with the network. This was also observed during the discussions with the MaMoni project team:

> We have already passed the second stage of quality improvement strategy at the national level. **We have built a QI cell in DGH** combining hospital management and director of hospitals and clinics along with a MaMoni representative. This **QI cell has developed a**

one-Year plan on how to improve quality in non-MaMoni districts by scaling up.

- MaMoni MNCSP Project Staff, Female, Dhaka

MNC providers position fulfilled as per sanctioned positions by the level of facility

Doctors, nurses, midwives, FWVs, and paramedics are among the most important MNC providers. In terms of both numbers and percentage of positions filled, the project achieved its annual target for 2020. Nonetheless, there are still a number of vacant positions that need to be filled. Except for Manikganj, the percentage of filled positions decreased in the remaining 9 districts in 2020. Among these districts, Brahmanbaria and Chandpur experienced 18 percentage points and 20 percentage points decline in the positions filled, respectively.

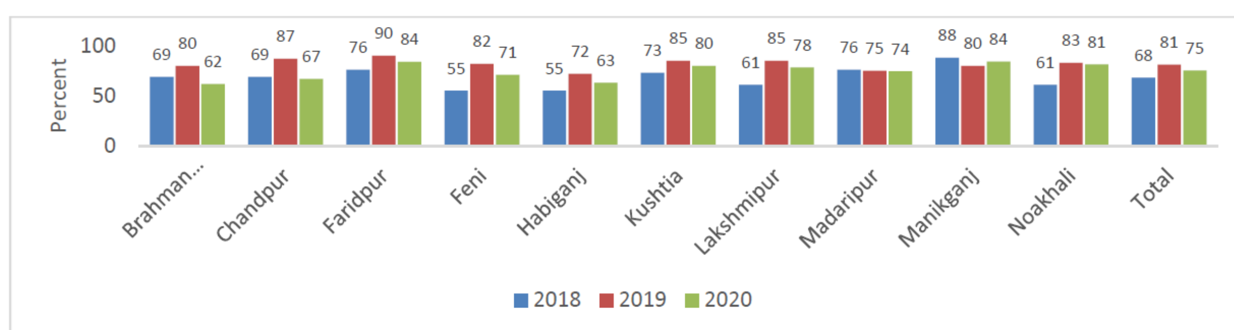


Figure 5: Percentage of MNC providers' position filled in MaMoni MNCSP districts

Source: Adapted from MaMoni MNCSP Annual Progress Report (Year 3)

During the IDIs and FGDs with different stakeholders, lack of adequate manpower such as pediatricians, anesthesiologists and gynecologists, lab technicians, and night guards also emerged as key barriers.

"COVID-19 has **badly affected our service delivery**. Service providers are falling ill. We are pulling every effort but cannot cope. I **used to have 6-7 senior staff nurses** in the morning ward, **now I have 2-3 of them**. Maximum of the nurses are either transferred to Covid-unit or infected by Covid."

-Healthcare providers, Female, Brahmanbaria

Number of union-level health facilities in the country using e-MIS

It was noted during the FGDs with MaMoni Technical team that the e-MIS scale up has begun at the last phase of MaMoni. As part of this approach, union level facilities are being brought under the coverage of e-MIS. In this regard, 1,220 union level health facilities in the country had been using e-MIS in 2020 whereas the target was set to 1,134, implying achievement of 108% of 2020 target.

Health facilities in the country implementing comprehensive newborn care packages (CNCP) by the level of facility

In 2020, only 8% of public health institutions reported offering full neonatal care services. This is a shortfall of 3 percentage points from last Year. There are different reasons for the low coverage of CNCP implementation as indicated in the annual progress report. First, the COVID-19 pandemic reduced the uptake of health services across all facilities. Moreover, medical college hospitals were also hesitant to provide data regularly. Lastly, SCANU and KMC services are not available in all DHs.

5. Engagement, Experience and Satisfaction of the MOH&FW, the District Health Offices, and Other Partners

This section elaborates on the engagements and satisfaction of various government stakeholders (central and local level) and partner organizations. At the national level, in-depth discussions had been conducted with representatives from MOHFW (MCRAH, MNCAH, QIS, MIS and BSMMU). At the district level, DDFP, Civil Surgeons, UHFPO, and UFPO were the key stakeholders who were interviewed. Lastly, IDIs were also arranged with a representative from each of the partner NGOs including DASCOH Foundation, Palashipara Samaj Kalyan Samiti (PSKS), Resource Integration Centre (RIC) and Shimantik.

5.1. National Government Health Offices Engagements and Satisfaction

The respondents (representatives from MCRAH, MNCAH, QIS, MIS and BSMMU) collectively identified that MaMoni works with various directorates of MOHFW at national level both in terms of policy development, preparation of guidelines, SOPs, and program implementation. They generate evidence and supports MOHFW to scale up proven MNH interventions. At the national level, MaMoni provides technical support and develops strategies, manuals, and guidelines for maternal and newborn care intervention. They also provide technical assistance for policy, advocacy, establishing program monitoring framework, facility readiness, service quality, strengthening the e-MIS, and data quality assurance etc. At the district level, MaMoni is contributing towards strengthening the quality of maternal and newborn health care services at the facilities, supporting in capacity building of local health managers and service providers, training, mentoring, planning, leadership, facility readiness, service management, data usage, decision making and procurement. Furthermore, they support in establishing and operating newborn care interventions like special care newborn units (SCANU) and kangaroo mother care (KMC).

> "One good thing about MaMoni is that they do not want to establish their project as a stand-alone program. They eventually want to **work within the network of the government**. If it proves to be useful, then the government might include them in its operational plan. Be it dissemination of study or project implementation, MaMoni has been able to show the government **what they do is effective**. MaMoni works as **facilitator, catalyst and has convinced** us that what they do works."

-Government Official, Male, National Level[15]

In addition, MaMoni's contributions in enhancing the quality of care were also highlighted. In this regard, a respondent pointed out that QIS had adapted and implemented many of MaMoni's interventions in its operational plan. The respondent also complimented the implementation of waste management through which post-delivery wastes are dumped into a bin and thrown under the ground.

[15] Name of the MOHFW wing has not been stated to protect the anonymity of the respondent

Furthermore, MaMoni had also supported on other aspects of quality assurance including cleanliness of labor room and operation theatre.

Furthermore, in addition to e-MIS support in all project supported districts, MaMoni has been supporting DGHS in developing and implementing OpenMRS system for automation of hospital services and information system. MaMoni is implementing OpenMRS at two hospitals in Manikganj. Further explaining MaMoni's role in e-MIS support at the national MIS program, one respondent added:

> We are **running the MIS** in 1,906 centers (11 district hospitals, 56 MCWCs, 122 UHCs, 1,465 UHFWCs, 107 union sub-centers, 88 rural dispensaries/Sadar clinics) in 36 districts. MaMoni provides us **support with developing, maintaining and synchronizing** these data systems. We can already see district, Upazilla upazilla and union wise **data of 3 crore people**. With increasing data utilization, we will be able to reach each pregnant mother individually within the next 2-3 Years. This might be one of the **strongest databases** in the whole country.

-Government Official, Male, National Level

All of the national level MoHFW representatives expressed **high satisfaction with MaMoni**. They particularly commended MaMoni's efforts in Hatiya. However, most national stakeholders did not want to assign a score to rank their satisfaction. Among those who did, they gave a score between 8 and 10.

> I also work with other multilateral organizations but I feel **more comfortable working with MaMoni**, particularly Save the Children, because there is **flexibility and scope of innovation**

-Government Official, Male, National Level

5.2. Suggestions from National Government Health Offices

In order to further improve its efforts, the respondents made the following suggestions for the MaMoni project:

- MaMoni should identify, address and prioritize the challenges of existing programs like CNCP and KMC.
- Collaborate with medical experts and academicians to identify additional mechanisms to improve MNH in scale-down districts from sustainable perspective.
- MaMoni should also provide high level advocacy at the government level for quality of care, human resources, and referral linkage so that even the prime minister feels the importance.
- Expand their coordination between government and MaMoni staff in cases of emerging issues.
- Arrange refresher (in-service, hands-on) training, particularly for the ones recruited by the MaMoni project

- Provide support in analyzing the large volume of data that is being generated
- MaMoni can take steps to connect the Upazilla upazilla and district consultants at least on weekly where the consultants, medical officers, medical professors, midwives, nurses can connect altogether. This will ensure that everyone is updated on the progress of work, existing challenges, and come up ways to overcome the barriers.
- The health managers, service providers, consultants of Upazilla upazilla level can meet up weekly a day and discuss the updates, challenges, and any other emerging issues.

6. Engagements and Satisfaction: Health Offices and Partners

The representatives from district health offices (DDFP, Civil Surgeons, UHFPO, and UFPO) described various engagements with and support from the MaMoni project. Describing their organizational limitations, one district official explained that often times, they have to depend on government employees who have very little idea about the work and their roles. Hence, it is not always possible to design work plans effectively. On the other hand, MaMoni has been offering supplementary support. In this regard, MaMoni has provided them administrative and technical support, in performing their responsibilities which include supervision and engagement for home visits, satellite clinic visits, overall clinical activities, FP methods, counselling methods, ANC, PNC, newborn care, and staff training.

One district health official stated:

> They **help us solve issues** related to the labor room, provide occasional **training** for our nurses and midwives, help to maintain **partograph, ANC and newborn resuscitation**. They also placed some **posters and festoons** (danger signs) in the labor room. Sometimes there is a shortage of government supply of **ANC & PNC registers**, then **MaMoni prints** those out for us. They **provided kit boxes** for **PPH, eclampsia, pre-eclampsia** etc. in our delivery rooms. They offer help with data register in DHIS when our sisters are too busy to enter the data there. But is important that government should come forward to resolve the challenges that the health facilities face.

-District Health Official, Female, Noakhali

In many cases, MaMoni has also extended manpower support including paramedics, midwives, nurses, maids, and night guards to enable health facilities to run smoothly. Additionally, MaMoni's helps them in holistic support in documentation, reporting, training and capacity building of healthcare providers. Furthermore, they support local government involvement is generating funds for renovation, maintenance and expansion of facilities. Local Union Parishad Members and Chairmen have a better understanding of their roles in health facility management. Highlighting this engagement one district official added:

> We were too busy to meet every UP member for meeting confirmation purposes. **Not all our staff were interested** in interacting with the local government because there might be a mutual dispute, they wanted to **avoid being monitored** by the local government. The upazilla coordinator of MaMoni **talked with the FP committee or FWC management committee** members over the phone or meets them for schedule confirmation before arranging any meeting. MaMoni's initiative worked as an ice breaker between us and the local government.

-District Health Official, Male, Brahmanbaria

During the discussions, many respondents also mentioned that e-MIS support is enabling district health stakeholders to understand gaps in data such as missing data, interruptions in service intake, poor ANC and PNC performance. In many healthcare centers, referral mechanisms have been placed. This included setting up of "Auto-rickshaw ambulance" and listing local auto-drivers to enable quick response during emergencies.

Despite effective engagement, the respondents, however, noted some challenges that have affected their collaborations with the MaMoni project. Many respondents stressed that the COVID-19 situation affected service delivery, and disrupted the periodic meetings that were conducted regularly. Shortages of human resources such as gynecologists, anesthetists, pediatric consultants, midwives and supporting staff are strong impediments to service delivery. For some respondents, due to a lack of doctors, intensive pediatric care services cannot be delivered in Madaripur. It was also noted that the number of FWV is decreasing day by day in the project districts which adversely affects MNH services delivery.

Based on the discussion, all the respondents exhibited high levels of satisfaction. On a scale of 10, the respondents gave 7-10 to the MaMoni project's engagement.

> "Unlike my tenure in the previous workplace, I can **get much support here** even without asking for it. If MaMoni could work in a **more organized and extensive way** then we might be able to achieve localized SDGs in Madaripur"
>
> -District Health Official, Male, Madaripur

6.1. Suggestions from District and Local Health Offices

The respondents observed that there is much room for improvement throughout the project which can increase their levels of satisfaction. Particularly, they highlighted lack of manpower, inter-agency coordination, and logistical issues as areas where MaMoni can work. The following suggestions were made by the respective stakeholders:

- Provide more staff at the upazilla level including one facilitator for every upazilla to work and give feedback with ready data so that DDFP or upazilla managers can make informed decisions
- Strengthen coordination between MaMoni project staff and district health offices
- MaMoni needs to provide regular feedback to the government field workers or officers
- Non-functioning machines need to be repaired to provide quick service
- ANC and PNC rooms should be decorated after the complete construction of the new hospital building in Noakhali.
- Circulate the contact numbers of healthcare service providers and project staff so that more patients can reach them
- Arrange union committee meetings every three months including refreshment for the members and honorarium for the UP Chairman.
- District coordinators should visit the upazilla at least twice a week.

6.2. Partners' Engagements and Experience

The staff from partner organizations mentioned that they complete all the objectives based on their scope of work (SOC) subject to the project budget. In this regard, their efforts have contributed towards facility readiness, capacity building for government staff, management, logistics and good governance. They also create awareness among the service recipients, such as pregnant women, their guardians, community, different stakeholders including local government, local administration, political person, and local elites. They also ensure service operation protocols and facility readiness by providing support for infrastructural readiness, skill development of the service providers, MNH components (EmONC & BEmONC services, neonatal health, family planning, postpartum FP etc.). In order to ensure EmONC, ANC & PNC and postpartum FP services, the PNGOs ensure the presence of a midwife at every upazilla health complex, and provide logistics, supply and information support. Furthermore, they strengthen the referral mechanism in case of emergency management.

Highlighting their human resource support, one respondent said:

> There is an **acute shortage of government service providers** in all four districts. We advocate for the **relocation of service providers** such as midwives explaining that the facilities will perform better and the delivery rate will increase in the presence of more midwives. In this manner, we regularly advocate for the relocation of human resources (i.e.: relocating excess visitors or SACMOs at the district level and midwives at the Upazilla Upazilla level). We are also getting success in these cases.

-PNGO Staff, Male[16]

In fulfilling their responsibilities, the representatives from PNGOs also faced several challenges. The challenges emerged from Save the Children, the government officials and due to the pandemic. Citing administrative and financial issues with Save the Children, it was noted that instructions often come from different personnel which is hard for the field staff of the PNGOs to coordinate. Furthermore, there are difficulties in maintaining workplans as various events are arranged without prior notice. In addition to delays in budget approval, funds are disbursed in a few different formats and across different periods. Moreover, the VAT is not deducted from the budget. Instead, they receive coupons. Some partners faced great difficulty in the last two Years due to these issues.

> "In a certain month, I may have a lot of activities. If I utilize all the working days of the month, only then all the tasks that I have planned will be successfully implemented. As there are multiple thematic teams, **different types of training, orientations and meetings are scheduled erratically** which disrupts the whole workplan. If this could be planned well ahead of time, then it would be better. Today is July 26, now, we are going to do the plan for

[16] Geographic location and name of the PNGO has not been mentioned to protect the anonymity of the respondent

> August. If we could know now, what trainings and orientations they have planned for August, then we can plan accordingly."

-PNGO Staff, Male

Several challenges while working with the government were also identified. First, getting government officials' schedules becomes challenging because of their erratic working time. Additionally, frequent transfer of government managers, vacant positions of service providers, elderly staff's reluctance to use e-MIS technology, lack of motivation among the service providers to provide quality service affect the PNGOs effort to effectively provide MNH support in the project districts. Lastly, COVID-19 has been identified as a "monumental challenge" by one respondent. The monthly and quarterly meetings have become irregular which has had implications for quality improvement and performance reviews. The PNGO staff noted that the different waves and the erratic rise and fall in covid infections has affected their service delivery.

> "The quality of service has fallen to some extent due to covid. When a patient (a mother or newborn) is being brought to the hospital or FWV, the **service provider is not doing the tests** she is supposed to do by touching the patient (e.g., taking the pulse). She probably does this because of fear."

