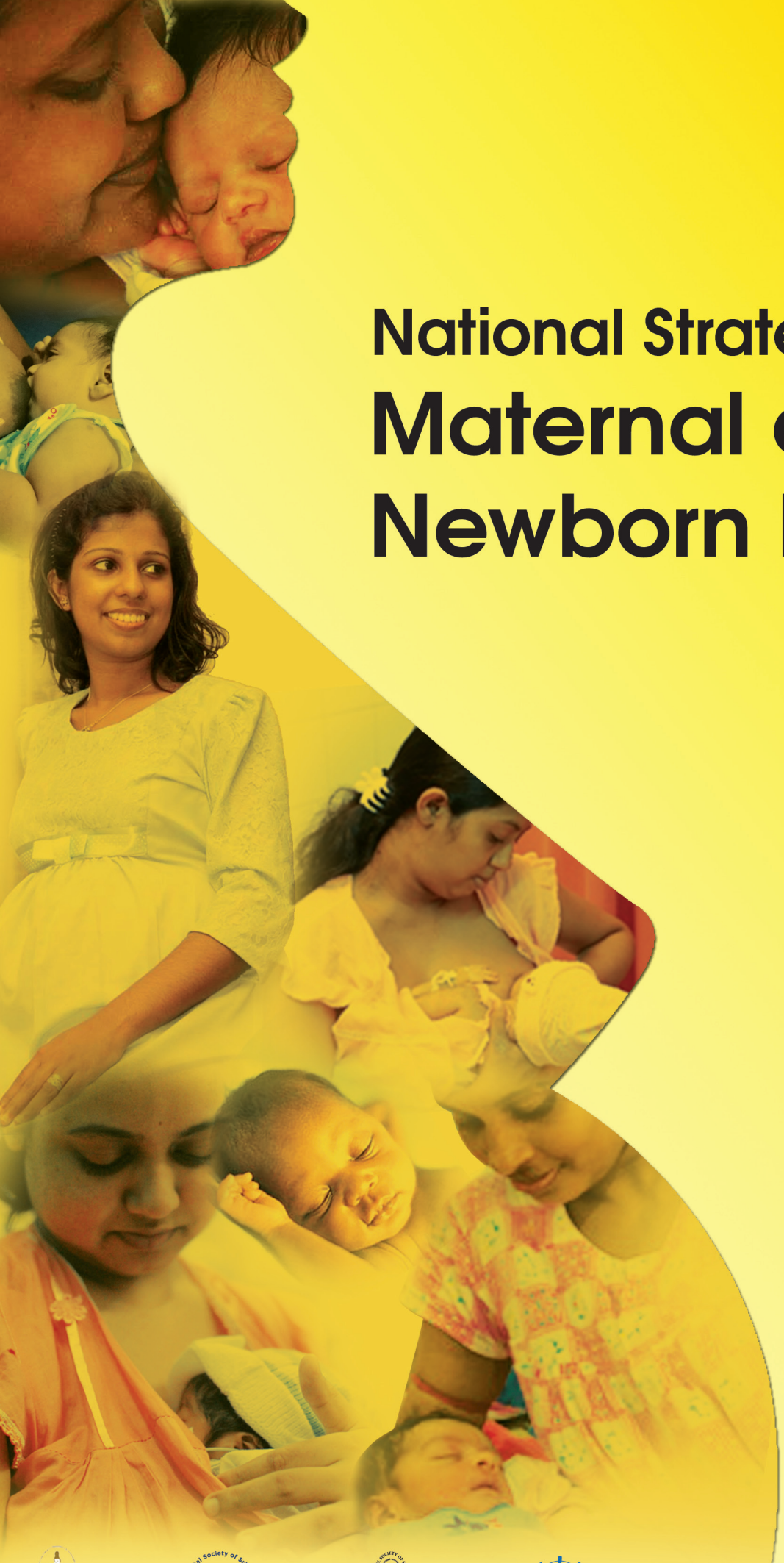

National Strategic Plan
Maternal and Newborn Health
(2017 -2025)

Perinatal Society of Sri Lanka
Towards healthier mothers and newborns

World Health Organization

unicef

UNFPA

National Strategic Plan

Maternal and Newborn Health

(2017 -2025)

Family Health Bureau

Ministry of Health

Sri Lanka

Forward

Sri Lanka can be proud of the progress achieved in the Maternal and Newborn Care Programme over the past decades. Maternal and Neonatal mortality in our country has declined to rates comparable to some developed countries in the world. Sustainable Development Goals for 2030 and the targets to address the unfinished agenda of Millennium Development Goals provide future directions to the maternal and newborn health programme.

Each year about 2000 babies die during the newborn period, another 2000 is lost as still births and about 110 mothers die at or around child birth in our country. Some mothers and/or babies suffer long term disability due to complications at birth or in the postnatal period. Detailed analysis shows that some of these disease conditions and deaths are preventable with existing evidence informed interventions.

In the global health agenda strategies and directions to improve maternal and newborn care are spelt out in two important documents; Strategies towards Ending Preventable Maternal Mortality (WHO, 2015) and the Every Newborn; An Action Plan to End Preventable Deaths (WHO, 2014). Sri Lanka too is a signatory to contribute to global achievements in the Sustainable Development Goals.

The Maternal and Newborn Health Strategic Plan (2017-2025) of Sri Lanka is developed with a vision of ensuring “A country in which there are no preventable deaths of mothers, foetuses and newborns, where every pregnancy is planned and wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential”.

The MNH SP (2017-2025) should guide development of action plans for Maternal and Newborn Care at Central, Provincial and District levels and at Hospitals providing maternity and newborn care services. Health care providers at all levels should take every initiative to implement the activities identified in this strategic plan under six broad strategic areas as per the given time lines so that the country would be able to achieve the targets set under SDGs by 2030.

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September, 2017

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Acknowledgement

Maternal and Newborn Health Strategic Plan (2017-2025) is the second MNH SP for Sri Lanka previous being the MNH SP (2012-2016). Many have contributed to its development over the past year.

We are extremely grateful to the guidance and unstinting support given by Dr J.M.W. Jayasundara Bandara, Director General Health Services and the former Director General Health Services Dr P.G. Mahipala, throughout the process. The leadership and support of Dr Lukshman Gamlath DDG PHS II is greatly appreciated. Dr R.R.M.L.R. Siyambalagoda former Additional Secretary Medical Services/Deputy Director General Public Health Services II who guided the Technical Advisory Committee for the development of the MNH SP (2017-2025) as its chairman is acknowledged with gratitude. The contribution of the Deputy Director Generals Medical Services I and II, Dr Luxmi Somatunga and Dr Amal Harsha de Silva is appreciated.

Most sincerely we thank all the members of the Technical Advisory Committee for the Development of MNH SP 2017-2025 for their valuable inputs in shaping this plan. We would like to express our deep appreciation to Dr LakKumar Fernando, President of the Sri Lanka College of Paediatricians, Dr Ramya de Silva, former President of the Sri Lanka College of Paediatricians, Prof Deepal Weerasekera, President of the Sri Lanka College of Obstetricians and Gynaecologists and Dr Gamini Perera, former President of the Sri Lanka College of Obstetricians and Gynecologists for their individual contribution and also for the valuable contribution of the members of their respective organizations.