-PNGO Staff, Male

6.3. Suggestions from PNGOs

In response to the aforementioned challenges and in light of additional efforts that can be concerted towards improving MNH in project districts, the respondents from PNGOs made the following set of recommendations:

- Both referral and emergency management need to be prioritised
- Creating the connection between primary health care facilities with secondary and tertiary level health care facilities is necessary so that the patients are not harassed and dissatisfied
- SC should disburse money for the whole Year. Then activities can be scheduled.
- Increase coordination between PNGO and SC. This includes setting up a mutually agreed work plan, where any deviations (e.g., announcement of training/meeting/field visit by SC on a short notice) would be discussed at least one month before scheduling such events. Additionally, financial coordination needs to be ensured. Funds need to be disbursed by SC on time.
- Monitoring for the implementation of the planning needs to be stronger. This could be done my hiring adequate field staff, which is currently insufficient.
- Service providers should be provided training to make them more responsible about their work, if possible, to bring a kind of transformation within them.

7. Engagement and Experience: Providers at Public Sector Health Facilities

This section elaborates the engagements and experiences of various MNH service providers at public health facilities at district, upazilla and union level (under both Directorate General of Health Services and Directorate General of Family Planning). At the district level, Superintendent/Director of District hospital, Consultant (OBGYN), Consultant (PED), MO, MCWC, Senior Staff Nurses, were the key stakeholders that were interviewed. At upazilla level, medical officers, MO-MCH-FP, Senior Staff Nurses, Midwives and at union level FWVs were also interviewed. The section describes the service providers' experience with MaMoni's support towards facility readiness, quality improvement, e-MIS adoption, expansion of UH&FWC, and local government engagements. These are examined through the various support they received, their overall satisfaction, challenges faced and suggestion to overcome the challenges.

Overall, the respondents (Hospital Superintendent, Consultants, Medical officers, MO/ MCWC, MO,-MCH-FP, Nurses, Midwives, and FWVs) collectively recognized that MaMoni is contributing towards strengthening the quality of maternal and newborn health care services at the public facilities through supporting in capacity building of local health managers and service providers, training, mentoring, planning, leadership, facility readiness, service management, data usage, data quality assurance, decision making, procurement and supply of logistics. Furthermore, MaMoni supports in establishing and operating newborn care interventions like special care newborn units (SCANU) and kangaroo mother care (KMC).

A number of respondents stressed that the COVID-19 situation affected service delivery, and disrupted the periodic meetings that were conducted regularly before the Covid-time. Shortages of human resources such as gynecologists, anesthetists, pediatric consultants, midwives and supporting staff are strong impediments to service delivery.

7.1. Facility Readiness for MNH services

The respondents were in consensus that MaMoni provided "visible, measurable and remarkable" support in facility readiness. MaMoni MNCSP established standard ANC and PNC corners, labor rooms and provided logistic support such as instruments, BCC materials and record keeping. In addition to supervision and monitoring, the service providers reported that MaMoni also provided guidelines for providing services including emergency management, maintaining delivery room protocols, and patient assessment.

> Previously the number of clinical deliveries was around 30-45. Now **it has gone up to 50 because of MaMoni's support**. We have had maximum 90 (monthly) deliveries at my upazilla and 30 at Doriya Doulat UHFWC as a model facility.
>
> -Healthcare Provider, Female, Brahmanbaria

In this regard, the healthcare providers interviewed mentioned the following supports from MaMoni:

- Arranged several trainings for consultants, medical officers, nurses, midwives

- Helped to organize emergency delivery tray and kit box for PPH and Eclampsia which made it easy to manage emergency patients.
- MaMoni provided necessary drugs whenever there was a shortage. Furthermore, if any facilities have any unused drugs in stock, they arrange for the distribution of the drugs to other facilities in need.
- They provided a number of emergency equipment, partograph, smart TVs, and refrigerators
- Regularly monitor the labor room activities, infection-prevention activities, partograph maintenance, and registries.
- Coordinated and arranged meetings where all the progress and issues are shared, evaluate the performance, identify the gaps, and sort out solutions.
- Speeding up of logistic delivery process from directorate warehouse through constant advocacy.
- Increased social accountability by establishing patient feedback mechanisms through opinion boxes where the patients can anonymously report on the quality of care.

Many respondents also highly commended MaMoni's support in the establishment of several units including SCANU, KMC corner, newborn unit and breastfeeding corner. These were supported through trainings on KMC for nurses, midwives and medical officers. During the COVID-19 pandemic, MaMoni provided critical medical and safety items including oxygen cylinders, nasal cannulas, masks, PPE, and sanitizer at per needs. All these supports helped positively in increasing the number of ANC, PNC, Deliveries, Newborn Care and PPFP services in these facilities and reducing number of deaths.

In regard to understanding the facility readiness, it is important to explore the findings from the observation data at facility level. Here we have summarized the findings of the interviews with designated stakeholders of Madaripur District Hospital, followed by Upazilla Health Complex, Rajoir; MCWC, Madaripur; UH&FWC, Badar Pasha and 20-bed Hospital, Kabirajpur, Rajoir respectively.

Key Findings from the Madaripur District Hospital

- This 100-bed District Hospital being a designated EmONC facility, had a severe scarcity of manpower for providing the obstetric and newborn care services as per its mandate.
- Having only one Consultant (Obs/Gyne) and 2 EOC trained doctors, it was not possible to provide 24/7 emergency obstetric care services.
- The position of Consultant (Anesthesia) was also vacant and the RMO who has training in Anesthesia attempts to extend the required services based on his availability of time and need.
- The position of Consultant Neonatology was also vacant for the last 20 months. Thus, the services for the 10 bed SCANU on the DH were greatly hampered
- One Medical Doctor with no formal training in neonatology was engaged in providing the care at SCANU that raises question about required skills and quality of care.
- Only 2 nurses were trained in EMT (Emergency Management Training) were engaged in providing services
- Staff demanded training on Comprehensive Newborn Care Practices (CNCP)
- There were 4 trained nurses for KMC

- Shortage of cleaners and OT-Boy was also reported. Thus, there are challenges in maintaining cleanliness of Obs/Gyn ward and OT due to unavailability of cleaners or lacking in effective management of the existing cleaners.
- Acute shortage of ayah and ward boy further hampered the services at the neonatal ward
- Providers at the DH were not trained on use of MgSo4 (the drug of choice for management and control of eclampsia) and neither there was regular supply of MgSo4. Rather Nalepsin was being used commonly.
- Partographs were not being used use to lack of motivation of the providers and shortage of nurses in the labor ward as it requires time for continuous monitoring
- Due to unavailability of blood bank in DH, the blood transfusion services were also not smooth
- There were no regular supply of Oxytocin (for prevention of post-partum hemorrhage)
- There was no regular supply of ANC cards in the DH
- No bilirubin meters
- Three out of 6 radiant warmers were non-functional
- DH also did not have a FP (Family Planning) service corner

Key Findings from Upazilla Health Complex, Rajoir

- This 50-bed UHC also suffers from acute shortage of EOC trained providers.
- All the 4 posts of consultants (including Obs-gyn and anesthetist) were vacant.
- Only one EOC trained doctor provide limited basic EmONC services
- However, 5 midwives (4 posted and 1 deputed-in) were engaged in providing ANC and 24/7 delivery services.
- This is a facility where midwives used partograph
- Both the posts of Lab technician were vacant (1 post vacant, one deputed-out for training).
- Authority trained 2 MSV on lab-technique and engaged in providing the selected simple test like hemoglobin, urine albumin tests etc. (may be an ethical issue)
- No supply of iron tables and antibiotic eye ointment for newborn

Key Findings from MCWC, Madaripur

- One trained FWV provides ANC. Need training for 2 FWVs on ANC
- Not familiar with ANC guidelines; No ANC cards provided / no supply.
- No register for ANC
- No lab support; no facilities for blood cross-matching
- Three EOC trained FWVs
- Twenty-bed facility. Bed occupied rate low 15% on the day of visit
- Normal delivery 2-3 / day; CS 8-10 / month; 1-2 referral / month; PPFP - 10 IUD, 10 ligation / month
- No Post Abortion Care (PAC) services and no training provided
- No regular use of partograph
- No training on MgSo4
- No elevator – difficult for the pregnant mothers to arrive the delivery room on the first floor by stair
- No guideline on unused drug stock

Key Findings from UH&FWC, Badar Pasha:

- It was a new model 2-storied UHFWC. The earlier old building was being used by
- Delivery services were provided by a trained FWV (with 6-month training on midwifery) supported by an Assistant Nurse. In the previous month of the visit 5 deliveries and before that month 13 deliveries were conducted.
- The FWV used to live within the compound
- A MaMoni supported three-wheeler was managed by the facility for transfer of patient which was an innovation
- Inadequate supply of medicine
- No clear guideline for storage of slow drugs like injection gentamycin

Key Findings from 20-bed Hospital, Kabirajpur, Rajoir:

- This 20-bed newly established with all the modern facilities for Comprehensive EmONC
- For long time in this facility there was no provider and thus was grossly underutilized
- However, recently, Ma-Moni through advocacy with the Government managed to post 3 medical doctors to provide the EmONC services
- One graduate midwife was also posted by the government very recently
- Support staff 2 Aya + 2 Guard were provided through community support
- Strong ownership by the community leaders were observed

Key Findings from Brahmanbaria District Hospital

- Brahmanbaria 250 bedded District Hospital is providing emergency obstetric and newborn care services. However, some of the signal functions such as assisted vaginal deliveries and MVA was not performed in last three months.
- Consultant OBS-GYN informed that there are doctors but the number of nurses is not adequate. During the pandemic nurses are mobilized to perform duty in the Covid dedicated ward which hampers the regular maternal newborn care services.
- The quality bundle (ANC & use of partograph) has been introduced in this hospital in January 2021.
- ANC corner has been set up in the outpatient department and well maintained with all necessary logistics, guidelines and trained providers. The number of ANC patient has been increased. Records are maintained. The hospital has the lab facilities and patients are referred to the hospital lab for routine blood and urine test. However, not all pregnant women can do the necessary lab test due to long que and the cost.
- The trained nurses in the ANC corner are maintained separate report regrading ANC quality bundle.
- The average patient for ANC care is 6-8/day
- There was no supply of ANC cards in the DH
- The labor/delivery area/room are well maintained. There has been no labor patient during the visit. The readiness items including the PPH and Eclampsia kits are available in the labor room.
- The nurses on duty cannot tell how many nurses receive training from MaMoni project. However, nurses received training on use of partograph and other management.
- Nurses informed they fill up partograph for the labor patients. Completed partograph was found with the patient file/record. A pattern was observed in the filled up partograph which

seems these are filled up after the deliveries (for example same no. uterine contraction throughout the labor which is unusual during the labor). The correctness of partograph need to be monitored carefully.

- There is gap in record keeping and reporting (the admission register, delivery register, monthly reporting format) for obstetric care patient specially the complication management. There is no match between the monthly reporting and the record. The feedback was given to the nurses and the MaMoni project officials present during the visit.
- The emergency department was not visited because the emergency set up for pre referral management has not been established yet into this hospital due to covid pandemic.
- Consultant OBGYN mentioned the absence /vacancy of MaMoni district coordinator for some time, and she welcomed the new district coordinator (who was present during this visit) and look forward to work with the project. She mentioned the lack of adequate number of nurses especially for the conduction of patient counselling.
- Consultant OBGYN also mentioned her observation regarding data analysis and reporting. Discrepancy has been observed in the DHIS 2 data and the hospital/district record. These need to be addressed. She also mentioned the DH providing PPFP, ligation and other long-term FP methods but this are not reflected in the DHIS2
- Consultant OBGYN is interested for research and requested the project if there is any opportunity, she and the district hospital is interested to participate.

Suggestions for District Hospital

- Continue provide training/refresher training to the doctor/nurses on MNH care
- All quality bundle needs to introduced/rolled out within a short period of time
- Record keeping and reporting need to be improved. Provide training to the nurses on record keeping and reporting. The project can work nationally with MIS, DGHS and DGFP for improve record keeping and reporting for EmONC
- National level advocacy for uniform ANC/PNC card, registers, reporting form among DGHS and DGFP
- Regular monitoring and supervision of the MNH care especially partograph fill up, management of complication, ENC, PNC etc.

Findings from Nasirnagar Upazilla Health Complex

- There is no EOC trained providers/Consultant OBGYN/ANESTHESIA in this 50 bedded UHC and are not providing comprehensive EmONC services.
- In the emergency department all set up including emergency medicine kits are available for prereferral/emergency management. However, the MA informed that they send the patient indoor (Obstetric emergency) for management as nurse/midwives are available 24/7 for providing services.
- There are 4 midwives and are engaged in providing ANC and 24/7 delivery services
- The ANC room with all necessary logistics, guidelines are available in the outpatient department. Trained midwives provide ANC services. Hemoglobin and urine test are available in the lab.
- The labor room is clean and well equipped with emergency PPH and Eclampsia kits. The newborn corner is available. Midwives uses partograph and filled up partograph was observed with the patient file/record. However, similar pattern was found in the filled up partograph similar to district hospital.

- Doctors/Nurses informed the NVD has been increased in this facility.
- There is gap in record keeping and reporting (the admission register, delivery register, monthly reporting format) for obstetric care patient specially the complication management. There is no match between the monthly reporting and the record. The feedback was given to the nurses and the MaMoni project officials present during the visit. For example, nurse mentioned they managed a retained placenta during the month of July (They also reported in the monthly EOC report in July 2021) but no record was found in the register.
- The hospital managed several patients of SAM.
- There is no mouthpiece for preterm baby, warmer and sucker machine for newborn
- Number of deliveries is less compared to the manpower and facility available (Less than 1 delivery/day)
- UHC do not have any monthly reporting register/format (EmONC/monthly DHIS2 reporting format)

Suggestions for UHCs

- Advocacy is needed by the MaMoni Programme for filling up the vacant posts of consultants and doctors in all the designated EmONC facility
- Continue provide training/refresher training to the nurses, midwives on MNH care
- All quality bundle needs to introduced/rolled out
- Record keeping and monthly reporting need to be strengthened. Provide training to the nurses on record keeping and reporting. The project can work nationally with MIS, DGHS and DGFP for improve record keeping and reporting for EmONC
- National level advocacy for uniform ANC/PNC card, registers, reporting form among DGHS and DGFP and ensure supply of these.
- Regular monitoring and supervision of the MNH care especially partograph fill up, management of complication, ENC, PNC etc.
- BCC activity/advocacy for increased utilization of MNH services from the UHC specially (NVD, ANC, PNC)

Findings from Vollacut UHFWC, Nasirnagar

- 24/7 Delivery services is provided by a trained FWV supported by a parttime hired cleaner. They perform average 8-10 delivery/month.
- The FWV stay in the same building (FWV accommodation in the 1st floor)
- SACMO positing is vacant. So, the FWV has to attend all the patient including mother, newborn, child and workload is very high.
- There is no aya or support staff.
- The labor room is equipped and emergency kit available. But Magnesium Sulfate is not available. The oxytocin is not supplied. And FWV purchased the oxytocin by herself.
- There is no indoor patient file/record for the delivery patient.
- ANC bundle is introduced and FWV perform the hemoglobin and urine test for ANC patients.
- FWV has a tab and use e-MIS and enter all patient's data.
- Local government is engaged and supported an alternate entry access road to the UHFWC
- Consent form for different long term FP method is not available

Suggestions for UH&FWC

- Advocacy for fill up the post of SACMO, Support staff
- Regular monitoring and supervision
- Continue to provide training/refresher training to FWV
- Advocacy for use and supply of uniform ANC/PNC card, registers among DGHS and DHFP
- Support in improving record keeping and reporting
- BCC activity for utilization of MNH care

Based on the discussion, all the respondents exhibited high levels of satisfaction. On a scale of 10, the respondents gave 7 to10 to the MaMoni project's engagement (average 8).