We would like to express our deep gratitude to Dr Mathews Mathai and Dr Katherine Bathike the WHO consultants who supported to refine the MNH SP 2017-2025 of Sri Lanka and for aligning it with the global strategies. Dr Vineetha Karunaratne, former Director MCH and the local consultant for the development of MNH SP 2017-2025 made an invaluable contribution by conducting the desk review and supporting to develop the MNH SP. Every participated member from different parts of the country, from the field and hospitals in the extensive stakeholder workshops for the development of MNH SP 2017-2025 has contributed to this plan and is immensely appreciated.

The technical and financial contribution of the WHO, and the collaboration of UNICEF and UNFPA at different stages of development of MNH SP is acknowledged with gratitude.

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List of Abbreviations

ACS	- Antenatal Corticosteroids
AMDD project	- Averting Maternal Deaths and Disability project
ANC	- Ante Natal Care
BCC programmes	- Behaviour Change Communication programmes
BHT	- Bed Head Ticket
BMI	- Body Mass Index
CCP	- Consultant Community Physician
CEMOC	- Comprehensive Emergency Obstetric Care
DDG PHS	- Deputy Director General of Public Health Services
DESC	- Drug Evaluation Sub Committee
DHS	- Demographic and Health Survey
DMPA	- Depot Medroxyprogesterone Acetate
DO	- Development Officer
eIMMR	- electronic Indoor Mortality and Morbidity Register
EmNOC	- Emergency New born and Obstetric care
EMOC	- Emergency Obstetric Care
ENAP	- Every New born Action Plan
EPMM	- Ending Preventable Maternal Mortality
FHB	- Family Health Bureau
GDM	- Gestational Diabetes Mellitus
GP	- General Practitioner
HDC	- Health Development Committee
HIV	- Human Immunodeficiency Virus
HRH	- Human Resources for Health
ICD 10	- International Classification of Diseases 10th revision
ICD-MM	- ICD Maternal Mortality
IMMR	- Indoor Morbidity Mortality Register
INBU	- Intra natal & New-Born care Unit
INC	- Intra Natal Care
IUCD	- Intra Uterine Contraceptive Device
IV	- Intra Venous
KMC	- Kangaroo Mother Care
LB	- Live Births
LSCS	- Lower Segment Caesarean Section
M & E unit	- Monitoring & Evaluation unit
M/BFH	- Mother Baby Friendly Hospital Initiative
MCH	- Maternal and Child Health
MCH/FP	- Maternal and Child Health /Family Planning
MD	- Maternal Death
MDG	- Millennium Development Goals
MH	- Maternal Health
MMR	- Maternal Mortality Rate
MNH SP	- Maternal and New born Health Strategic Plan

MO	- Medical Officer
MOH	- Medical Officer of Health
MOMCH	- Medical Officer of Maternal & Child Health
NBH	- New born Health
NHDC	- National Health Development Committee
NICU	- Neonatal Intensive Care Unit
NIHS	- National Institute of Health Services
NMMS	- National Maternal Mortality Surveillance
NMMSS	- National Maternal Mortality Surveillance System
NMR	- Neonatal Mortality Rate
NO	- Nursing Officer
NPM	- National Programme Manager
NPMSS	- National Pregnancy Mortality Surveillance System
NSACP	- National STD/AIDS Control Programme
NSP/MNH	- National Strategy Plan/Maternal and New born Health
NTSs	- Nurses Training Schools
PHDT	- Plantation Human Development Trust
PHM	- Public Health Midwife
PHNS	- Public Health Nursing Sister
PMCU	- Primary Medical Care Unit
PNC	- Post Natal Care
PPTCT	- Prevention of Parent to Child Transmission
PROM	- Premature Rupture Of Membranes
RDHS	- Regional Director Health Services
RHMIS	- Reproductive Health Management Information System
RSPHNO	- Regional Supervising Public Health Nursing Officer
RTCs	- Regional Training Centres
SBR	- Still Birth Rate
SDG	- Sustainable Development Goals
SRH	- Sexual & Reproductive Health
STIs	- Sexually Transmitted Infections
TAC	- Technical Advisory Committee
TACMWH/FP	-Technical Advisory Committee on Maternal Health, Women's Health and Family Planning
TACNCH	-Technical Advisory Committee on New born and Child Health
UHC	- Universal Health Coverage
UNFPA	- United Nations Fund for Population Activities
UNICEF	- United Nations Children's Fund
VDRL	- Venereal Disease Research Laboratory
VOG	- Visiting Obstetrician & Gynaecologist
WHO	- World Health Organization
WIT	- Work Improvement Team

Executive Summary

Maternal and Newborn Health Strategic Plan (MNH SP) 2017 – 2025 is developed in order to address the unfinished agenda of the Millennium Development Goals (MDGs) and to address inequities within and between districts and population groups and to help the country to begin implementing the 2030 agenda for Sustainable Development Goals (SDGs) without delay. The MNH SP, spanning 9 years of the SDGs, provides guidance to accelerate momentum for maternal and newborn health in the country. It is expected to achieve a transformation in health and sustainable development by 2030 for all women and newborns and their families.

With closure of MDG time period by end of 2015 the United Nations (UN) set a broader agenda encompassing social, economic and environmental dimensions with 17 Sustainable Development Goals for countries to move forward in the next one and a half decades. National governments will be responsible for implementation of the global goal (SDGs) from 2015 through to 2030, with support from the UN and other international organizations. Sri Lanka has set very ambitious targets under SDGs to reduce Maternal Mortality Ratio to less than 10 per100,000 LB and Newborn Mortality to less than 2.2 per 1000 LB by 2030.

The Working Committee to develop the MNH SP 2017-2025 for Sri Lanka decided on the broader goals of the MNH SP and key strategies and major activities to be focused. It was the decision of the working committee to set the goals in line with the SDG goals (2030) and to develop the MNH SP from 2017- 2025. Also it was decided to develop the action plan initially from 2017 – 2020.

The Vision of the MNH SP (2017-2025) is “A country in which there are no preventable deaths of mothers, foetuses and newborns where every pregnancy is planned and wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential”.

It is envisaged to work towards this vision by fulfilling six strategic objectives; Strengthening and investing in improving quality of maternal and newborn care, particularly during labour, birth and the first day and week of life, Addressing all causes of maternal, perinatal and neonatal mortality and morbidity, Strengthening health systems to respond to the needs and priorities of women, newborns and

their families, ensuring universal health coverage for comprehensive (essential and emergency) maternal and newborn health care, Addressing inequities in access to quality care, Counting every mother, fetus and newborn through measurement, programme tracking and accountability and Harnessing the power of individuals, families and communities in support of MNH.

The guiding principles to achieve the above strategic objectives would be; Universal coverage, Equity, Integration and collaboration with other sectors, Accountability /Responsibility, Innovation, Human Rights and Community Involvement/participation.

Under each strategic objective major strategies and activities are identified in the MNH SP. In the activity plan (Annex II under each major activity sub activities are identified. The activity plan is developed up to 2020 identifying individuals and organizations responsible for the activities. Key performance indicators to monitor the activities are spelt out (Annex I).

01
Introduction

The National Maternal and Newborn Health Strategic Plan (MNH SP) 2017 – 2025, spanning over nine years, is the second strategic plan in the history of maternal and newborn care in Sri Lanka. The first ever strategic plan for maternal and newborn health in Sri Lanka (2012-2016) had a vision to ensure optimum survival and quality of life for both mother and newborn through provision of evidence based, best available care and services during pre-pregnancy, pregnancy, delivery and post-partum periods. It was built on the principles of continuum of care for the mother and newborn including the life stages from adolescent, pre pregnancy, pregnancy, through birth, the newborn period, infancy and childhood.

The previous strategic plan for maternal and newborn health in Sri Lanka enabled remarkable achievements in maternal and newborn health between 2012 – 2016 and guided the country in the path towards achieving the millennium development goals. Health is a devolved subject in Sri Lanka and the strategic plan provided the strategic direction from the centre to the provincial ministries. It galvanized the concepts of delivery of evidence based interventions in packages across the life cycle. The six building blocks of the health system - health service delivery, health workforce, health information, medical products, vaccines and technology, health financing and leadership and governance - were strengthened to improve the maternal and newborn health programme. Most of the strategies in service delivery in maternal and newborn health were accomplished through effective programme implementation under the guidance of the Technical Advisory Committees on Maternal and Newborn Health and through policy directives of the National Committee on Family Health.

When we developed the Maternal and Newborn Health Strategic Plan (2017 – 2025), we paid attention to provide essential, good quality maternal and newborn health services to every woman and every newborn . Though all women reach the health services for antenatal care and child birth, gaps in the provision of quality care exist in the field and institutional setting. In addition to gaps in quality of care, there are gaps in reaching and provision of services in postnatal care. As a result, further reduction of maternal and neonatal mortality and reduction of still births have slowed down. Many more women and newborns suffer illness and disability and fail to reach their full potential, resulting in enormous loss and costs for the country both today and for future generations.

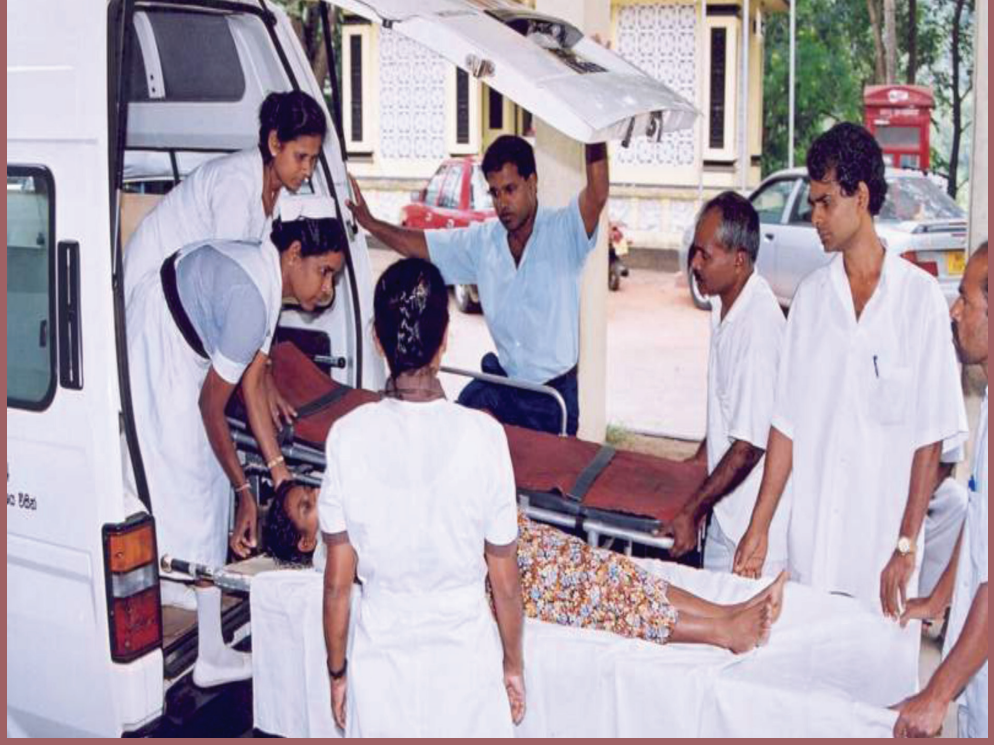
Maternal and Newborn Health Strategic Plan (2017 – 2025) is developed in order to complete the unfinished work of the millennium development goals: to address inequities within and between districts and population groups and to help the country to begin implementing the 2030 agenda for Sustainable Development without delay. This strategic plan, spanning 9 years of the sustainable development era, provide guidance to accelerate momentum for maternal and newborn health in the country. It is expected to achieve nothing less than a transformation in health and sustainable development by 2030 for all women and newborns and thereby families.

02

Situational Analysis

Maternal care

Maternal care programme introduced the safe motherhood concept to all pregnant women in the country. Comprehensive obstetric care facilities are available to all mothers in the country through the widely distributed specialist hospital network. With high coverage indicators and low maternal mortality, implementation of the maternal care programme is a success story so far. Changing trends of demographics, obstetric transition and changing perception of clients warrants timely improvements in maternal care programme .



Key Points

367,500 pregnancies were registered in (2014)

76.2% start receiving antenatal care before 8 weeks of gestation

92.5% of mothers get more than 4 antenatal clinic visits to government institutions.

Almost all deliveries take place in hospitals. Of them, 92% have delivered in specialist care hospitals.

For every 100 deliveries, 34.5 occur from Ceasarian section.