> MaMoni has contributed a lot towards the quality of MNH. Majority people are now **interested in institutional deliveries** because of **MaMoni's advocacy** at people's doorstep.

- Health Care Provider, Female, Noakhali

> The hospital environment is improved a lot since the intervention of MaMoni. They arranged trainings. **We have learnt new things**. They gave us mobile phones with monthly recharge to follow-up on patients for ANC visits. They arrange weekly meetings where we discuss about our service progress. The number of hospital deliveries has increased.

- Healthcare Provider, Female, Brahmanbaria

7.2. Overall Key Challenges

The healthcare providers observed a number of challenges that impaired their ability to provide quality MNH services. These are summarized below:

- **Lack of adequate human resource** for functioning critical care services such as EmONC, SCANU, KMC, etc. The upazilla facilities and especially, the UHCs have a chronic shortage of gynecologists and anaesthesiologists.
- There are some **challenges in implementing e-MIS** including network issues, server problems and lack of skills in using digital tablets. Troubleshooters often are not in touch with staff who are directly involved in data entry. Even the troubleshooters are unaware of their roles and responsibilities. Moreover, only one troubleshooter per upazilla poses challenges to perform the role effectively.
- **Quality maintenance** is quite a challenge due to lack of pathology and diagnostic facilities at many unions and upazilla facilities. Often, to perform a simple blood test, the patients have to go to private diagnostic centers. As a result, patients prefer going to private clinics where diagnostic and healthcare is available.

- Due to **lack of capacity**, some nurses are still not used to partograph. They fill the report after the delivery is done, which is against the protocol. Since it is a challenge to ensure effective partograph usage, staff would require more trainings on it.
- The referred patients often **lack the financial means** ability to pay the ambulance fare.
- **Lack of awareness** among the benefits of institutional delivery results in high preference for deliveries at home. Moreover, in Noakhali, pregnant women from the villages are **not comfortable consulting male doctors** at all.
- All **quality bundles are not available** at all facilities. This means that there is a disparity in the quality of services provided by different healthcare facilities.
- Strong supervision and monitoring by managers would help boost accountability and QoC as well.

7.3. Suggestions from Healthcare Service Providers

The respondents observed that there is scope for improvement throughout the project which can increase their levels of satisfaction through the improvement of program quality. Particularly, they highlighted lack of human resources, capacity building, and logistical issues as areas where MaMoni can work. The following suggestions were made by the service providers:

In order to further improve its efforts, the respondents made the following suggestions for the MaMoni project:

- Facilities need more manpower and logistical supports,
- Capacity building of the service providers (Doctor, Nurse, midwife, statisticians etc.).
- Arrange newborn related refreshment trainings
- Strengthen coordination and monitoring
- Expand coordination between government and MaMoni staff
- Provide support in analyzing the large volume of data that is being generated
- Supply newborn equipment for gap management and newborn resuscitation management readiness.
- Facilities need logistics such as warmer, phototherapy machine, incubator, sucker machine, oxygen saturation machine, central oxygen line etc.
- Visit health facilities more frequently instead of once or twice weekly or monthly.
- Establish a head office at the district level so that healthcare providers can reach out to them easily.
- Conduct death review meeting on a weekly or monthly basis with the staff involved with SCANU
- MaMoni can support in making some videos using local FWV's speech and display the video all around the locality in order to raise awareness. The FP department advised to make and display videos based on each upazilla's aspect.
- More focus needs to be given to FP counseling. Sometimes the 4th ANC is skipped, which is a problem. 100% partograph usage should be ensured.
- Raise awareness so that more people get to know about the quality service and thus visit the hospitals.
- Conduct BCC activities to raise awareness among the community,

- Provide nursemaids/support workers to ensure the hygiene of the labor room during deliveries
- Increase the number of MaMoni field workers who will motivate more women to get Institutional deliveries done.
- MaMoni's service should be in place for 5 more Years here to help in achieving the maternal and newborn related SDGs. The service they are providing along with our own services has led to an improvement of quality. This improvement rate would increase substantially if they are present for five more Years.

8. Data-Driven Results and Learning

MaMoni MNCSP promotes the deployment of ICT-based innovations in health information systems and data usage. It focuses on expanding facility e-MIS in ten priority areas, as well as improving the quality and utilization of national MIS data by health facilities and management. Against this backdrop, the study team interviewed many stakeholders including national stakeholders, district health offices, healthcare providers and partner organizations who are involved in supporting these activities and the use of data.

> MaMoni provides us support with **developing, maintaining and synchronizing** these data systems. We can already see district, upazilla and union wise data of **3 crore people**.

- Government Official, Male, Nationals

There are two modules of e-MIS: community and facility (UHFWCs, UHCs, MCWCs). Since the launching of e-MIS in 2015, the government has received various support from MaMoni including digitization of reports, applications development, provision of tablets, training, monitoring, software development, and data synchronization.

A national stakeholder mentioned that one troubleshooter has been hired and trained for each upazilla. Anyone facing issues with e-MIS contact the local troubleshooter first. If the troubleshooters are unable to resolve the issue, experts at DDFP are contacted. The respondents also mentioned that peer networking is another component of problem-solving. There are some districts and upazilla based social media network groups where these issues are discussed and resolved among the members. Many trivial problems are now being solved locally after peer network activation.

8.1. Use of data for implementation and adjustment

The discussions revealed that the use of data has been useful in conducting review meetings, highlighting issues of concern and taking remedial measures. These meetings also help in reviewing data duplication and identifying gap analysis. Data entry, input, recording and reporting have been improved a lot in terms of MNH, ANC & PNC, facility delivery services. Noting this issue, a respondent observed that an FWV has to maintain 17-18 registers of every client's information which are then entered into the e-MIS server. At any given time, if a client/patient's information is required, the FWV can find all relevant data and history from the server by using the phone number of the client.

> At the end of each month, the field **workers discuss the challenges** and **cross-check their data** so that data duplication can be avoided. MaMoni facilitates this and we have achieved **a moderate success** at this practice.

-Healthcare Provider, Male, Noakhali

Noting the benefits of data, a healthcare provider also described a situation where the availability of data assisted in decision-making at a district facility. For example, partograph was effectively used earlier in the district hospitals. It was observed that nurses were administering unnecessary doses of

antibiotics when the water did not break and gave oxytocin when the cervix would not open. After reviewing data, they interfered and instructed accordingly to maintain protocol. Data from January 20212021 revealed that 100% of partograph was maintained which improved the quality of the prenatal service.

Citing similar experience, a district healthcare provider said:

> We had found **inconsistencies** in the number of registered pregnant women, death registration etc. across different registries. Community registration and facility registration vary as well. We observed that s**ome data are not being entered.** We **identified the manpower shortage** while we analyzing the data. We reanalyzed the quality bundle program of MaMoni and found further scopes of improving the quality of our work.
>
> \- Healthcare Provider, Male, Brahmanbaria

From Madaripur, another district official noted that, before MaMoni's intervention, it was not possible to check the quality of ANC & PNC services despite the increase in their numbers. MaMoni MNCSP facilitated in comparison between e-MIS data and survey data in terms of ANC components and thus we took necessary actions to minimize the gap. We can see significant improvement in data quality now. (DDFP Madaripur).

8.2. Challenges in Effective Data Usage

Despite e-MIS and data support, there are several challenges including technical problems and lack of manpower that affect effective project implementation.

- Several respondents mentioned that there are network issues. This is more severe at the union levels. Furthermore, the software or server goes down sometimes. As a result, data has to be kept both manually and digitally.
- Record-keeping in both manual and digital format is quite cumbersome for the FWVs.
- Data is often not recorded properly. For example, the percentage of service delivery in upazilla health complexes are not being reflected in the District Health Information System 2 (DHIS 2). One respondent noted that based on the rate of service delivery should rank the Chatkhil upazilla among the top ten performing upazilla. However, this is not reflected in the DHIS2 database. The respondent felt that data are not being input properly.
- Lack of skills to use digital tablets and inadequate refresher training results in errors in data entry and missing data.
- There are several registers for ANC, PNC, delivery, operation, birth, general patients, adolescent patients etc. The number of registers is too many to maintain, which increases the workload of the staff.
- The government healthcare providers also lack the capacity and motivation to use modern technology. They often give excuses such as being overburdened with work to enter data.
- Lack of coordination between DDFP and DGFP also create problems for data interpretation. A gynecologist noted that they provide a lot of contraceptive services such as birth control pills to almost every patient after delivery, conduct 25-30 ligations per month, give implants,

and copper T's. However, all these services are being enlisted as DGFP services. These cannot be found on DHIS2 for individual hospital names.

9. Scaling-down MaMoni MNCSP Activities

As per the project plan, MaMoni MNCSP will be scaling down from Habiganj, Noakhali, Lakshmipur and Kushtia. By the end Year 4, September 2021, MaMoni MNCSP plans to limit its activities and supports in the 4 of out of 10 districts. These are Habiganj, Noakhali, Lakshmipur and Kushtia where MaMoni/SCI has been working for more than 5 Years. From October 2021, the project human resource structure will be one district implementation manager from SCI and one district coordinator from partner NGO for each of the 4 districts. One M&E manager will support two districts. Each district will have a number of upazilla coordinators (i.e., 40-50% reduction). The position of upazilla facilitator have to be removed from the scale down districts and the project-supported service providers will be gradually reduced. In all four districts most of the project interventions demonstrated and proved successful implementation including the government capacity to deliver quality MNH services from the facilities. Hence, MaMoni intends to scale down the project investment but continue some level of project's support through system strengthening approach before completely phasing out from those districts by the end Year 4, September 2021. Therefore, the project plans to slowly phase out from these districts with gradual withdrawal of human resources.

MaMoni has a plan for the continuation of supports to the routine MNHQI interventions at district, upazilla and union level facilities. In the district hospital project will continue its technical support for functioning of CEmONC services, functioning of SCANU, KMC and IMCI services for small and sick newborn. It will also continue TA support for continuation of MNHQI services including post-partum family planning services. Technical support for continuation of BEmOC services including midwifery services, small and sick newborn services through functional KMC and IMCI will also be continued. Facilitation for quality normal delivery services including PPFP will also be continued.

The technical support from project will include:

- Facilitate the maintenance of facility readiness for MNH services across the different tier of facilities through mobilization of government resources.
- Facilitation and advocacy with the service providers to provide quality MNH services according to the national standard.
- Facilitation for establishing internal monitoring mechanism by the government managers such as, monitoring of clinical standard, on job training, joint supervisory visit etc.
- Facilitation for functioning of quality improvement committee where the facility level providers and the managers will set a mechanism for local level problem solution on quality MNH service delivery.
- Facilitation for data-driven decentralized planning and review of district and upazilla level facilities for strengthening quality MNH services from those facilities. This planning will include service readiness and availability of MNH services as per standard, internal monitoring structure with periodic review of the service utilization and local level resource mobilization.
- Provide technical support to district and upazilla health management team review meetings. Facilitation for use of HMIS data by the government managers for program planning and review process. Support to DDFP to run the e-MIS by themselves, technical support for expansion of community module if DGFP expands it.

However, demonstration of some interventions is still ongoing in those districts and project plans to continue the activities related to those interventions. These are:

- Operational study on management of KMC and SCANU and post discharge follow up at Laksmipur
- Documentation of role of midwives at Lakshmipur
- Intervention of social accountability at Noakhali
- Interventions on HTR areas where already initiated
- Piloting of CG based cMPM in selected unions that already initiated
- ICT innovation on mHealth visit reminder through SMS/Voice in Habiganj. It will expand to rest of upazilla of Habiganj.

Moreover, project will continue maintenance support to SCANU at district hospital until government take this responsibility and budget for it under operation plan. However, the project will not introduce any new intervention including quality of care bundle implementation and any capacity building activities in those districts except any orientation required for continuing demonstration activities. The findings of the study are consistent with the activities planned for the scale-down districts.

During the discussion with various respondents, it was noted that the rationale for scaling down is based on the fact that the project has been able to place system strengthening in the scale down districts so that the districts can carry out MNH activities on their own. The discussions with the government stakeholders and service providers revealed that the presence of MaMoni MNCSP has enhanced their overall capacity to deliver MNH services on their own.

Findings summarized from the discussions with the primary implementing organizations include the following key points:

- It should not be sudden withdrawal
- It should be negotiated with the government
- The donor should be involved to discuss the smooth transition of these districts.

The district health stakeholders, the national government stakeholders and PNGOs highlighted the following key concerns associated with scale-down:

- Not all districts ready for scale down
- Their overall contribution is positive enough but since they switch to other districts too soon, the sustainability of their contribution remains questionable.
- MaMoni's service should be in place for 2-5 more Years in certain districts
- While it is a good decision, there are some new initiatives such as KMC, SCANU which will be seriously hampered.

However, some concerns were raised by all the respondents which will need to be addressed to ensure sustainability. Issues such as manpower shortage and logistical inadequacies were highlighted that will need to be ensured in the absence of MaMoni MNCSP. Several respondents also noted that there are some upazillas, particularly in Noakhali, that are hard to reach. The respondents felt that MaMoni needs to continue their support at Kabirhat, Companiganj, Subornochar, and Hatiya for a longer period. In other word, the respondents suggested that the phase-out should be done gradually.

It had emerged during the discussion that MaMoni MNCSP's phasing out in some districts had left a shortage of paramedics and midwives, which were hired by MaMoni. However, those vacancies have been covered by the local government.

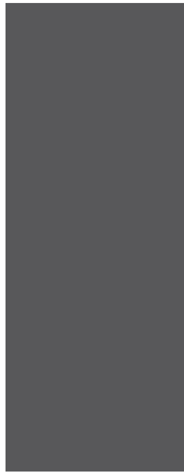
> "When we had **withdrawn our critical gap management support** from Noakhali, Habiganj and Lakshmipur, those positions were filled through the Union Parishad if not nationally. In Hatiya, we have tried **to hire a permanent government-supported surgeon** while our project doctor was still on duty. But the government ones did not stay for long."

-MaMoni MNCSP Project Team Member, Male

To sustain their efforts, one respondent mentioned that MaMoni needs to redesign its scope of work to provide data management, medical work management, and supervision. Several respondents also noted that at least 3 service providers will be essential at a 24/7 delivery service point, especially paramedics, gynecologists and anesthesiologists. It will also be necessary to ensure coordination with the health department and the local government to identify and solve resource constraints including manpower shortage and logistical issues.

> Scaling down should not be an issue if the gap in government support is minimized through **proper local govt engagement**.

-PNGO staff, Male



RECOMMENDATIONS

10. Recommendations

Maternal Health

- MaMoni MNCSP project should continue to support the district and upazilla level public health facilities in project districts to provide emergency obstetric and newborn care services with an increased focus on midwifery led care at the UHCs, facility readiness, and diligent supervision and monitoring

    - Aligned with government strategy, MaMoni's objective is to increase institutional deliveries in the public health facilities. MaMoni already demonstrated success in institutional deliveries in the intervention districts. The data shows the increases has been more in the UHFWC compared to the other type of health facilities (43% occurred at UHFWCs, 23% at upazilla health complexes (Source: Year 3 project report). UHCs are a missed opportunity. UHCs has sufficient manpower especially nurses and midwives to provide ANC, PNC and perform normal deliveries and ENC compared to UH&FWC. However pregnant women are not coming to the UHC for MNH care. Chances of sustainability is more if UHC can be transformed into a hub of basic maternal and newborn health care in the upazilla.

    - Awareness interventions (BCC activities) for mothers at the village level are required to enhance equitable utilization of quality MNH services. Collaborative partnerships with the MOHFW, NGO, private sector and donors may be formed for community mobilization.

    - The training needs of the nurses/midwives for maternal and neonatal care should be assessed and accordingly training should be imparted to promote evidence-based practices such as use of MgSo4, partograph, newborn care, etc.