88.8% of mothers were screened for aneamia during the first trimester

99.3% of women were protected for Tetanus before they deliver

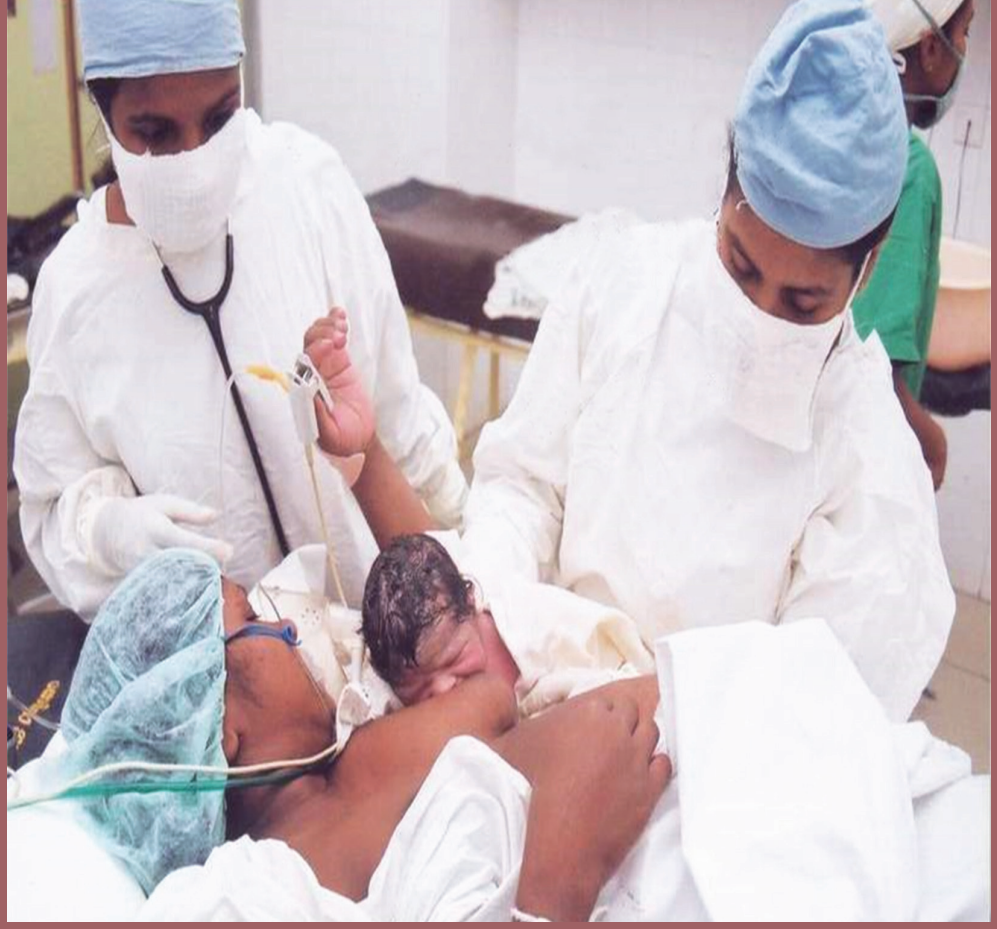
77.2% of pregnant women were screened for syphilis during the first trimester

There were no cases of mother to child transmission of HIV during 2016

Newborn Health

Sri Lanka managed to halve the number of neonatal deaths over the past few decades. Essential newborn care, care for the sick newborn, early initiation of breast feeding and combined postnatal care from the hospital and field managed to improve the neonatal survival and outcomes. High institutional delivery rates and skilled birth attendence at almost all births complimented the favourable outcome of neonates.

Yet we have to achieve many mile stones such as ending all preventable neonatal deaths, strengthening the care around the birth, improving the quality of newborn care to provide optimum care for all newborns in the country.



Key Points

331,000 newborns were added on to the population in 2016.

105 neonatal intensive care and special care baby units in the country are organized in four levels.

92% newborns receive their first breast feed in the first hour.

Almost all newborns are examined by a medical officer within the first day of life

All specialist hospitals are equipped with an infection control unit and pay attention on infection control in labour room and neonatal care units.

Essential new born care training, sick newborn care training, lactation management and breast feeding counseling is in place to develop human resources who are engaged in providing new born care.

Newborn screening for congenital hypothyroidism and critical congenital hheart diseases is currently implemented in all districts in the country.

Maternal morbidity and mortality surveillance

Counting every maternal death is a huge achievement towards preventing all preventable maternal deaths. For the past two decades an intensive process of identification, notification, investigation and review of all maternal deaths take place in all twenty six health districts in the country. Recommendations made in the national reviews assisted to reduce the three delays in maternal health services.

Perinatal death surveillance, birth defects surveillance, feto-infant death surveillance and surveillance of maternal near-misses were added later and currently are getting established within the system.

Key Points

Maternal mortality surveillance is in place since 1987 It covers all districts and all hospitals in the country, including private sector.

For 100,000 children born alive 33.7 mothers die in the country as of 2015.

Most of the deaths are due to indirect causes such as heart disease, liver diseases etc.

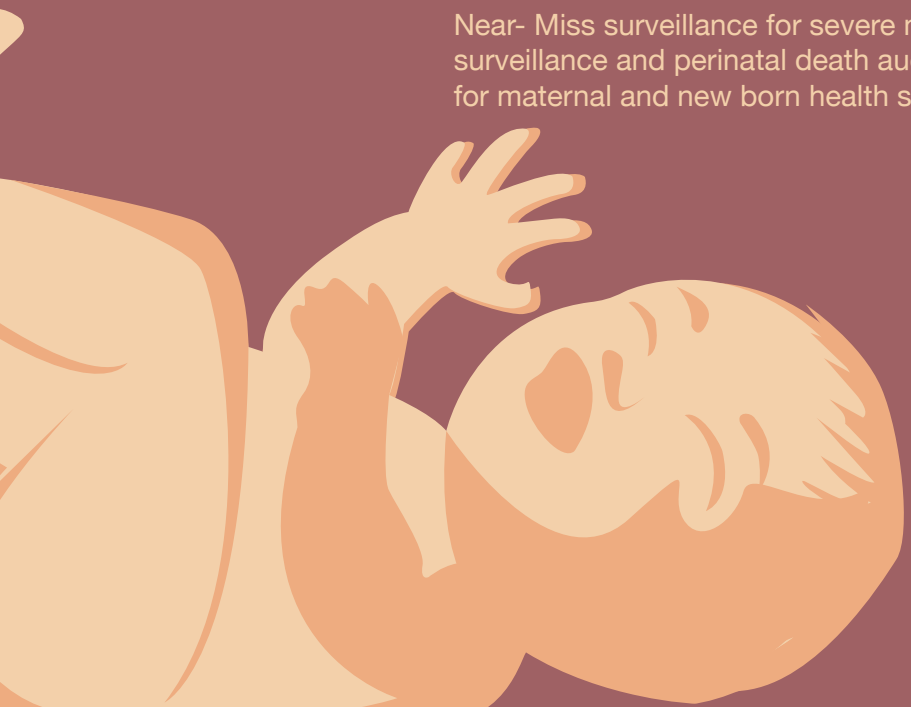
Of every 100 mothers who deliver, 27 report of some morbidity during their antenatal period.

Newborn mortality rate in 2015 was 6.6 per 1000 live births.

Common causes for newborn deaths are

- congenital anomalies (41%)
- prematurity (21%)
- birth asphyxia (21%)
- infections (11%)

Near- Miss surveillance for severe maternal morbidities, birth defect surveillance and perinatal death audits further expanded the surveillance for maternal and new born health service provision.



Care for reproductive age females

Reproductive health concept introduced new components to fill the gap in life cycle approach. Adolescent health, women's health and gender, pre-conception care and family planning programmes contribute immensely to the success of maternal and new born health programme. Life cycle approach is the key to success in achieving further improvements in neonatal and maternal outcomes.

Key Points

Coverage of the recently initiated programme for newly married couples is 26%.

For every 100 pregnant women registered, 5 are girls below 19 years of age.

Aneamia among women in the reproductive age group is 25.7%.

Of 100 women who get registered for antenatal care before 12 weeks,

20 are under weight (body mass index less than 18.5)

20 are over weight (BMI more than 25.0)

at the time registration of the pregnancy.

Modern contraceptive methods are used by 55.9% of eligible females in the country.

But 27% of maternal deaths could have being prevented by use of contraceptive methods.

03

Development of the MNH Strategic Plan

In mid 2016, Family Health Bureau initiated the development of the Maternal and newborn health strategic plan for 2017 and beyond. The National Programme Manager (Intranatal and Newborn Care) as the coordinator for the development of maternal and newborn health strategic plan 2017 and beyond, - presented the road map to develop the plan at the Technical Advisory Committee on Maternal and Women's Health and Family Planning (TACMWH/FP) and at the Technical Advisory Committee on Newborn and Child Health (TACNCH). Both committees approved the proposal and the chairperson of the Technical Advisory Committees gave concurrence to proceed with the presented road map.

A working group was appointed under the chairmanship of the Deputy Director General Public Health Services II. A National Consultant was appointed to conduct a desk review on the status of implementation of the maternal and newborn health strategic plan (2012-2016), to understand the problems and issues encountered in the implementation of the previous plan, to identify the areas which need special focus in the 2017 plan and to support the development of the strategic plan.

Dr Vineetha Karunaratne, Consultant Community Physician, former Director Maternal and Child Health was appointed as the National Consultant. The desk review was conducted in June 2016. Many documents related to the MNH programme were reviewed. The National Emergency Obstetric and Newborn Care Needs Assessment Survey of 2012, the WHO multi-country survey on Maternal and Newborn Health of 2014, the Bottle Neck Analysis on newborn care in Sri Lanka of 2015, the Annual Reports on Family Health and many other relevant documents were reviewed. Following the review the National Consultant provided recommendations to the working committee.

Services of two experts from World Health Organization on Maternal and Newborn Health strategy development, Dr Matthews Mathai and Dr Katherine Ba Thike were obtained to sharpen the framework for the development of maternal and newborn health strategic plan (2017-2025). The two international consultants conducted key informant interviews with a wide spectrum of stakeholders including the Director General Health Services, Deputy Director Generals, Health care workers in MNH from the hospitals and from the field, members from the Professional Organizations (Obstetrics, Paediatrics and Perinatalogy), relevant national programme managers from the Family Health Bureau and civil society groups to understand the current gaps in the maternal and newborn health programme and the important issues that should be addressed in the next strategic plan. The current global documents were perused for guidance to develop the framework for the new MNH SP. The Global Strategy for Women's, Children's and Adolescents' Health 2016 -2030, WHO Every Newborn: An Action

Plan to end Preventable Deaths of 2014, WHO Strategies to Ending Preventable Maternal Mortality 2015, were particularly perused to ensure inclusion of evidence based strategies and guidance to achieve sustainable development goals. This process led to the development of a framework to develop the next maternal and newborn health strategic plan for the country, which was finally presented to the Director General Health Services, Dr Palitha Maheepala to obtain concurrence.

Following discussions, the Working Committee, decided on the broader goals of the strategic plan and the key strategies and major activities to be focused. Working committee decided to set the goals in line with the sustainable development goals (2030) and to develop the maternal and newbon health strategic plan from 2017- 2025. Also it was decided to develop the initial action plan from 2017 – 2020.

A large scale stakeholder workshop was conducted on the 18th October 2016. A wide group of stakeholders from all levels and from different categories participated at this workshop. A broad overview of the current status of the maternal and newborn health programme, the status of implementation of the previous strategic plan for maternal and newborn health (2012-2016) and the draft vision, goals, major strategies and activities and the justification for their selection for the next plan were presented to the participants. Six groups were formed to discuss six major strategic areas and participants were allocated to the groups according their field of expertise. Each group was introduced to the key strategic objective and the broad activity areas identified to achieve the respective strategic objective. Relevant reference material including the new evidence under each of the strategic areas were provided to each group. Each group was facilitated by a Consultant Community Physician with expertise in the specific area under the strategic objective. The participants had the opportunity to discuss and include major and sub activity areas under each of the strategic objective. Later in the day the rapporteur from each group presented the activities to be discussed with the wider group. The group leaders provided the summary of discussion to the working committee later on.

The editorial team later formulated/revised/updated the programme objectives, major activity areas, sub activity areas, and developed the key performance indicators, activity plan and the monitoring and evaluation plan and was presented to the working committee for comments and approval. The final draft was later presented to the technical advisory committee on Maternal and Women's Health and Family Planning and to the Technical Advisory Committee on Newborn and Child Health and was approved.

04

National Strategic Plan on Maternal and Newborn Health (2017-2025)

National Strategic Plan on Maternal and Newborn Health (2017-2025)

Vision

A country in which there are no preventable deaths of mothers, foetuses and newborns where every pregnancy is planned and wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential.

Goals

1. *To reduce maternal mortality ratio from 32.5 for 100,000 live births (2013) to less than 10 per 100,000 live births by 2030.*
2. *To reduce neonatal mortality rate from 6.5 per 1000 live births (2013) to less than 2.2 per 1000 live births by 2030.*
3. *To reduce the still birth rate from 6.4 per 1000 births (2013) to less than 2 per 1000 births by 2030*

The National Maternal and Newborn Health Strategic Plan is from 2017 – 2025. However the targets are set for 2030 in parallel with the targets of the sustainable development goals to steer the country to achieve them by 2030.

Ending Preventable Maternal Mortality - a landmark publication by World Health Organization - recommended to reduce maternal mortality ratio by at least two thirds for the countries with a current maternal mortality ratio is less than 420 per 100000 live births. Based on that, the target goal for maternal mortality ratio for Sri Lanka was set.

Similar recommendations were given by the Every Newborn Action Plan in 2014 for reductions in neonatal mortality rate and still birth rate based on which the targets were set for Sri Lanka. In order to achieve the global targets in neonatal mortality and still births in 2030, Sri Lanka should achieve a Neonatal Mortality Rate 3.4/1000LB by 2025, and < 2.2/1000LB by 2030, and Still Birth Rate of 3.5/1000 births by 2025 and <2/1000 births by 2030.