    - Regular on the job training for nurse/midwives need to the conducted either through the project or through other sources including MOHFW operational Plan funding. The project may revise the training plan for MNH care based on needs assessment

    - Strong monitoring & supervision need to be introduced for ensuring governance and accountability (Joint visit with checklist and provide feedback)

- Ensuring compliance at all facility level, more specifically for the implementation of clinical and operational quality bundles, would require skilled personnel and thus, ensuring skilled personal should require strong national level advocacy by the MaMoni MNCSP (along with other partners)

- The shortage of the support staff (OT/Ward boy, ayah, cleaners) also should be assessed and sensitize the authority to fill-up the gaps. Also, measures should be taken for effective use of the existing support staff by strengthening their monitoring and supervision.

- Side-by-side, innovative measures like local level hiring of specialists; development and testing of various non-financial motivational intervention for the doctors to be developed and tested to ensure availability of doctors in public facilities.

- The rise in disparity in institutional delivery resulted from the COVID-19 pandemic and preference of the poor for delivering at home. This urges to introduce awareness program and engage LGIs more effectively to increase the facility delivery among the poor. Facility-specific interventions and awareness programs need to be introduced and strengthened.

- An assessment should be done on availability/functionality of the blood-bank in the DHs and accordingly advocacy should be done at the national level for measures to Ube taken for establishing blood bank in each of the DHs.

- Advocacy for regular supply of oxytocin, uniform ANC card to be ensured by sensitizing the relevant authorities.

- Promote and advocacy for a separate FP corner in each DH

Newborn health

- MaMoni MNCSP helped establish newborn management areas in all district hospitals and MCWCs, selected UHCs and UHFWCs in the project districts to improve preparedness to provide essential newborn care (ENC) at facilities providing delivery services. The project should monitor the functionality and maintenance for these areas. The project should also advocate at the national level to scale up these to all health facilities in the country

- Further efforts are required at the facility level to improve the performance of the indicator "infants were put to the breast within the first hour after birth".

- MaMoni MNCSP facilitated the development of the NNHP monitoring checklist, incorporating newly developed newborn signal functions. The project also facilitated NNHP for use of the checklist in the field. The project should facilitate implementation of NNHP monitoring checklist in the project intervention districts and support compiling the findings from this monitoring visit and share the findings with NNHP for corrective measures.

- The project should expand KMC corner at the selected health facilities in the intervention districts. Collaborative partnerships with the MOHFW, NGO, private sector and donors may be formed for community mobilization and awareness creation for promotion of KMC for the preterm/low-birth weight babies.

- Project may consider to ensure ENC, and use of 7.1% chlorhexidine to the newborn umbilical stump during labor/delivery among home birth (Aligned with National Newborn Health strategy) to support achieving the national targets

e-MIS:

- Strengthening the local trouble shooter groups is key to improve the response time for device/software related problems. In MaMoni working area, strengthening this group and promoting them local champions would ensure smooth e-MIS operation.

- Ownership of the e-MIS application by the local level managers is critical. MaMoni needs to strengthen the e-MIS district implementation committee and provide technical support to district and upazilla level managers for monitoring and supervision.

- In paperless district it is learned that there are still practices of using both paper and electronic registers, MaMoni should identify the reasons and support for the implementation of real paperless practice.

- For e-MIS it is important to establish district/regional level buffer stock of TABs. It is especially critical for paperless districts as the TAB is the primary means recording and reporting service details.

HMIS:

- Project has made efforts to improve the data quality with a moderate level of success. The data quality is still an issue between records and report. The project should work with district heath offices to increase motivation to and compliance from service providers and reporting focal person.

- Project has made progress in putting a process, tools and capacity building for use of data in planning and review meetings of district and upazilla health offices. The project should continue to be strengthening it as it is more a sustainable approaches of development assistance.

- Based on the findings, for digital health, the provider particularly the FWVs should record and report in one system that is through e-MIS. They should not maintain both of paper based and TAB based e-MIS system.

- The project should facilitate for combined MNC register at facilities across all the districts instead of using separate register for ANC, Delivery and PNC.

- The project should advocate and facilitate to improve the coordination in using the MIS system between DGHS and DGFP. All these would help ensure validation and quality of data, which are imperatives for policy formulation.

General/Cross cutting:

- Given that the COVID-19 had a severe impact on project's outcome level indicator, MaMoni should increase the efforts to improve the outcome level results in the remaining period of the project.

- MaMoni should plan for the sustainability and exit strategy for the project. As it is in later part of activity period, project should increase the efforts at institutionalizing the implementation and accountability in district health system so that they take over and manage it responsibly.

- Project should take action for ensuring timely fund disbursement to the PNGOs.

- The project must take initiative to share the best practices at the national level and documentation

MNHQI

- MaMoni MNCSP scaled up MNH-QI bundles in the project intervention districts in phases. Most of the facilities are aware of/implementing ANC bundles and Partograph bundle (Correct use of partograph). Most of the facilities demonstrated satisfactory performance on quality of ANC care. The rest of the quality bundles are not rolled out to all health facilities in the project district. The project may consider introduced/ roll out the all-quality bundles successively within an acceptable period of time

- MNC record keeping and reporting need to be improved in the public health facilities. Project should provide training to the nurses on record keeping and reporting. The project can work nationally with MIS, DGHS and DGFP for improve record keeping and reporting for EmONC.

- The project should consider increasing focus on regular monitoring and supervision of the implementation of quality bundles especially partograph fill up, management of complication, ENC, PNC etc.

- Ensuring compliances with set standards of MNH-QI Bundle would provide a better impact on postnatal care, essential newborn care, and quality resuscitation care.
- Ensuring compliance at all facility level, more specifically for the implementation of clinical and operational bundles, would require skilled personnel and thus, ensuring skilled personal should require strong advocacy by the MaMoni MNCSP

Facility readiness:

- The Project has successfully demonstrated facility readiness interventions in the selected districts and all the stakeholders appreciated this endeavor. The project should continue this activity to the new districts. The project should carefully document this and conduct advocacy at the national level to scale up nationally.

National support:

- Lack of adequate manpower such as pediatricians, neonatologist, anesthetists and gynecologist, consultants, lab technicians, and night guards also emerged as key barriers to the performance indicators. Therefore, strong advocacy is needed by the MaMoni MNCSP Program for filling up the vacant posts for effective use of the SCANU services and KMC.
- A policy should be taken to ensure availability of at least 2 pairs of specialists (Obs-Gyn and Anesthesia) in each of the DHs and implementation of that policy should be ensured through strong advocacy at the national level.

- Supply of all required MNH drugs to be ensured. An assessment is needed about the required need of routine and emergency MNH drugs and accordingly policy advocacy is needed to fill-

up the gaps to ensure routine/emergency drugs for all the pregnant women. Guideline should be developed for unused drugs.

- The project should conduct advocacy for uniform ANC/PNC card, registers, reporting form among DGHS and DGFP

LGI mobilization:

- MaMoni has made amazing progress in engagement of local government institutions in MNH and strategy is a best practice. The strategy will be highly useful for MOHFW to adopt nationwide use. Therefore, we recommend MaMoni to document the LGI engagement as a best practice and improve and revise the guideline and tools to be available for MOHFW and any development partners to use.

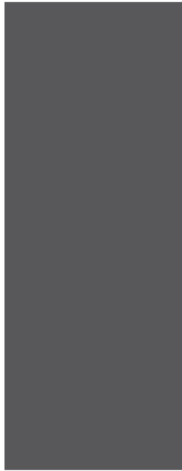
- As assistance from the LGIs for MNH services is not same for the sample districts and the periodic meetings with LGIs during the COVID-19 pandemic were irregular, MaMoni should devise strategies for more engagement of LGIs with health facilities and regular meetings with LGIs

24/7 UH&FWC:

- Despite the UHFWCs conduct the highest percentage of deliveries compared with DHs, UHCs and MCWCs, it suffers from the shortages of FWVs, support staff (maid, cleaners, etc.) which require proper attention of the government. MaMoni's strong advocacy is this regard might contribute to quality MNH services.

Scale down:

In the absence of MaMoni MNCSP, there are some hard-to-reach (HTR) upazilla the scale down districts that would face serious challenge and thus, it is imperative for continued support at Kabirhat, Companiganj, Subornochar, and Hatiya for a longer period. Gradual phase-out with proper judgement is required.



ANNEX

ANNEX I: Consent Form

Midterm Review - MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP)
Save the Children, Bangladesh

Consent Form for

- **Healthcare service providers**
- **National and local government representatives**
- **Officials of Save the Children**
- **Implementing Partners**
- **Observation of facilities**

The consent applies to individual or group interview and online or in-person.

This Informed Consent Form has two parts:

- Participant Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you agree that you may participate). In case of online discussion, voice consent is recorded.

Part I: Participant's information Sheet

Interviewer. Please read the following participant information sheet loudly and clearly.

Introduction

We are commissioned by Save the Children in Bangladesh to conduct the Midterm Review of the project "MaMoni Maternal and Newborn Care Strengthening Project (MaMoni- MNCSP)". In our study, we will talk to you in the form of an interview and ask a number of questions related to the work of Save the Children in your area. After you have heard more about the study, and if you agree, then we will ask you for your agreement and consent. You must agree before we begin and interview you.

Purpose

In this study we will talk to about the work of Save the Children in this area. We invited you to share your insights with us so that we will better understand the issue and share these insights with organizations and stakeholder who work towards meeting the needs and interests of the community.

Selection of Participants

Since we cannot talk to everyone in the community, we want to talk to selected individuals (like yourself). We would like to ask to participate because you live in this area and we think that you know about the issues related to work of Save the Children.

Voluntary Participation

It is not mandatory you agree to talk to us. You can choose not to answer any particular questions. You can ask as many questions as you like and we take the time to answer them.

Procedure

I (name of the interviewer) will take this interview and this discussion will be guided by a question guide. We will answer any questions about the study that you might have. Then we will ask questions about supports provided by MaMoni MNCSP in national/district/upazilla/health facility in maternal and newborn health care strengthening. We will talk or discuss about health system factors and other relevant topics where MaMoni has been supporting. We will not ask you to share personal stories or anything that you are not comfortable sharing. The discussion will take place in private setting and no one else but the people who take part in the discussion and the note taker and I will be present during this discussion. The entire discussion will be recorded with digital recorder, and written notes but no-

one will be identified by name on the record. The information recorded is confidential, and no one else except the study team will be allowed to listen to the records. The data will be stored in an offline server for up to 3 Years and then destroyed.

Duration
We are asking you to participate in an interview discussion which will take about 40 – 60 minutes depending on the kind of discussion we will have with you.
Risks and Discomforts
You must know that you should not answer any question or take part in the discussion that are too personal or if talking about them makes you uncomfortable.

Benefits
There will be no immediate and direct personal benefit to you, but your participation will help us find out more about the health care services in this area and develop the service provision (including your insights about the problems and the solutions to address the problems). We hope that these will help the MaMoni program and organizations such as Save the children better plan their work.

Reimbursements
You will not be provided with any payment to take part in the discussion or interview. We do not provide any incentives beyond reimbursements for transportation to the place of discussion as needed. Tea and drinks (such as bottled water) might be provided.

Confidentiality
We will not be sharing the information outside of the study team. The information that we collect from this study will be kept confidential. Any information about our discussion and interview will have a number on it instead of your name. Only the study team will know what your number is and we will lock that information up with a lock and key.

Right to refuse or withdraw
You may choose not to participate in this study and you do not have to take part if you wish to do so. Choosing to participate or not will not affect either your work or relationship with Save the Children. You may stop participating in the discussion at any time.

Who to Contact
If you have any question you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact Mr. Bal Ram Bhui whose address is listed on this card or sent over emails.
Interviewer: **Please provide the card.**

PART II: Consent Form

I have been asked to give consent to participate in this study which will involve participating in a discussion about work of Save the Children in my area. The information has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this discussion.

Name: ____________________

Signature: ______________________________

Date: ____________________

Statement by the person taking the consent
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the person understands what will be done. I confirm that the study participant was given an opportunity to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Name of the person taking the consent: ___________________________
Date: _________________
Signature of the person talking the consent: _____________________________
Date: ____________________

ANNEX 2: ERC APPROVAL

SC ERC approval.pdf

ANNEX 3: Questionnaire and Observation Checklist

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)
IDI with ADG PLANNING OF DGHS

Respondent's Information	
Name of the Respondent	
Designation	
Name of Organization	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

- How long have you been working here?
- Could you please tell us about your engagement with MaMoni MNCSP project for Maternal and newborn healthcare services?
- How does MaMoni contribute for such engagements? Please tell us MaMoni's some activities with DGHS.
- How is MaMoni helping you in leveraging the support of Maternal and newborn healthcare improvement at the national level?
- Tell us some of the activities MaMoni MNCSP project has done or supported for Maternal and newborn healthcare improvement.
- What other areas MaMoni could support to improve Maternal and newborn healthcare at the national level?
- What are the key health challenges in regard to Maternal and newborn healthcare? How MaMoni can help to address?
- Could you please tell us what motivational factors have made MaMoni's engagement successful?
- What has worked well and what has not? Probe for success stories and challenges and how they were addressed.
- What additional support do you need from the MaMoni?
- What are the top three suggestions/recommendations you have for MNH improvements?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with Director, Hospital and Clinics

Respondent's Information	
Name of the Respondent	
Designation	
Name of Organization	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

1. How long have you been working here?
2. Could you please tell us about MaMoni MNCSP project for Maternal and newborn healthcare services?
3. How does MaMoni contribute? Probing: hospital readiness, healthcare services, equipment, management, MIS…….
4. How is MaMoni helping you in leveraging the support of Maternal and newborn healthcare improvement at the national level?
5. Tell us some of the activities MaMoni MNCSP project has done or supported for Maternal and newborn healthcare improvement at the facility level.
6. How MaMoni is contributing towards the development of maternal and newborn care at the national level.
7. What other areas MaMoni could support to improve Maternal and newborn healthcare at the national level?
8. What are the key health challenges in regard to Maternal and newborn healthcare? How MaMoni can help to address?
9. Could you please tell us what motivational factors have made MaMoni's engagement successful?
10. What has worked well and what has not? Probe for success stories and challenges and how they were addressed.
11. What additional support do you need from the MaMoni for maternal and newborn healthcare improvements at hospitals?
12. What are the top three suggestions/recommendations you have for MNH improvements at hospitals?

Anything else you would like to share?
Are there any questions you may have?

IDI with National Representatives for DGFP-MIS and DGHS-MIS

Respondent's Information	
Name of the Respondent	
Designation	
Name of Organization	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

1. **Discussion**
    - How long have you been working here?
    - What has been your engagement on the MaMoni MNCSP project? (*Probe for mechanisms of engagement – program review, meeting, field visits, etc.*)

DGFP MIS

- What has been your engagement on the MaMoni MNCSP project? (*Probe: e-MIS and mHealth and ICT support for DGFP.*)
- What support have you received from MaMoni MNCSP's to develop, implement and scale up e-MIS in the country?
- What is the impact of e-MIS in national HMIS? What kind of results/impact are seen/enjoyed by providers, clients and management in the facilities where e-MIS has been implemented? Please share some data and success stories.
- What is the status of e-MIS implementation and the plan for nationwide scale up?
- What are the opportunities and challenges in e-MIS scale up, integration in national HMIS and strengthening the implementations?
- How about MaMoni's support to mHealth implemented in Madhapur Upazilla Upazilla of Habiganj? How does it add value to e-MIS? Do you have plan to scale up mHealth in other districts as well?
- Please tell us about ICT support MaMoni has been providing to DGFP MIS? Prob: Server for e-MIS for district beyond MaMoni, ICT support for transitioning e-MIS to national computer center, ICT for service statistics information system.
- Please tell us about online learning management system MaMoni has supported DGFP MIS? How is it being used? What is your plan ahead for increased use of it?
- How do you value MaMoni support for your program? What you liked, appreciated?