Table 1: Targets for maternal mortality ratio, neonatal mortality rate and still birth rate for 2020, 2025 and 2030

	2020	2025	2030 (SDG)
Maternal mortality ratio (per 100,000 live births)	25	15	< 10
Neonatal mortality rate (per 1000 live births)	4.2	3.4	< 2.2
Still birth rate (per 1000 births)	4.5	3.5	< 2

Objectives:

1. To increase the proportion of newly married couples receiving the pre-conception care package to 90% by 2025
2. To maintain the rubella immunization coverage at the time of pregnancy at 99% through 2025
3. To increase the proportion of pregnant women who have received pre-conceptional folic acid supplementation to 90% by 2025
4. To reduce unmet need of family planning from current level of 6.6%* to 5% by 2025
5. To increase proportion of pregnant women registering for antenatal care before 8 weeks of gestation from 78.5%* to more than 90% by 2025
6. To increase the proportion of couples attending all three antenatal classes from 33.9%* to 80% by 2025
7. To maintain the antenatal syphilis screening before 12 weeks at 99% through 2025
8. To increase the proportion of pregnant women screened for HIV during pregnancy to 100% by 2025
9. To maintain the proportion of pregnant women with HIV who received ante retroviral therapy during pregnancy at 100% by 2025
10. To increase the proportion of pregnant women screened for anaemia before 12 weeks of gestation from 88.8%* to 98% by 2025
11. To increase the proportion of pregnant women screened for hyperglycaemia during pregnancy before 12 weeks of gestation from 76.2%*to 95% by 2025
12. To increase the proportion of pregnant women screened for hyperglycaemia during pregnancy at or around 28 weeks of gestation from 83.9%* to 98% by 2025
13. To increase the proportion of health institutions using $MgSO_4$ for prevention and management of eclampsia to 100 % by 2025
14. To increase the proportion of pregnant women with the risk of delivering < 34 weeks of gestation receiving one dose of antenatal corticosteroids to 100% by 2025

15. To increase the proportion of pregnant women whose labour was monitored using the partograph from 41.7%** to 100% by 2020 and maintain

16. To increase the proportion of women who have a companion of choice during labour and delivery to 100% by 2025

17. To increase the proportion of institutions following induction of labour guidelines to 100% by 2020 and maintain through 2025

18. To increase the proportion of mothers receiving pain relief during labour to 100% by 2025

19. To reduce the primary caesarean section rate to 25% by 2025

20. To increase the proportion of newborns who initiated breastfeeding within one hour from 91%*** to 98% by 2025

21. To increase the proportion of asphyxiated newborns who received timely resuscitation to 100% by 2025

22. To maintain the proportion of newborns examined by a Medical Officer within 24hrs at 100% through 2025

23. To increase the proportion of newborns weighing less than 2000g receiving Kangaroo Mother Care to 100% 2025

24. To increase the proportion of newborns screened for congenital hypothyroidism to 95% by 2025

25. To increase the proportion of newborns screened for critical congenital heart disease to 95% by 2025

26. To increase the proportion of newborns screened for congenital deafness to 75% by 2025

27. To increase the proportion of postnatal domiciliary visits (at least one visit within first 10 days postpartum) to 98% by 2025

28. To increase the proportion of postpartum mothers screened for Psychosis on the 5th day to 100% 2025

29. To increase the proportion of postpartum mothers screened for post partum depression at 4 weeks to 100% by 2025

30. To increase the proportion of postpartum women who are following a modern family planning method at 6 weeks to 90% by 2025

* FHB, 2015

** EmONC Survey, 2012

*** DHS 2016

Strategic Objectives and Guiding Principles

Strategic Objective 1:

Strengthen and invest in improving quality of maternal and newborn care, particularly during labour, birth and the first day and week of life

Strategic Objective 2

Address all causes of maternal, perinatal and neonatal mortality and morbidity

Strategic Objective 3:

Strengthen health systems to respond to the needs and priorities of women, newborns and their families

Strategic Objective 4:

Ensure universal health coverage for comprehensive (essential and emergency) maternal and newborn health care, addressing inequities in access to quality care.

Strategic objective 5

Count every mother, fetus and newborn through measurement, programme tracking and accountability.

Strategic Objective 6:

Harness the power of Individuals, families and communities in support of MNH.

Guiding Principles

Universal coverage

Country is primarily responsible for providing quality health care for mothers and newborns. Establishing good governance and leadership in health services is a pre requisite for improving health care in the country. The government is responsible to improve health systems in a way that would ensure quality health care delivery. Cost effectiveness of the interventions need to be considered especially as the country provides free health care at the point of delivery to all the citizens.

Equity

Universal coverage of high impact interventions, encompassing all population groups, ensuring equity is well covered in the maternal and newborn health strategic plan for (2017-2025) true to the meaning. The right of every woman and newborn to life, survival, health and development will be assured.

Integration and collaboration

Providing every woman and newborn with good quality care that is available, accessible and acceptable, requires an integrated service delivery. Sri Lanka has adopted the life cycle approach with continuum of care across the health systems which are the corner stone of integration.

Accountability /Responsibility

A sense of accountability needs to be incorporated, for equitable coverage of interventions, and to deliver them with quality while utilizing the resources optimally. Accountability lies with the government, the community and civil society. Health care providers in government and private sector need to be accountable for their care provision. This concept is deficient in the current system. The systems and procedures need to be established to ensure accountability among all categories of staff.

Innovation

Innovation is essential to optimize the application of evidence based interventions and strategies for the improvement of maternal and newborn care programmes. While applying the best practices, innovation within the country with knowledge of successful applications increase participation of all stakeholders and enable to reach the whole population.

Human rights

Concerns of human rights including the rights of the patients and patient safety are increasingly brought to light. There is a strong need to focus on all aspects which concern the patient's or client's respect, dignity and satisfaction with services delivered to them. Patients and clients have a right to demand such services. Hence the principles and standards derived from international human rights treaties guide all planning and programming for maternal and newborn health.

Community Involvement/participation

Community involvement and participation has been a corner stone in the maternal and newborn health care provision for a long time in the Sri Lankan health system. The need to systematize community involvement focusing on empowering the community to improve their health is identified.

Strategic Objective 1:

Strengthen and invest in improving quality of maternal and newborn care, particularly during labour, birth and the first day and week of life

Rationale

Most maternal, perinatal and newborn deaths occur around the time of birth. These deaths can be prevented through early identification and timely management of complications around the time of birth. This concept is called the triple investment in preventing maternal and neonatal deaths and still births. Quality pre-pregnancy and antenatal care help in identifying pre-existing illness that could lead to indirect deaths. Packages of evidence based interventions should be provided through the continuum of care from home to facility and back to home. However over-medicalization and misuse or overuse of interventions should be avoided while also ensuring that the woman and her family are satisfied with the provision of care at all levels.

In Sri Lanka almost all births take place in hospitals of which about 92% occur in hospitals that are served by specialists. Adequate numbers of trained staff should be available at these hospitals around the clock. Maldistribution of staff should be avoided while taking action to retain those who are trained in maternal and newborn health care to serve the purpose.

Quality is central to all programmes and interventions. Organizing sustainable quality assurance systems is of utmost importance when it comes to maternal and newborn care. Even a small lapse of quality during and around the time of delivery can affect the outcomes badly. Sri Lanka has made many advances towards quality improvement. Every mother and newborn receives an essential package of care while Emergency Newborn and Obstetric care (EmNOC) also been made accessible to women. The interventions have to be evidence based and as per national guidelines and not based on individual experiences or practices. Inappropriate utilization of interventions such as caesarean section has created concern today by reversing their advantages.

As stated in the previous strategic plan (2012-2016), a good human resource development plan is required for adequate and trained staff availability and their proper distribution for maternal and newborn health services at hospitals and field level There should be a policy on human resources in health, Management Directorate for human resources, information system, regular recruitment procedures, training programmes and deployment plan based on the need. Staff training should be updated in terms of both technical and nontechnical aspects such as kind courteous services, good communication with good counselling ability, and the ability to understand cultural values, needs, difficulties of underserved populations during service provision. It has to be well engraved in the minds of health staff, that healthcare is a major right of every family unit irrespective of race, religion, cast, social or economic status. Therefore not only the women and their newborns , their immediate family members such as husband, parents, in-laws need kind attention, reliable information from service providers without harming their respect and dignity. It is important to give confidence and support to the woman to go through the process of labour and delivery safely. These humanistic approaches need to be incorporated to all the staff training programmes.

To achieve the ambitious 2030 targets set by the country essential and emergency services need to be scaled up and monitored at district and national levels.

Strategies

1. Ensure implementation of evidence-based interventions during pregnancy, childbirth and post natal period
2. Ensure adequate, competent human resource with appropriate skill mix to provide high quality maternal and newborn health services
3. Ensure quality care during pregnancy, labour and post natal period
4. Ensure women in child bearing age and their partners receive a comprehensive package of pre pregnancy care
5. Promote client friendly care during pregnancy, childbirth and postnatal period

Strategy 1

Ensure Implementation evidence-based interventions during pregnancy, labour and post natal period

Major activities:

A1.1 Provide evidence based essential maternal care package (antenatal, intra-natal, postnatal) to all pregnant women and emergency care package to manage obstetric emergencies

A1.2 Provide evidence based essential new born care package to all newborns and sick newborn care package to manage newborn complications

A1.3 Protect, promote and support breast feeding practices in all settings

A1.4 Monitor, evaluate and strengthen evidenced based practices related to delivery and immediate postnatal care

A1.5 Update and/or develop national guidelines for induction of labour and decision making for caesarean section and assisted vaginal deliveries

Strategy 2

Ensure adequate, competent human resource with appropriate skill mix to provide high quality maternal and newborn health services

Major activities:

A2.1 Establish an human resource policy for maternal and newborn health or ensure that human resources for MNH addressed in health sector HR policy (Refer C4.1)

A2.2 Establish training centres where needed and strengthen existing centers (National Institute of Health Science, Nurses Training Schools, Regional Training Centres) to support basic and in-service training

A2.3 Establish training facilities for essential regular skill development in hospitals

A2.4 ncrease the number of trainers and strengthen their capacity to conduct training related to maternal and newborn health

A2.5 Update/develop curricula/in-service training packages to incorporate new evidence based interventions/competencies / skills focusing on labour, delivery and care of newborn on first day and first week of life among all staff providing maternal and newborn care

A2.6 Conduct regular pre-placement training

A2.7 Regularly improve and update knowledge and skills of general practionerss & private hospital staff providing maternal and newborn care

Strategy 3

Ensure quality care during pregnancy, childbirth and post natal period

Major activities:

A3.1 Implement a uniform sustainable, quality assurance system on pre-pregnancy care, antenatal care, intranatal care, postnatal care and new born care at institutional and field level

A3.2 Introduce clinical audits as quality improvement procedure at institutional and field level

A3.3 Introduce a system for accreditation of hospitals as Mother Baby Friendly (M/BFHI)

A3.4 Sensitize the public to increase their demand for quality maternal and newborn health services.

A3.5 Introduce a reward system related to implementation of standards and guidelines at different levels

Strategy 4

Ensure women in child bearing age and their partners receive a comprehensive package of pre pregnancy care

Major activities:

A4.1. Strengthen the implementation of service package for newly married couples.

A4.2. Develop/ introduce service delivery package for inter pregnancy period

Strategy 5

Promote client centred respectful care during pregnancy, childbirth and postnatal period

Major activities:

A5.1 Provide respectful kind courteous care to all women, newborns and their families

A5.2 Develop a system to support informed decision making for the management to be carried out on the baby or mother during pregnancy, delivery and post-partum period

A5.3 Encourage the participation of a birth companion during labour and childbirth

A5.4 Strengthen positive birth care practices including pain relief during labour

A5.5 Reduce over-medicalization of pregnancy and childbirth

Strategic Objective 2:

Address all causes of maternal, perinatal and neonatal mortality and morbidity

Rationale

Maternal and newborn health are closely related. Any risk conditions in the pregnant woman affects the health and life of the foetus and the newborn. Maternal & newborn mortality are unacceptable outcomes of a pregnancy affecting the family and the country at large. For every maternal death another ……women are left with some life threatening disability. In order to prevent mortality and morbidity among women and newborns it is important to identify the causes of the event.

We have observed a change in the pattern of causes of maternal mortality and morbidity Causes of mortality of the country are generated annually from the well-organized maternal mortality audits while morbidity figures are generated from the routine MCH information system. With the reduction of the total number of maternal deaths the proportion of indirect deaths have increased relatively (65% in 2015…..) . Heart disease , liver disease, viral pneumonia are important causes of indirect maternal deaths.

Direct causes have reduced considerably but obstetric haemorrhage continues to be leading while anaemia and under nutrition are still prevalent, about 20% of mothers are overweight and incidence of diabetes in pregnancy also is increasing. Facts and figures have revealed that unwanted pregnancies and inadequate inter pregnancy spacing also contribute to maternal mortality and morbidity. A fair number of suicides (……..in 2015) are also reported as causes of maternal death.

In 2012 WHO revised the categorization of maternal deaths by application of ICD-10 to deaths which occur during pregnancy, childbirth, and the puperium. This resulted in a separate set of coding rules and grouping of causes of maternal deaths as ICD-MM including them under direct, indirect, unspecified and coincidental causes of deaths. Under this coding system suicidal deaths

(during pregnancy, childbirth and pueperium) are categorized as direct causes of maternal death. Therefore Sri Lanka needs to adopt this system and work towards prevention.

More efforts should to count maternal morbidity especially near misses and follow up the long term effects on RH and future pregnancies of the women.

The situation with regard to neonatal mortality shows that congenital anomalies account for 41 % of infant deaths. Prematurity, asphyxia and sepsis are other important causes of perinatal deaths. While survival rates for very small and extremely small babies have increased, further reductions in perinatal and neonatal mortality can be achieved only through greater investments in improving prenatal diagnosis, counselling and treatment, as well as strengthening neonatal intensive care. There is also need for long term follow up of and care for survivors of both maternal & neonatal morbidity.

Strategies

1. Ensure prevention, early Identification and management of direct and indirect causes of morbidities and mortalities to ensure optimal maternal, perinatal & neonatal outcomes.
2. Ensure early identification and management of causes of morbidities and mortalities in all newborns
3. Ensure health and nutrition of women using life cycle approach enabling them to go through pregnancy, labour & postnatal period safely
4. Enable all couples / individuals optimally time and space their pregnancies while preventing unintended conceptions

Strategy 1

Ensure prevention, early Identification and management of direct and indirect causes of morbidities and mortalities to ensure optimal maternal, perinatal & neonatal outcomes.

B1.1. Strenghten the health services available for prevention and early identification and proper management of conditions that may lead to adverse maternal and neonatal outcomes.