- What challenges have you experienced working with MaMoni MNCSP and how were they resolved??
- What changes need to be made to make the support provided by the project more effective?
- What additional areas of support would you like from MaMoni?

DGHS MIS

- What has been your engagement on the MaMoni MNCSP project? (*Probe: OpenMRS.*)
- What are the supports MaMoni MNCSP is providing to implement OpenMRS hospital automation system in Manikganj district hospital and Daulatpur Upazilla Health Complex? How is it being implemented? Prob: is it following national HMIS tools, reporting policies or so on? What is value added or special functionalities of the OpenMRS model?
- What kinds of results/impact are seen/enjoyed by providers, clients and management in the facilities where OpenMRS has been implemented? Please share some data and/or success stories.
- What are challenges faced in implementation of OpenMRS in the districts? What mechanism has been put in place by national level to facilitate the smooth implementation of OpenMRS in the districts.
- What suggestions you have for MaMoni in relation to OpenMRS in Manikganj?
- Can you also tell us about national scale up of OpenMRS? How many more hospitals are targeted and how many have started the work? What is more coming?
- How do you organize a coordination and collaboration among partners involved in OpenMRS implementation in the country?
- How do you value MaMoni support for your program? What you liked, appreciated?
- What challenges have you experienced working with MaMoni MNCSP and how were they resolved??
- What changes need to be made to make the support provided by the project more effective?
- What additional areas of support would you like from MaMoni?

3. On a scale 1-10, please tell us how satisfied you are with the support that MaMoni project provides.

4. What are the top three suggestions/recommendations you have for MaMoni?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with Representatives for MCRAH, MNCAH

Respondent's Information	
Name of the Respondent	
Designation	
Name of Organization	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. **General Discussion**
    - How long have you been working here?
    - What has been your engagement on the MaMoni MNCSP project? (Probe for mechanisms of engagement – program review, meeting, field visits, etc.)

2. **MNH program**

[National Newborn Health Program (NNHP), Comprehensive Newborn care Package (CNCP), Monitoring Cell, MCH Monitoring Cell)]

- What has been your engagement on the MaMoni MNCSP project? (*Probe for mechanisms of engagement – program review, meeting, field visits, etc.*)
- What support have you received from MaMoni MNCSP's to improve maternal, newborn health and FP programs in the country?
- Please tell more about MaMoni's support in maternal health?
- Please tell us about MaMoni's support in family planning?
- Please tell more about MaMoni's support in NNHP?
- Please tell us more about how MaMoni's supporting CNCP?
- Please tell us more about MaMoni's support toward national newborn cell (MNCAH-DGHS)? MCH monitoring cell (MCRAH – DGFP)?
- Please tell us how MaMoni is supporting in quality of care in maternal and newborn [Probe: QIC support, QI bundles, RRT, clinical mentorship, national monitoring)]?
- Please tell us about MaMoni support in SCANU?
- Please tell us about MaMoni support in KMC?
- Please tell us how MaMoni is supporting in national policy, plan and strategy development and implementation on MNH.
- What are supports provided by MaMoni to develop national capacity in MNH/FP?
- Please tell about how MaMoni is supporting MNH program in districts?
- How do you value MaMoni support for your program? What you liked, appreciated?

- What challenges have you experienced working with MaMoni MNCSP and how were they resolved??
- What changes need to be made to make the support provided by the project more effective?
- What additional areas of support would you like from MaMoni?

3. On a scale 1-10, please tell us how satisfied you are with the support that MaMoni project provides.

4. What are the top three suggestions/recommendations you have for MaMoni?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with Representatives from QIS

Respondent's Information	
Name of the Respondent	
Designation	
Name of Organization	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. **General Discussion**
    - How long have you been working here?
    - What has been your engagement on the MaMoni MNCSP project? (Probe for mechanisms of engagement – program review, meeting, field visits, etc.)

2. **Quality Improvement Program**
    - What has been MaMoni MNCSP's support to Quality Improvement Secretariat? Probe: Please share the details of the support for the full duration of the support in this phase and the previous phase [Probe for support with national QI policy, plan and strategy development, harmonization of QI approaches in the country, integration of QI Data in HMIS, development of QI training and mentorship materials, job aids, etc.]
    - Please tell us more about MaMoni support in implementation of national MNH quality activities?
    - What are supports provided by MaMoni to develop national capacity in QIS?
    - Please tell about how MaMoni is supporting quality improvement program in districts.
    - How do you value MaMoni support for your program? What you liked, appreciated?
    - What challenges have you experienced working with MaMoni MNCSP and how were they resolved?
    - What changes need to be made to make the support provided by the project more effective?
    - What additional areas of support would you like from MaMoni??
    -

3. **On a scale 1-10, please tell us how satisfied you are with the support that MaMoni MNCSP project provides.**

4. What are the top three suggestions/recommendations you have for MaMoni MNCSP?

5. Anything else you would like to share?

6. Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with Civil Surgeon, DDFP, UHFPO, UFPO and Facility Manager

Respondent's Information	
Name of the Respondent	
Designation	
Name of District Hospital	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. General Discussion

- How long you are working here;
- Overall, how maternal and newborn care is going on;

2. Assessment of MNH

2.1 Technical MNH

[ANC, Labor and Delivery; PNC, FP; SCANU, KMC, ENC; Emergency Management; PE/E and PPH Management;]

- How are the Maternal and newborn program activities going on in your districts/ facility?
- What supports MaMoni MNCSP project is providing to improve MNH services in your districts/ facility?
- Could you please tell us more about MaMoni support in labor and delivery services?
- Can you tell more about MaMoni support newborn health program? How about SCANU, KMC, ENC?
- How about MaMoni support in postpartum family planning service?
- What support is being provided to ensure appropriate management of emergency obstetric and newborn care? Prob: Can you tell more about MaMoni support in PE/E and PPH Management?
- How has MaMoni helped with capacity building for health providers? What are the trainings provided? Were there effective? Has there been any noticeable changes in the care for patients and performance of providers?
- Please share with us some key results of maternal and newborn program in past 2 Years attributable to MaMoni support? Please share some data and success stories?
- What are the challenges?

- What changes or additional activities would you like MaMoni to consider to further improve MNH/PPFP services in your districts?

2.2. Health Facility Readiness (HFR) for MNH

[ANC; Labor and delivery; Newborn Care; Availability of Essential Drugs for MNH; FP]

- In your opinion, what are the key requirements to make health facilities ready to provide quality MNH (MNH/PPFP) services? Probe: how about current level of readiness related skilled providers, essential equipment, essential drugs and diagnostics services of the facility
- What supports MaMoni MNCSP project is providing to improve facility readiness for ANC, labor and delivery and newborn care services in our districts/ facility? Probe for details.
- What are the improvements in readiness of health facilities for MNC in past 2 Years? Please tell about some data or examples for the reflection of readiness?
- What are the current and future challenges in health facility readiness?
- What changes or additional activities would you like MaMoni to consider to further improve MNH/PPFP services in your districts?

2.3. Quality of Care in MNH

[ANC; PNC; Labor and Delivery; CPU; QIC, Private Sector; Social Responsibility]

- How do you manage quality of care in your district/ facility?
- Are there quality improvement committees? Probe: How about quality improvement committee (QIC) as various levels? , how are they functioning? How often they meet, what are some of their activities in past six months?
- Please tell us about various quality improvement activities MaMoni is supporting in your district/ facility to improve quality of maternal and newborn care? Prob: how about quality improvement bundles?
- What quality bundles are going on? (ANC, PNC, labor delivery and neonatal care)- Prob: which facilities are these going on in?
- Can you share some of achievement of quality improvement bundle activities?
- <Beside quality bundles>, what other activities MaMoni is supporting to improve quality of are in MNH? Prob: Mentoring, Coaching, monitoring.
- What are some of the improvements you have observed attributable to MaMoni support on QI? Are there any success stories you could share with us?

- Could you please tell how you are working with private sectors in the areas of quality care in their facilities?
- Tell us about the social accountability mechanisms that your districts/ facility is using to engage clients. Prob: What kind of methods/ activities are there to collect client's feedback? What are some of the feedbacks in past six months and how they were addressed?
- What are the opportunities and challenges to improving quality care for MNC?

- What changes or additional activities would you like MaMoni to consider to further improve quality of care in MNH/PPFP services in your district/ facility?

3. Data-Driven Management Practices [Not Applicable for Facility Manager]

Now we would like to move on to different topics. First of all, I would like to talk about data based management practice. .

- What data sources are available to you for management of MNH services in your districts? *Prob: How about hospital registers, reports, patient's folder?*
- Please tell us about quality of data? Probe: How about completeness of reports, timeliness of reports and accuracy of report. Share with us some instance of data quality issues and how they were resolved.
- What activities/ practices are put in place to ensure accuracy of reports?
- How do you use data in your monthly/ quarterly program review meetings? Rob: Tell us about some of data you use in review meetings?
- Can you show/ share some of meeting minutes or materials from review meetings held in past three months that shows use of data and decision making?
- How do you find data useful for planning, monitoring and assessing the results? Can you share some examples of use of data that led to improved program results?
- How has the MaMoni project supported to you in capacity building, management of data, improvement in quality of data and use of data for program management?
- How about joint program review meeting MaMoni organized between health and family planning directorates? Prob: How useful has it been? What suggestions you have to improve it?
- What changes or additional activities would you like MaMoni MNCSP to consider to further improve quality and use of data for improved planning, monitoring and performance of MNH/PPFP services in your district/ facility?

4. MaMoni's Digital Health Information System for MNH (Only for Selected District/Upazilla)

4.1 e-MIS (all districts DDFP and DGFP run facilities)

- You are implementing e-MIS for some Years now; please tell us about how is it going on?
- How is MaMoni supporting you in e-MIS since introduction, expansion and till now? What kinds of training, IT support, hardware, trouble shooting, and capacity building support you are receiving form MaMoni?
- How has e-MIS benefited the providers, patients and management in facilities where they are implemented? *Prob: use cases*
- What are some of the existing challenges and how could they be addressed? What additional support, if any, do you need from MaMoni?

4.2: Open MRS (Manikganj only)

- As you know MaMoni has implemented OpenMRS hospital service automation in your Manikganj district hospital and Daulatpur Upazilla Upazilla hospital. Please tell us about how is it going on?
- What are the benefits of OpenMRS to providers, clients and management? How can its benefits be maximized?
- What has been challenges and how were they resolved? What will be challenges ahead?
- What are your plans for expanding this system to other facilities in your districts? Prob: how would you mobilize funds for the expansion?
- What additional supports, if any, do you expect from MaMoni?

4.3: mHealth (Madhabpur Upazilla Upazilla upazilla of Habiganj district)

- As you know, MaMoni is implementing mHealth SMS reminder system in your Upazilla Upazilla upazilla/ facility, please tell us about how is it going?
- Do you think mHealth is helping to increase the utilization of MNH services? How does it help you? What do women who receive the message say about it? Share some success stories about it. (prob: if answer was no change or not sure in increased service utilization, what could be reasons for that? How can it be addressed?
- What do you think are challenges with mHealth and how it could be resolved?

5. Local Government Mobilization for Health Care Improvement

- Please tell us about the engagement of local government (LG) for health care, especially maternal and new born care. *Prob: tell us about their engagement at district, Upazilla Upazilla and union level.*
- How is MaMoni helping you in leveraging the support of local government?
- Tell us some of the activities LG has done or supported for your district/ facility. For DH, MCWC, UHC and UH&FWC?
- How much of resource LG has mobilized in last Year and what is the plan ahead?
- What other areas could they support to improve care in the districts?
- What are the key health challenges in union level that you think LG can help to address?
- What do you think are the motivation and factors that made LG engagement successful?
- What are some of the challenges to leverage optimal LG support for health?
- What additional support do you need from the MaMoni?

6. Expansion and Improvement of 24/7 UHFWC [Not applicable for DH Super and UHFPO of UHC]

- What number or percentage of UHFWC are providing normal delivery care? How many of these facilities provide 24/7 normal delivery care? *Prob: how many facilities have staff quarter? Do provider reside in UHFWC or close by so that they are available on a call?*
- How and what has MaMoni supported in upgradation of UHFWCs to provide normal delivery 24/7 hours?

- How many new or additional UHFWC started providing 24/7 NVDs in 2020? What was done to upgrade them to 24/7 facility?
- What has been some of remarkable achievements or result of 24/7 UHFWC in 2020? Please share some data or success stories? What are prospects/ opportunity to improve quantity and quality of normal delivery care at UH&FWC?
- What were the challenges in upgrading to 24/7 service and how were they addressed?
- How many more of UHFWCs do you plan to upgrade to provide 24/7 NVD by this Year. How would you achieve it?
- What supports do you expect from MaMoni for further expansion and improvement 24/7 UH&FWC?

7. How has MaMoni contributed to development of district/ Upazilla Upazilla upazilla/ facility leadership and management?

8. Could you please tell us how MaMoni plays role in strengthening health system? [Not applicable for facility manager]

9. Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?

10. What are the top three suggestions/recommendations you have for MaMoni to improve maternal and newborn care in your district/ facility?

11. MaMoni's Scale-down District Only

- MaMoni is planning to scale down its support to your district. How will you keep up with progress made, capacity built while withdrawing of support from MaMoni? *Prob: what would be positive effect? What would negative effect?*
- What kind of support is expected from MaMoni that will help you sustain the progress during scale down phase?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI Guideline for the Lead of MFI/ PDCA in DH/UHC/UF&FWC

Respondent's Information	
Name of the Respondent	
Designation	
Name of District	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. What are PDCAs have been applied in your facilities?
2. Do you have QI team in the facility? How do the QI team function? Members, meeting, funding etc?
3. Do you have smart objectives? Target? How do you decide on the targets?
4. How many providers received training? What are those trainings? What is your opinion on quality of training?
8. How the QI bundle works in your facility – describe the process from start until now? *Prob: Tell us about problem identification, root cause analysis, baseline and target setting, implementation of activities, monitoring and maintenance of QI storyboard?*
9. What is your opinion on facility management's support to QI team?
10. How do you feel about PDCAs? How about your experience?
    - **a.** Does it improve service quality? If yes, how? If no, why?
    - **b.** What are the improvements have you seen after application of PDCAs? Give some examples.
    - **c.** What is your opinion on how these changes happened? What is the motivation behind such change?
11. What are the barriers and challenges in implementing PDCAs?
    - **a.** Workforce (?) (retention, skills, practices)
    - **b.** Financing/Budget (?)
    - **c.** Workload/Burden (?)
    - **d.** Others (?)
12. How implementation of PDCAs have made changes in quality of care as well as facility readiness and utilization of care? (Positive changes/Negative change; Interviewer needs to understand the notion of the respondent and prob for following theme according to that): Prob: use of evidence based practice, improved facility readiness, improved quality of recording and reporting, improved

provider- clients communication, increased utilization of service, decrease in ANC1-ANC4 dropouts, what else?

13. What are the supports you have received from MaMoni for PDCA? Prob: training, coaching, monitoring?
14. Observe quality improvement story board:
    - **a.** Are there objective with baseline and target values written?
    - **b.** Are the root cause analysis shown?
    - **c.** Are there action plan written?
    - **d.** Are there monitoring chart shown? What is the trend? What are explanations for ups and downs in the monitoring chart?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with LGIs at District, Upazilla Upazilla and Union

Respondent's Information	
Name of the Respondent	
Designation	
District	
Upazilla Upazilla	
Union	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

- Could you please tell us about your engagement with DH/UHC/MCWC/UHFWC?
- How does MaMoni contribute for such engagements? Please tell us MaMoni's some activities with you.
- How is MaMoni helping you in leveraging the support for health care improvement at DH/UHC/MCWC/UHFWC?
- Tell us some of the activities LG has done or supported for your DH, MCWC, UHC and UH&FWC.
- How much of resources LG has mobilized in last Year and what is the plan ahead?
- What other areas could you support to improve health care in the districts/Upazilla Upazilla upazillaupazillas ?
- What are the key health challenges in your district/Upazilla Upazilla upazilla? How LG can help to address?
- Could you please tell us what are the motivation factors that made LG engagement successful?
- What are some of the challenges to leverage optimal LG support for health?

10 What has worked well and what has not? Probe for success stories and challenges and how they were addressed.

11 What additional support do you need from the MaMoni?

12 What are the top three suggestions/recommendations you have for MNH improvements?

13 MaMoni's Scale-Down District Only

- As you know any project is not a permanent and one day will end or move out. MaMoni is considering to reduce level of efforts in your districts given that project has work for over 5 Years. The project believes that it has contributed in strengthening the health system, readiness of health facilities, improvement and expansion of 24/7 UHFWCs and many more. Besides, it has worked with LGI – your office and leadership exemplarily to improve LGI engagement and obligation to health care as per the government policy. Given all these, MaMoni is looking up at you to continue and increase your efforts while the project is scaling down its efforts.
- In this context, what are your thoughts and how would you do to maintain and accelerate the change? If there are areas that you would still need MaMoni support for next few months, what would that be?

Anything else you would like to share?

Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with NURSE/MIDWIFE at Upazilla Health Complex

Respondent's Information	
Name of the Respondent	
Designation	
Name of Upazilla	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

1. **General Discussion**
   - How long you are working here;
   - Overall, how your work is going on;

2. Assessment of MNH

2.1 Technical MNH

[ANC, Labor and Delivery; PNC, ENC; Emergency Management; PE/E and PPH Management;]

- What specific MNH/FP interventions is MaMoni supporting in this facility? Probe: support on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP. What are your key activities for ANC? Delivery care? PNC? PPFP? Probe for routine and emergency care provided for each service previously mentioned
- What support MaMoni has been provided? Probe: training, infrastructure, equipment and supplies, supervision, use of data for decision-making, quality improvement including respectful care, social accountability mechanisms, protocol development)
- How do you manage a client with PE/E? When do you refer and where to?
- How do you manage a client with PPH? When do you refer and where to?
- What NH services do you provide? Probe ENC, KMC, Referral etc. For each of the NH services mentioned, what are your key activities? Probe for routine and emergency care provided for each service previously mentioned"
- What has worked well and what has not? Probe for successes (including specific success stories)

- What has been the key results/impact from this support on MNH/FP services in your facility on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP? Probe for increased service utilization, improved quality, improved delivery outcome, reduced maternal and newbonr complication and mortatliy, etc

- What are the challenges?

- How has MaMoni supported with capacity building? What are the trainings provided?

- How do you work together with MaMoni?
- What additional support would you like the project to provide in your facility to continue to improve MNH/FP services?
- What and how should be done to improve the maternal health program further? Could you please share your opinion?

2.2. Health Facility Readiness (HFR) for MNH

[ANC; Labor and delivery; Newborn Care; Availability of Essential Drugs for MNH; FP]

- What support MaMoni has been provided for the readiness of this health facility to provide quality MNH/FP services? Probe for skilled manpower, essential equipment, essential drugs and diagnostics services of the facility about ANC, labor delivery, and maternal complication management, PNC, PPFP
- What has been the improvement/impact from this HFR support on MNH/FP services in your facility? Probe: availability of skilled manpower, essential equipment, essential drugs, diagnostics services etc
- What are the challenges?
- How do you work together with MaMoni for HFR?
- What additional support would you like the project to provide in your facility for HFR to continue to improve MNH/FP services?
- What and how should be done to improve the HFR for maternal health program further?

2.3. Quality of Care in MNH
[ANC; PNC; Labor and Delivery; CPU; QIC, Private Sector; Social Responsibility]

- What Quality Improvement intervention is MaMoni supporting in this facility? Probe: QI on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP

- What quality bundles are being implemented in your facility? Probe: ANC, labor delivery and PE/E, PPH, PNC, PPFP etc.
- How are these quality bundle planned, implemented, monitored and performance assessed?
- Beside quality bundles, what other activities are being implemented to improve quality of care in MH? Probe: Mentoring, Coaching, monitoring
- Please tell us about functioning of quality improvement committee? Probe: How often the QI committee meet, what are some of their activities in past six months?
- What are the challenges for QI implementation?

- What are the improvements in quality of care in this regard over the past 2 Years? Please tell about some data for the reflection of measuring quality of care?

- What additional support would you like the project to provide in your facility for QI to continue to improve quality of MNH/FP services? How about the district as a whole?
- What and how should be done to improve the QI initiative for MNH/FP program further?

3. Use of data

- Please tell us what are different kinds of data available to you use for monitoring and improvement of maternal and newoborn health in our facility? Probe: SCANU data, KMC data, ANC, labor and delivery register, PNC register, patient folder, what else?
- How do you use these data to improve MNH service? Probe: Describe the process for reviewing performance data in this facility, Probe for frequency of data review, persons engaged in the review, and what information is reviewed, in what format – tables, running chart, others, and what is being assessed, service utilization, facility maternal and newborn deaths, availability of supplies, equipment etc?
- What are the challenges in use of data to improve patient care and monitoring of program and how it could be resolved?
- How has been the MaMoni project's support to you in management of data, improvement in quality of data and use of data for program management?

- What can be done to further improve the data and it's use?

4. Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?
5. What are the top three suggestions/recommendations you have for MaMoni to improve MNH program?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with OBGYN at District Hospital

Respondent's Information	
Name of the Respondent	
Designation	
Name of Upazilla	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

1. **General Discussion**
    - How long you are working here;
    - Overall, how your work is going on;

2. Assessment of MNH

2.1 Technical MNH

[ANC, Labor and Delivery; PNC, ENC; Emergency Management; PE/E and PPH Management]

- What is your engagement with the MaMoni project? Probe for: engagement with facilitating training, mentorship, supervision, performance review of MNH/FP activities at facility where you are working.
- What specific MNH/FP interventions is MaMoni supporting in this facility? Probe: support on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP
- What support MaMoni has been provided? Probe: training, infrastructure, equipment and supplies, supervision, use of data for decision-making, quality improvement including respectful care, social accountability mechanisms, protocol development)

- What has been the key results/impact on MNH/FP services in your facility e. g. ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP? Probe for increased service utilization, improved quality, improved delivery outcome and reduced complication and mortality, etc. Provide some data and/ success stories.

- What are the challenges?

- How has MaMoni supported with capacity building? What are the trainings provided?

- How do you work together with MaMoni?
- What additional support would you like the project to provide in your facility to continue to improve MNH/FP services? How about the district as a whole?
- What and how should be done to improve the maternal health program further? Could you please share your opinion?

- Share any recommendations/suggestions you have for Improving MaMoni's support to your facility or the district as a whole? Probe – engagement with obstetricians, facility management, district management, MNH/FP service performance review, etc

2.2. Health Facility Readiness (HFR) for MH

[ANC; Labor and delivery; Availability of Essential Drugs for MH; FP]

- What support MaMoni has been provided for the readiness of this health facility to provide quality MNH/FP services? Probe for skilled manpower, essential equipment, essential drugs and diagnostics services of the facility about ANC, labor delivery, and maternal complication management, PNC, PPFP
- What has been the improvement/impact from this HFR support on MNH/FP services in your facility? as well as the district as a whole? Probe: availability of skilled manpower, essential equipment, essential drugs, diagnostics services etc
- What are the challenges?
- How do you work together with MaMoni for HFR?
- What additional support would you like the project to provide in your facility for HFR to continue to improve MNH/FP services? How about the district as a whole?
- What and how should be done to improve the HFR for maternal health program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for health facility readiness to your facility or the district as a whole?

2.3. Quality of Care in MH
[ANC; PNC; Labor and Delivery; CPU; QIC, Private Sector; Social Responsibility]

- What Quality Improvement intervention is MaMoni supporting in this facility (or the district)? (Probe: QI on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP)
- What is your engagement with the QI initiative in your facility? and in the district?

- What quality bundles are being implemented in your facility? Probe: ANC, labor delivery and PE/E, PPH, PNC, PPFP etc.
- How are these quality bundle planned, implemented, monitored and performance assessed?
- Beside quality bundles, what other activities are being implemented to improve quality of care in MH? Probe: Mentoring, Coaching, monitoring
- Please tell us about functioning of quality improvement committee? Probe: How often the QI committee meet, what are some of their activities in past six months?

- What are the improvements in quality of care in this regard over the past 2 Years? Please tell about some data for the reflection of measuring quality of care?

- What are the challenges?
- What additional support would you like the project to provide in your facility for QI to continue to improve quality of MNH/FP services? How about the district as a whole?
- What and how should be done to improve the QI initiative for maternal health program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for QI to your facility or the district as a whole?

3. Use of data

- What are different kinds of routine data for maternal health are in use for program management? Probe: ANC register, labor and delivery register, PNC register, reporting format etc?
- How do you use these data to improve maternal health service? Probe: How do you use labor and delivery report to understand the summary of performance and problems? What are major obstetric complications you see in your facility based on data? How about PE/E and PPH?
- What do you think are challenges in use of data to improve patient care and monitoring of program and how it could be resolved?
- How has been the MaMoni project's support to you in management of data, improvement in quality of data and use of data for program management?
- What additional support would you like the project to provide in your facility for data improvement to continue to improve quality of MNH/FP services? How about the district as a whole?

6. Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?

7. What are the top three suggestions/recommendations you have for MaMoni?

Anything else you would like to share?

Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with Pediatrician at District Hospital

Respondent's Information	
Name of the Respondent	
Designation	
Name of District	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. **General Discussion**
    - How long you are working here;
    - Overall, how your work is going on;

2. Assessment of MNH

2.1 Technical NH

[ENC, KMC, SCANU, Emergency Management of sick newborn;]

- What is your engagement with the MaMoni project? Probe for: engagement with facilitating training, mentorship, supervision, performance review of newborn health activities at the facility where you are currently working.
- What specific NH interventions is MaMoni supporting in this facility (or the district)? Probe: support on ENC, KMC, SCANU, emergency management of sick newborn
- What support MaMoni has been provided? Probe: training, infrastructure, equipment and supplies, supervision, use of data for decision-making, quality improvement including respectful care, social accountability mechanisms, protocol development, referral protocol)

- What has been the key results/impact from this support on NH services in your facility e.g on ENC, KMC, SCANU, emergency management of sick newborn. Probe for increased service utilization, improved quality and improved birth outcome, reduced newborn complication and mortality? Share some data and success stories.

- What are the challenges around SCANU and how they can be resolved?

- How has MaMoni supported with capacity building? What are the trainings provided for NH?

- How do you work together with MaMoni?
- What additional support would you like the project to provide in your facility to continue to improve NH services? How about the district as a whole?
- What and how should be done to improve the newborn health program further? Could you please share your opinion?

- Share any recommendations/suggestions you have for Improving MaMoni's support to your facility or the district as a whole? Probe – engagement with professional body, facility management, district management, NH service performance review, etc

2.2. Health Facility Readiness (HFR) for NH

[Newborn Care; Availability of Essential Drugs for NH, KMC, SCANU]

- What support MaMoni has been provided for the readiness of this health facilities to provide quality NH services? Probe for skilled manpower, essential equipment, essential drugs and diagnostics services of the facility about SCANU, KMC, ENC
- What has been the improvement/impact from this HFR support on NH services in your facility? as well as the district as a whole? Probe: availability of skilled manpower, essential equipment, essential drugs, diagnostics services etc
- What are the challenges?
- How do you work together with MaMoni for HFR?
- What additional support would you like the project to provide in your facility for HFR to continue to improve NH services? How about the district as a whole?
- What and how should be done to improve the HFR for NH program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for health facility readiness to your facility for NH or the district as a whole?

2.3. Quality of Care in NH
[Newborn Care, KMC, SCANU, QIC, Private Sector; Social Responsibility]

- What Quality Improvement intervention is MaMoni supporting in this facility (or the district)? (Probe: QI on SCANU, KMC, ENC)
- What is your engagement with the QI initiative in your facility? and in the district?

- What NH quality bundles are being implemented in your facility?
- How are these quality bundle planned, implemented, monitored and performance assessed?
- Beside quality bundles, what other activities are being implemented to improve quality of care in NH? Probe: Mentoring, Coaching, monitoring
- Please tell us about functioning of quality improvement committee? Probe: How often the QI committee meet, what are some of their activities in past six months?
- What are the improvements in NH quality of care in this regard over the past 2 Years? Please tell about some data for the reflection of measuring quality of care?

- What are the challenges?
- What additional support would you like the project to provide in your facility for QI to continue to improve quality of NH services? How about the district as a whole?
- What and how should be done to improve the QI initiative for newborn health program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for QI to your facility or the district as a whole?

3. Use of data

- What are different kinds of routine data for newborn health are in use for program management? Probe: SCANU data, KMC data, labor and delivery register, PNC register, patient folder, what else?
- How do you use these data to improve newborn health service? Probe: How do you use SCANU data? What are key reasons for admission of sick newborn in SCANU based on SCACNU data? What are major causes of death? How can death in SCANU be reduced?
- What do you think are challenges in use of data to improve patient care and monitoring of program and how it could be resolved?
- How has been the MaMoni project's support to you in management of data, improvement in quality of data and use of data for program management?
- What additional support would you like the project to provide in your facility for data improvement to continue to improve quality of newborn health services? How about the district as a whole?

4. **Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?**
5. **What are the top three suggestions/recommendations you have for MaMoni?**

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with FWV at UH&FWC

Respondent's Information	
Name of the Respondent	
Designation	
Name of UHFWC	
Union/Upazilla/District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer Phone #	
Signature of the Respondent	

1. **General Discussion**
   - How long you are working here;
   - Overall, how your work is going on;

2. Assessment of MNH

2.1 Technical MNH

[ANC; Labor and Delivery; PNC; FP; KMC, ENC; Emergency Management; PE/E and PPH Management;]

- What MNH and FP services are provided in this facility? Probe: ANC, delivery, PNC/FP/PPFP etc.
- What are your key activities for ANC? Delivery care? PNC? PPFP? FP? Probe for routine and emergency care provided for each service previously mentioned
- How do you manage a client with PE/E? When do you refer and where to?
- How do you manage a client with PPH? When do you refer and where to?
- What NH services do you provide? Probe ENC, KMC, Referral etc. For each of the NH services mentioned, what are your key activities? Probe for routine and emergency care provided for each service previously mentioned"
- Could you please tell us how you manage emergency of maternal complication?? What care do you provide?
- Could you please tell us how you manage newborn illness or complication?? What care do you provide?
- How has the MaMoni project supported you to provide the MNH/FP services? Probe for support in training, infrastructure, material and equipment supplies, mentorship,

data collection and use, etc" For each type of support mentioned – ask what assistance did MaMoni provide?

- What improvements have you observed since MaMoni started providing support to this facility? Please tell about some data and any success stories?
- How has MaMoni helped with capacity building? What are the trainings provided?
- What are the challenges?
- How do you work together with MaMoni?
- What can be done to further improve MNH/FP services in this facility and how should be done?

2.2. Health Facility Readiness (HFR) for MNH

[ANC; Labor and delivery; Newborn Care; Availability of Essential Drugs for MNH; FP]

- What support MaMoni has been provided for the readiness of this facility to provide quality MNH/FP services? Probe for skilled manpower, essential equipment, essential drugs and diagnostics services of the facility about ANC, labor delivery, and maternal complication management, PNC, PPFP, NH services
- What are the challenges?
- What has been the improvement/impact from this HFR support on MNH/FP services in this facility? Probe: availability of skilled manpower 24/7, essential equipment, essential drugs, diagnostics services, protocol, job aid, etc
- What additional support would you like the project to provide in your facility for HFR to continue to improve MNH/FP services?
- What can be done for HFR to further improve MNH/FP services in this facility and how should be done?

2.3. Quality of Care in MNH
[ANC; PNC; Labor and Delivery; CPU; QIC, Private Sector; Social Responsibility]

- What Quality Improvement intervention is MaMoni supporting in this facility? Probe: QI on ANC, PE/E, Delivery, AMSTL, Partograph use, PPH, ENC, PNC, PPFP)
- What quality MNH bundles are implemented in this facility? Probe: ANC, PNC, labor delivery PE/E, PPH, neonatal care. How the bundles are rolled out?
- Beside quality bundles, what other activities are being implemented to improve quality of care in MH? Probe: Mentoring, Coaching, monitoring

- What are the challenges for implementation of QI?
- What are the improvements in quality of care in this regard over the past 2 Years? Please tell about some data for the reflection of measuring quality of care?
- How do you work together with MaMoni for quality improvement interventions?
- Do you have a social accountability mechanism in this facility? Probe: describe the mechanisms, how do you get clients input, is the mechanism confidential – how so, how is the information collected analyzed, how is the action to take determined and monitored, does it include a feedback mechanism to the clients/community?

- How can the social accountability mechanism be improved?
- What are the challenges for social accountability mechanism?
- What additional support would you like the project to provide in your facility for QI to continue to improve quality of MNH/FP services?
- What can be done to further improve the QI interventions to continue to improve quality of MNH/FP services?

3. Use of data

- Please tell us what are different kinds of data available to you use for monitoring and improvement of maternal and newborn health in our facility? Prob: ANC register, labor and delivery register, PNC register, patient folder, what else?
- Do you have to prepare any monthly/quarterly MNH report? Probe: number of ANC, deliveries, FP services. Can you show copy of reports for past three months?
- Do you have a monitoring table/ chart/ display or in any form to monitor progress and problem in maternal and neonatal health? Please show those tools if any?
- Can you give some examples of data driven action taken? Prob: what were it, how was it done and what was the result?
- Do you share data in UHFWC Facility Management Committee (FMC) meetings? When was the last meeting of FMC? Probe: for any record/minute of the meeting
- What are the challenges in use of data to improve patient care and monitoring of program and how it could be resolved?
- How has been the MaMoni project's support to you in management of data, improvement in quality of data and use of data for program management?
- What can be done to further improve the data and it's use?

4. MaMoni's Digital Health Information System for MNH (Only for Selected District/Upazilla Upazilla)

4.1 e-MIS (all districts and DGFP run facilities)

- You are implementing e-MIS for some Years now; please tell us about how is it going on?
- What are benefits of e-MIS ?
- What are challenges and how can that be resolved?
- What is your plan to optimal use of e-MIS
- What kind of support you need from MaMoni

5. Delivery care (UHFWC that provide normal delivery care or 24/7 normal delivery care)

- How many deliveries do you do in a month in average? How many providers are there in the facility?
- Do you (providers) reside in the facility? If no, where? Are you available immediately on call for delivery?
- Do you provide delivery care 24/7? Since when this facility is providing 24/7 delivery care?

- What are the supports MaMoni has been providing to your facility to improve delivery services? Prob: capacity building, facility readiness, LG mobilization, monitoring and supervision, e-MIS etc.
- What are the improvements or progress you have made in delivery care with of MaMoni support? Prob: Is delivery number increased? Is quality of care delivery improved? Is stabilization and referral of complication improved? How and how much of those improved?
- What are the challenges in increasing the number of deliveries?
- What and how should be done to increase the number of delivery further? Could you please share your opinion?
- What additional support would you like the project to provide in your facility to continue to improve normal delivery/ 24/7 delivery service?

6. Local Government Mobilization for Health Facility Improvement

- What are the supports Union Parishad has provided to you in past 2 Years? Prob: Budgetary support, in-kind support, infrastructure support, additional staff, reward/incentive for staff, community mobilization.
- How has MaMoni been supporting your facility in getting support from Union Parishad?
- What are additional or other supports you would like to receive from Union Parishad to improve the utilization of service by community?
- How can you persuade Union Parishad to provide more supports to your facility?
- What supports you would like to receive from MaMoni?

7. Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?

8. What are the top three suggestions/recommendations you have for MaMoni?

11. MaMoni's Scale-Down District Only

- How will the stakeholders keep up with progress made, capacity build in the course of withdrawing of support from MaMoni?
- What kind of support is expected from MaMoni that will help stakeholder sustain the progress during scale down phase?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

IDI with Pediatrician at District Hospital

Respondent's Information	
Name of the Respondent	
Designation	
Name of District	
District	
Phone #	
Date of Interview	
Start Time	
End Time	
Name of Interviewer	
Interviewer phone #	
Signature of the Respondent	

1. General Discussion

- How long you are working here;
- Overall, how your work is going on;

2. Assessment of MNH

2.1 Technical NH

[ENC, KMC, SCANU, Emergency Management of sick newborn;]

- What is your engagement with the MaMoni project? Probe for: engagement with facilitating training, mentorship, supervision, performance review of newborn health activities at the facility where you are currently working.
- What specific NH interventions is MaMoni supporting in this facility (or the district)? Probe: support on ENC, KMC, SCANU, emergency management of sick newborn
- What support MaMoni has been provided? Probe: training, infrastructure, equipment and supplies, supervision, use of data for decision-making, quality improvement including respectful care, social accountability mechanisms, protocol development, referral protocol)
- What has been the key results/impact from this support on NH services in your facility e.g on ENC, KMC, SCANU, emergency management of sick newborn. Probe for increased service utilization, improved quality and improved birth outcome, reduced newborn complication and mortality? Share some data and success stories.
- What are the challenges around SCANU and how they can be resolved?
- How has MaMoni supported with capacity building? What are the trainings provided for NH?

- How do you work together with MaMoni?
- What additional support would you like the project to provide in your facility to continue to improve NH services? How about the district as a whole?
- What and how should be done to improve the newborn health program further? Could you please share your opinion?

- Share any recommendations/suggestions you have for Improving MaMoni's support to your facility or the district as a whole? Probe – engagement with professional body, facility management, district management, NH service performance review, etc

2.2. Health Facility Readiness (HFR) for NH

[Newborn Care; Availability of Essential Drugs for NH, KMC, SCANU]

- What support MaMoni has been provided for the readiness of this health facilities to provide quality NH services? Probe for skilled manpower, essential equipment, essential drugs and diagnostics services of the facility about SCANU, KMC, ENC
- What has been the improvement/impact from this HFR support on NH services in your facility? as well as the district as a whole? Probe: availability of skilled manpower, essential equipment, essential drugs, diagnostics services etc
- What are the challenges?
- How do you work together with MaMoni for HFR?
- What additional support would you like the project to provide in your facility for HFR to continue to improve NH services? How about the district as a whole?
- What and how should be done to improve the HFR for NH program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for health facility readiness to your facility for NH or the district as a whole?

2.3. Quality of Care in NH
[Newborn Care, KMC, SCANU, QIC, Private Sector; Social Responsibility]

- What Quality Improvement intervention is MaMoni supporting in this facility (or the district)? (Probe: QI on SCANU, KMC, ENC)
- What is your engagement with the QI initiative in your facility? and in the district?

- What NH quality bundles are being implemented in your facility?
- How are these quality bundle planned, implemented, monitored and performance assessed?
- Beside quality bundles, what other activities are being implemented to improve quality of care in NH? Probe: Mentoring, Coaching, monitoring
- Please tell us about functioning of quality improvement committee? Probe: How often the QI committee meet, what are some of their activities in past six months?
- What are the improvements in NH quality of care in this regard over the past 2 Years? Please tell about some data for the reflection of measuring quality of care?

- What are the challenges?
- What additional support would you like the project to provide in your facility for QI to continue to improve quality of NH services? How about the district as a whole?
- What and how should be done to improve the QI initiative for newborn health program further?
- Share any recommendations/suggestions you have for Improving MaMoni's support for QI to your facility or the district as a whole?

3. Use of data

- What are different kinds of routine data for newborn health are in use for program management? Probe: SCANU data, KMC data, labor and delivery register, PNC register, patient folder, what else?
- How do you use these data to improve newborn health service? Probe: How do you use SCANU data? What are key reasons for admission of sick newborn in SCANU based on SCACNU data? What are major causes of death? How can death in SCANU be reduced?
- What do you think are challenges in use of data to improve patient care and monitoring of program and how it could be resolved?
- How has been the MaMoni project's support to you in management of data, improvement in quality of data and use of data for program management?
- What additional support would you like the project to provide in your facility for data improvement to continue to improve quality of newborn health services? How about the district as a whole?

4. Overall, please tell us how satisfied are you with MaMoni support in a scale 1-10?

5. What are the top three suggestions/recommendations you have for MaMoni?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with Partner Organizations

(DASCOH Foundation, Palashipara Samaj Kallyan Samiti (PSKS), Resource Integration Centre (RIC) and Shimantik)

Respondent's Information	
Name of the respondent	
Designation	
Name of organization	
Phone number	
Date of interview	
Start time	
End time	
Name of Interviewer	
Interviewer phone number	
Signature of the respondent	

1. What implementation supports have they been providing to MOHFW under the MaMoni project? Probing Technical: ANC, Labor and Delivery; PNC, FP; SCANU, KMC, ENC; Emergency Management; PE/E and PPH Management; e-MIS , OpenMRS, mHealth.
2. What challenges they have experienced with providing this implementation support and how were they addressed
3. What health facility readiness supports have they been providing to MOHFW under the MaMoni project? Probing; A NC; Labor and delivery; Newborn Care; Availability of Essential Drugs for MNH; FP
4. What challenges they have experienced with this readiness-related support and how were they addressed
5. Share your engagements with quality of care in MNH improvements.
6. Could you define your role in engaging LGs with health facility improvements and resource mobilization?
7. Could you please explain your role to the expansion and improvements of 24/7 UH&FWC?
8. Can you share some of the results of MaMoni that you have directly contributed to?
9. Tell us about the strategy and working relationship with MOHFW at district below level? Share any success stories related to your support to MOHFW. What are successful approach

to working with government counterparts? What are challenges and how were they resolved? What could be done to improve this support?

10. What are key MNH coverage improvements that MaMoni has contributed to? Prob: How about public facility delivery coverage, ANC1 and ANC4 coverage, PPFP, Consumption of Misoprostal at home delivery? What districts are doing better, and which ones are not so as expected? What are possible explanation for good performing districts? What are reasons for inadequate performance in some districts? At the current rate of improvement, do you think project will be able to meet its end of project targets? What should be or are you doing to accelerate the improvement on the coverage indicators?

11. Please tell us about impact of COVID-19 on performance on the project performance? Prob: Please provide examples of negative impact of COVID-19? What kinds of mitigation strategies and activities were taken? What has been effect of mitigation activities?

12. Please tell us about your organizational support to MaMoni MNCSP project? Prob: Management support, program support.

13. Please tell us about your working relationship with the SCIB MaMoni team? Probe for transparency, sharing of information, engagement in project dissemination activities, joint meetings (how frequent, purpose, etc)

14. What support do you get from SCI MaMoni team? Probe for technical support – type, frequency, how, etc.

15. What has been some of the challenges working with SCIB MaMoni team? How were these resolved

16. What are your recommendations for improvement of your working relationship with SCIB MaMoni team?

17. What overall three suggestions do you have for improving MNH/FP services in the districts your organization supports?

18. MaMoni's Scale-Down District Only

    - How will the stakeholders keep up with progress made, capacity build in the course of withdrawing of support from MaMoni?
    - What kind of support is expected from MaMoni that will help stakeholder sustain the progress during scale down phase?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI MNCSP)

IDI with Primary Implementing Organization

(Officials of Save the Children- MaMoni Project)

Respondent's Information	
Name of the respondent	
Designation	
Name of Organization	
Phone number	
Date of interview	
Start time	
End time	
Name of Interviewer	
Interviewer phone number	
Signature of the respondent	

MaMoni MNCSP Thematic Team Lead (TTL):

19. Please tell us about evolution of project from beginning to now? What has been opportunities and challenges and how did project address it.

20. How is the overall management structure contributing to the achievement of this goal? Probe –structure at national, regional, district and sub-district levels?

21. What are the key mechanisms for working with consortium (i.e., IHI, Jhepeigo, Icddr,b, PHD, Dnet _and local (PNGOs such as DASCOH Foundation, Palashipara Samaj Kallyan Samiti (PSKS), Resource Integration Centre (RIC) and Shimantik)partners? Prob: how do you keep unified understanding, communication and working relationships?

22. How do you work with Donor/ USAID? Prob: how do you address their priorities, feedbacks, guidance?

23. What are the main mechanisms for project engagement with MOHFW at national, district and sub-district level? Probe for TWGs, joint work planning, joint supervision, performance review, field visits, etc. -

24. What recommendations/suggestions do you for improving the engagement mechanisms of partners, MOHFW, and donor?

25. What are key achievements of MaMoni in past 2 and half Years? What are priorities for remaining period of project?

Ask these questions in customized way to TTL, Technical Specialist and Field Team

26. What are key maternal and newborn health (MNH) interventions or program that MaMoni MNCSP is supporting MOHFW at national and district level and at various tiers of health facilities? Prob: Prob intervention support for ANC, Labor and Delivery; PNC, FP; SCANU, KMC, ENC; Emergency Management; PE/E and PPH Management, supervision, monitoring, on the job coaching. What are the project's implementation approaches and activities for improving evidence based MNH practices in public sector facilities? Please share some of the results and success stories. What were challenges and how were they addressed. Tell us top 3 suggestions to improve use of evidence based practice in MNH?

27. What are MaMoni MNCSP's objectives, strategies and activities for improving the quality of care in MNH improvements? Prob: How it is planned, implemented and monitored? Please share some of the results and success stories? What were challenges and how were they addressed. Tell us top 3 suggestions to improve quality of care in MNH?

28. What ministry unit at national level do you work with for quality of care on MNH? Tell us about supports provided in so far? What are some of key results and success stories? What were challenges and how were they addressed. Tell us top 3 suggestions to improve engagement with national level on quality of care for MNH?

29. What are MaMoni MNCSP's objectives, strategies and activities for engagement of Local Government in health problems at district and below level? Prob: Was objective includes their support for health facility improvements and resource mobilization? Prob: How it is planned, implemented, monitored? Who are the stakeholders and how all worked together for LG engagement? What are key results and success stories? What were challenges and how were they addressed. Tell us top 3 suggestion to improve engagement and resource mobilization from LGI?

30. Could you please explain your strategies and activities to support the expansion and improvements of 24/7 UH&FWC? How it is planned, implemented, monitored? Who are the stakeholders and how all worked together for expansion and improvement of 24/7 UHFWCs? What are key results and success stories? What were challenges and how were they addressed. Tell us top 3 suggestion to improve the expansion and improvements of 24/7 UH&FWC?

31. What are MaMoni MNCSP program on digital health information system? Prob: Tell us about e-MIS – facility module, community module, OpenMRS, mHealth. What are the state of implementation of them? Where are they implemented? What are key results? How does it improve the availability of quality data? How is it improving the care for the clients? How is it improving the management? What are the challenges and how were they addressed? Tell us top 3 suggestions to improve MaMoni MNCSP support digital health information system?

32. What ministry unit at the national level do you work with for MaMoni MNCSP support to digital health information system? Tell us about working approach and relationship? What are some of key results and success stories? What were challenges and how were they addressed. Tell us top 3 suggestion to improve engagement with national level on digital health information system?

33. Please tell us about use of data and learning to improve program planning, implementation and results with MaMoni MNCSP? What organizational or management practice is put in place in MaMoni for culture of data use? Prob: Is the information system in place? What are sources of data? Is there database system? How often the data is reviewed? How is the learning learnt? Are there regular forum or meetings where data is presented, discussed and action taken? What are challenges and how were they resolved? What could be done to improve use of data and learning within MaMoni?

34. How does MaMoni help health district and Upazilla Upazilla upazilla health office in management, quality and use of data in their program management? Prob: What are key data used for program management? What forums/meetings are the data presented, discussed and actions taken in in district and Upazilla Upazilla upazilla health management? What are challenges and how were they resolved? What could be done to improve use of data and learning within district and Upazilla Upazilla upazilla health management?

35. What health facility readiness supports have they been providing to MOHFW under the MaMoni project? Probing; A NC; Labor and delivery; Newborn Care; Availability of Essential Drugs for MNH; FP. What challenges you have experienced with this readiness-related support and how were they addressed.

36. What districts are doing better, and which ones are not so as expected? What are possible explanation for good performing districts? What are reasons for inadequate performance in some districts? At the current rate of improvement, do you think project will be able to meet its end of project targets? What should be or are you doing to accelerate the improvement on the coverage indicators?

37. Tell us about the strategy and working relationship with MOHFW at district and below level? Share any success stories related to your support to MOHFW. What are successful approach to working with government counterparts at this level? What are challenges and how were they resolved?

38. Please tell us about impact of COVID-19 on performance on the project performance? Prob: Please provide examples of negative impact of COVID-19? What kinds of mitigation strategies and activities were taken? What has been effect of mitigation activities?

39. MaMoni's Scale-Down District Only

- Could you please share your thoughts or rationales for scale-down?

Anything else you would like to share?
Are there any questions you may have?

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

Observation Checklist for ANC at DH & UHC

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available- A, Not Available- NA
1	Staff trained; At least one provider of ANC ever receiving in-service ANC training on duty		
2	Guidelines on ANC: National or other ANC guidelines available at the facility		
3	Equipment: Functional blood pressure apparatus		
4	Diagnostic capacity: Hemoglobin tests;		
5	Urine protein testing capacity		
6	Medicines: Iron or folic acid tablets or combined		

Observation Checklist for Labor Delivery

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available-A, Not Available-NA
1	At least one skilled/trained staff available on duty: at least one skilled provider present 24 hours a day, seven days a week (by shifts).		
2	Availability of service guidelines		
3	Equipment/Tracer Items:		
	Delivery pack		
	Suction apparatus		
	Neonatal bag and mask		
	Partograph		
	Gloves		
4	Medicines and commodities:		
	Injectable oxytocin		
	Injectable antibiotic		
	Magnesium sulfate		
	Skin disinfectant		
	Intravenous solution with infusion set		
5	Nine Signal functions for comprehensive emergency obstetric and neonatal care (CEmONC)		
	Application of parenteral Antibiotics		
	Application of parenteral uterotonics (Oxytocin)		
	Application of parenteral anticonvulsants		
	Perform assisted vaginal delivery		
	Perform manual removal of placenta		

	Perform removal of retained products of conception (MVA)		
	Perform neonatal resuscitation		
	Perform blood transfusion		
	Conduct caesarean section		
6	Basic sanitation available for women during and after labor and childbirth		

Observation Checklist for Maternal (Obstetric) Complications

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available-A, Not Available-NA
1	Staff (Doctor, nurse, and midwife) with up-to-date training: at least one skilled provider present 24 hours a day, seven days a week (by shifts). Probe; Duty schedule.		
2	Availability of service SOP, Protocols for PPH, Eclampsia, Active Management of third stage of labor, Register, Referral slip		
3	Medicines & Equipment: PPH Kit, Eclampsia Kit, Emergency kit Injectable antibiotic, Magnesium sulphate, Oxytocin, misoprostol, IV fluid with infusion set		
4	Pre referral treatment information		
5	MNH bundle (PPH bundle, Eclampsia)		
6	Signal functions for emergency obstetric and newborn care 1. Application of parenteral Antibiotics 2. Application of parenteral uterotonics (Oxytocin) 3. Application of parenteral anticonvulsants 4. Perform assisted vaginal delivery 5. Perform manual removal of placenta 6. Perform removal of retained products of conception (MVA) 7. Perform neonatal resuscitation 8. Perform blood transfusion 9. Conduct caesarean section		

Observation checklist for Newborn Care

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SN	Readiness item	Observed Available– OA, Observed not available – ONA,	Self-report: Available, - A, Not available- NA
1	Neonatal resuscitation		
2	Newborn Care Practices:		
	Delivery to the abdomen (skin-to-skin);		
	Drying and wrapping newborns to keep warm		
	Kangaroo mother care		
	Initiation of breastfeeding within the first hour		
	Routine complete (head-to-toe) exam of newborns before discharge		
	Suctioning the newborn with suction bulb		
	Weighing the newborn immediately upon delivery		
	Giving full bath shortly after birth		
3	Essential Medicines for Newborn Care:		
	Antibiotic eye ointment for newborn		
	Injectable gentamicin		
	Injectable Ceftriaxone		
	Amoxicillin syrup/suspension		
	Ampicillin injection		
	7.1% chlorhexidine solution		

Observation checklist for KMC

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SL No	Items	Observed Available– OA, Observed not available – ONA,	Self-report: Available, - A, Not available- NA
1	Separate room or space for Kangaroo Mother Care		
2	Staff trained; At least one provider of KMC ever receiving in-service KMC training on duty		
3	Guidelines on KMC: National or other relevant guidelines available at the facility		
4	Equipment and instrument-		
i	Curtain for privacy		
ii	Head adjustable bed/ KMC pillow		
iii	Functional nearby bathroom		
iv	KMC binder		
v	Cap		
vi	Socks		
vii	Diaper		
viii	KMC flipchart		
ix	KMC booklet		
x	KMC register		

Observation checklist for SCANU

Name of facility:
Type of facility:
District:
Upazilla Upazilla :

SL No	Items	Observed Available– OA, Observed not available – ONA,	Self-report: Available, - A, Not available- NA
1	Staff trained; At least one provider of SCANU ever receiving in-service SCANU training on duty		
2	Facility has the SCANU Standard Operating Procedure (SOP) document/ETAT training manual		
3	Number of available functional SCANU beds in the facility		
4	Are following services available/offered from SCANU:		
i	Phototherapy for mature and pre-mature babies suffering from Hyperbilirubinemia		
ii	Radiant warmer for the pre-mature, sick mature new-born		
iii	Oxygen support for new-born with infection and respiratory problem:		
	functioning bCPAP equipment		
	Availability of oxygen (filled oxygen cylinder/piped in)		
iv	Intravenous antibiotics to infection management		
v	Functioning bag and mask:		
	Size 0		
	Size 1		
5	Functional Equipment and instruments		
i	Radiant warmer		
ii	Phototherapy machine		
iii	Neonate Stethoscope		
iv	Mobile examination light		
v	Penguin sucker		
vi	Baby Weighing Scale		
vii	Suction pump		
viii	Pulse oximeter		
ix	Functional Hand washing facilities		
XI	SCANU register		

MIDTERM REVIEW - MAMONI MATERNAL AND NEWBORN CARE STRENGTHENING PROJECT (MAMONI- MNCSP)

Observation Checklist for ANC at UH&FWC

Name of facility:
Type of facility:
District:
Upazilla:
Union:

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available-A, Not Available- NA
1	Staff trained; At least one provider of ANC ever receiving in-service ANC training on duty		
2	ANC/PNC corner		
3	Guidelines on ANC: National or other ANC guidelines or available at the facility		
4	Equipment: Blood pressure apparatus, Stethoscope, weight machine		
5	ANC card, ANC, PNC Register		
6	Diagnostic capacity: Hemoglobin tests;		
7	Urine protein testing capacity		
8	Medicines: Iron or folic acid tablets		

Observation Checklist for Labor Delivery at UH&FWC

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available-A, Not Available-NA
1	Staff with up-to-date training: at least one skilled provider present 24 hours a day, seven days a week (by shifts). Probe; Duty schedule.		
2	Availability of service guidelines, SOP, delivery register, referral slip		
3	Equipment/Tracer Items: Delivery pack, Suction apparatus, Neonatal bag and mask, Partograph & Gloves, PPH kit, Eclampsia kit.		
4	Medicines and commodities: Injectable oxytocin; Injectable antibiotic; Magnesium sulfate; Skin disinfectant; Intravenous solution with infusion set.		
5	Respectful care for mother, maintain privacy, allow companion according to the choice of mother		
6	Pre referral treatment information		
7	Basic sanitation available for women during and after labor and childbirth		

Observation Checklist for Newborn Care at UH&FWC

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available-A, Not Available-NA
1	Neonatal resuscitation		
2	Newborn Care Practices: • Keep the baby with mother with skin-to-skin contact to maintain body temperature; • Drying and wrapping newborns to keep warm; • Kangaroo mother care; • Initiation of breastfeeding within the first hour; • Routine complete (head-to-toe) exam of newborns before discharge; • Suctioning the newborn with suction bulb; • Weighing the newborn immediately upon delivery; • Delayed bathing at least for 72 hours • Application of 7.1% chlorhexidine solution to umbilical stump		
3	Essential Medicines for Newborn Care: • Antibiotic eye ointment for newborn; • Injectable gentamicin; Injectable Ceftriaxone; • Amoxicillin syrup/suspension; • Ampicillin injection; • 7.1% chlorhexidine solution		
4.	Equipment: Newborn Weighing scale, Resuscitation kit, suction kit		
5	Job aid for counselling, register		

Observation Checklist for FP at UH&FWC

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available- A, Not Available- NA
1	Staff trained; At least one provider of FP services ever receiving in-service FP training		
2	Guidelines on FP: National or other FP guidelines, protocol, SOP, Job aid available at the facility		
3	Equipment: Blood pressure apparatus, Stethoscope, weight machine, gloves, equipment for instrument sterilization		
4	FP methods: Pill, IUCD, Implant, Condom, Injectable (DEPO)		
6	FP register, consent form		
7	Tubal ligation, vasectomy		

Observation Checklist for KMC at UH&FWC

SN	Readiness item	Observed Available– OA, Observed Not Available – ONA,	Self-report: Available- A, Not Available- NA
1	Staff trained; At least one provider of KMC ever receiving in-service KMC training		
2	KMC Corner, Arm chair for sitting of mother, screen for privacy		
3	KMC binder, cap, socks, Diaper, KMC pillow		
4	KMC register, booklet, KMC counselling board, poster, Flipchart		
5	KMC monitoring chart		

Of the 21 indicators reported annually, 16 met more than 90% of the annual targets. The project

could not meet the targets for five indicators, primarily due to delays in the funding flow and the COVID-19 pandemic. The indicators not meeting set targets included MNH training, QI training, QIC meetings, national comprehensive newborn care package (CNCP) service delivery and community microplanning.

ANNEX 4: Facts and Findings

Annex Table 1: Progress and performance of indicators

Sl.	Indicator	2018 Baseline Value	2020 Target	2020 Midline Value	Remarks
1	Neonatal mortality rate (*per 1000 live birth*)	19/1000	NA	NA	Not to be measured in midline
2	Neonatal facility mortality rate in public sector facility (*per 1000 live birth in facility*)	11/ 1000	10/1000	11/1000	
3	Maternal facility mortality rate in public sector facility (*per 1000 women admitted for delivery or obstetric management in the facility*)	30/1000	14.5/1000	1/1000	
4	Percentage of deliveries in public sector health facilities	15%	16.4	15.90%	
5	Percentage of the women receiving quality ANC 4+ visits for the last pregnancy	13%	16.6%	12%	
6	Ratio of coverage for facility delivery between richest and the poorest wealth quintiles	2.5	2.2	2.9	
7	Percentage of women delivering at home reporting receiving essential newborn care	9%	12.4%	11.50%	
8	Percentage of facilities meeting service provision readiness for MNC according to the applicable criteria	0%	3.7%	29.0%	
9	Number (Percent) of USG-assisted service delivery sites providing family planning (FP) counselling and/or services	82%	85%	93.5%	
10	Percentage of health offices conducting data-based	30%	50%	49.0%	

Sl.	Indicator	2018 Baseline Value	2020 Target	2020 Midline Value	Remarks
	performance reviews at least once a quarter				
11	Amount of USD equivalent funds mobilized from local government institutions for MNC service strengthening	0	USD 125,000	USD 567,709	
12	Percentage of UHFWCs providing 24/7 normal delivery services[4]	29%	NA	28%	Definition revised; baseline value revised
13	Percentage of health facilities having essential medicines for delivery services	3%	11.3%	33.90%	
14	Number of persons trained in MNC by type and level with MNCSP support	NA	5,302	952	
15	Number of health facilities (institutional settings) gaining access to basic drinking water services as a result of USG assistance	539	580	764	
15.a	Percentage of health facilities (institutional settings) gaining access to basic drinking water services as a result of USG assistance	67%	72%	95%	
16	Percentage of facilities with basic sanitation available for women during and after labor and childbirth (toilet, latrine)	93%	94%	95%	
17	Percentage of health facilities with functional community accountability mechanisms	35%	42.8%	71%	
18	Percentage of health facilities that had participated in MNH QOC Learning Network that have improved on at least	0%	17%	NA	Not measured in midline QoC survey as the indicator was revised

Sl.	Indicator	2018 Baseline Value	2020 Target	2020 Midline Value	Remarks
	50% of Core MNC QOC Indicators applicable to the level of facility				
19	Percentage of women who delivered in public sector health facility that has participated in MNH QoC learning network reporting positive experience of care for Maniganj district	47%	50.6%	81%	
20	Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs	67,206	78,478	104,691	
21	Percentage of women with severe pre-eclampsia/ eclampsia received appropriate management in health facilities that had participated in QOC Learning Network for Maniganj district	65%	70.3%	80%	
22	Number of newborns not breathing spontaneously at birth who were successfully resuscitated through USG-supported programs in the country	27,190	21,801	34,764	
23	Percentage of scheduled meetings held by QI committees at national, division, district and Upazilla Upazilla upazilla level	0%	25%	18%	
24	Percentage of health facility participating in MNH QOC learning network	0%	10%	11%	
25	Number of people trained in QI	0	1520	644	

Sl.	Indicator	2018 Baseline Value	2020 Target	2020 Midline Value	Remarks
26	Percentage of health facilities participating in MNH QOC learning network monitoring Core MNC QOC indicators	0%	100%	96%	
27	Percentage of women initiating modern method of FP in the post-partum period (PPFP)	40%	47%	40%	
28	Number of deliveries in public sector health facilities	83,399	90,269	98,368	
29	Couple-Years of protection (CYP) in USG-supported programs	1,561,967	1,519,074	1,385,701	
30	Percentage of women who delivered at home who consumed misoprostol tablets for PPH prevention	15%	18.6%	14.40%	
31	Number of pregnant women reached with nutrition-specific interventions through USG-supported programs	79,598	185,391	204,034	
32	Percentage of infants who were put to the breast within the first hour after birth	72%	77.6%	57.6%	
33	Percentage of UHFWC Management Committee meetings held at least bi-monthly	0%	38%	38%	
34	Percentage of household reporting intention to use public sector for MNH services	NA	NA	81%	The indicator was revised at midline. so value of midterm survey will serve as baseline value
34a	Percentage of households reporting a public sector health	73%	Unavailable	Unavailable	

Sl.	Indicator	2018 Baseline Value	2020 Target	2020 Midline Value	Remarks
	facility providing delivery care as their nearest facility for delivery care				
35	Percentage of Community Clinics held a microplanning/ CHW coordination meeting in the last three months	0%	17%	8%	
36	Number of individuals residing in hard-to-reach and underserved areas reached through alternate service provision mechanisms for MNH	0	1,244	1,244	
37	National scale up plan for MNH QI strategy rolled out	0	1	1	
38a	Number of MNC providers position fulfilled as per sanctioned positions by level of facility	3,039	3,226	4,004	
38b	Percentage of MNC providers position fulfilled as per sanctioned positions by level of facility	68%	73%	76%	
39	Number of facilities initiated accreditation process	0	5	NA	The decision on accreditation was delayed
40	Number of union level health facilities in the country using e-MIS	334	1134	1220	
41	Percentage of health facilities in the country implementing comprehensive newborn care package by level of facility	11%	11%	8%	
42	Percentage of UHFWC providing 24/7 normal delivery services in the country	13%	15.8%	NA	BHFS has not been done yet