B1.2. Introduce a case based auditing system for severe maternal morbidities and mortalities and perinatal deaths at the field and hospital level

B1.3. Develop regionalized Highly specialized centers to manage women with severe obstetric complications eg: placenta accreta, eclampsia, heart disease complicating pregnancies etc.

B1.4. Develop / strengthen Multi disciplinary teams / clinics to manage obstetric complications and medical disorders complicating pregnancy with continuum of care

B1.5. Strengthen Referral, back referral systems and follow up of pregnant and post partum women eg: common pregnancy record - single record for a mother, communication system

B1.6. Create awareness among health workers, pregnant women, spouses, families and the community on the need to prevent complications and to seek timely health care for any abnormality detected during pregnancy or postpartum period.

B1.7. Update / Develop/ implement national guidelines, protocols and standards for management of medical diseases complicating pregnancies and obstetric emergencies

B1.8. Establish a mechanism to follow up women with pregnancy related medical or mental health problems with necessary counselling & interventions during inter-pregnancy period

B1.9 Strengthen the linkages among Family Health Bureau, Epidemiology Unit, HEB and stakeholders for early identification and prompt action on epidemics such as influenza, dengue other communicable diseases.

B1.10 Strengthen identification of HIV and STIs and care during pregnancy, labour and postnatal period to prevent mother to child transmission of HIV and STIs

Strategy 2

Ensure early identification and management of causes of morbidities and mortalities in all newborns

Major activities:

B2.1. Strengthen existing Newborn screening programmes such as congenital hypothyroidism, critical congenital heart diseases and introduce screening for congenital deafness

B2.2. Strengthen regionalization of new born care by establishment and implementation of levels of newborn care according to the Circular FHB / INBU/ 2014/03

B2.3. Scale up neonatal retrieval system by establishing retrieval teams in all provinces

B2.4. Establish a national neonatal care Bed availability system to facilitate care for critically ill newborns

B2.5. Establish Neonatal intensive care surveillance system to improve quality of advanced newborn care

B2.6. Introduce a case based auditing system for severe neonatal morbidities and mortalities at the field and hospital level

B2.7. Strengthen the care and management of the sick new born and follow up

B2.8. Create awareness among health workers, mothers, families and the community on the need toprevent and seek timely health care for any illness in the newborn

Strategy 3

Ensure health and nutrition of women using life cycle approach enabling them to go through pregnancy, labour & postnatal period safely

Major activities:

B3.1. Strengthen implementation of national programmes to improve the health and nutritional status of every girl child from birth to adulthood/ reproductive age.

B3.2. Implement appropriate BCC programmes on MNH and nutrition targeting all stages of the life cycle.

Strategy 4

Enable all couples / individuals optimally time and space their pregnancies while preventing unintended conceptions

Major activities:

B4.1. Strengthen pre pregnancy, interpregnancy and maternal care programmes to empower couples for appropriate use of contraception to plan pregnancies.

B4.2. Ensure the implementation of circular ..... on providing contraceptive services in the health sector with appropriate method mix

B4.3. Generate client demand for contraceptive services

B4.4. Establish/strengthen contraceptive services for high risk groups such as those with medical contraindications for pregnancy (heart disease, malignancies), sexually active single individuals including adolescents and widows.

B4.5. Strengthen services for sub fertile couples.

Strategic Objective 3:

Strengthen health systems to respond to the needs and priorities of women, newborns and their families

Rationale

This strategy is based on a well-functioning and responsive health system. However it will require strengthening of the six health system building blocks - service delivery, health workforce, health information, medical products, vaccines and technology, health financing, leadership and governance.

Sri Lanka is fortunate to have an established strong foundation of curative and preventive health services which has a reasonable coverage e across the country. In 1989 health became a devolved subject and health care delivery to the people took place with responsibility shared between the central ministry and the provincial health ministries. Family Health Bureau as the central organization for maternal and child health is under the central ministry and maintains good collaboration with the provincial health authorities to strengthen maternal and child health services to achieve set targets in maternal and newborn health.

National strategic plan on maternal and newborn health (2012-2016) identified a range of strategies to ensure the support of the health system in terms of its structure and functions. Following the strategic directions many important steps such as establishment of National Steering Committee(2008) to provide leadership, policy guidance and stakeholder (inter-sectoral and inter-ministerial) collaboration and advisory committees on maternal health and newborn health to provide technical guidance took place. A separate budget line for maternal and child health has been identified with cabinet approval to ensure financial stability for service provision.

Our country has pledged and was in line with millennium development goal from 2000 to 2015 and presently with sustainable development goals from 2015 to 2030. To realize this aim/objective the task ahead is challenging and needs much political leadership and commitment and support at national level. Progress should be monitored regularly at different levels and most importantly at national level. Therefore the gaps in different aspects of the health system should be addressed in a more sustainable manner.

Strategies

1. Ensure governance and leadership for maternal and newborn health
2. Ensure financial security for maternal and newborn health service delivery
3. Streamline the maternal and newborn health service delivery system
4. Ensure adequately staffed, teams of competent health care workers provide care during pregnancy, labour and postnatal period for every mother and baby
5. Ensure high quality medicines, equipment and appropriate technologies for maternal and newborn health services
6. Ensure the availability of up to date information for planning, monitoring and decision making in maternal and newborn health care

Strategy 1

Ensure governance and leadership for MNH

Major activities:

C1.1. Advocate to revive the National Health Council to monitor and address health related issues including target achievement in maternal and newborn health

C1.2. Strengthen National committee on Family Health, Technical Advisory Committees on Maternal Health and Family Planning (TACMHFP) and Newborn and Child Health (TACNCH)

C1.3. Advocate for maternal and newborn health / family planning related issues as agenda items at the Provincial Health Minister's meetings, National Health Development Committee (NHDC), Health Development Committee (HDC) and Hospital Directors Meeting

C1.4. Ensure the implementation and monitoring of national strategic plan on maternal and child health at central, provincial , district and divisional levels.

C1.5. Develop a national master plan for improving maternal and newborn health services while ensuring equity, universal health coverage, accountability & transparency

C1.6. Strengthen the national focal point (Family health Bureau) to plan, coordinate, monitor and provide technical guidance and direction to the national maternal and newborn health programme

C1.7. Strengthen collaboration to improve maternal and newborn health outcomes with professional colleges, private sector, development partners and community as appropriate.

Strategy 2

Ensure financial security for maternal and newborn health service delivery

Major activities:

C2.1. Strengthen the separate budget line for maternal and child health and closely monitor for regular cash flow to implement planned maternal and newborn health activities at all levels.

C2.2. Cost all the interventions and the annual maternal and newborn health plans well ahead of the financial deadlines.

C2.3. Strengthen collaboration with development partners and other stakeholders to generate additional resources (financial & other) to strengthen maternal and newborn health services and address inequity.

C2.4 Establish a mechanism to involve financial authorities in the planning, monitoring & evaluation processes of the programme at central, provincial &district levels

Strategy 3

Streamline the maternal and newborn health service delivery system

Major activities:

C3.1. Establish Clinical governance system for maternal and newborn health

C3.2. Strengthen shared care, referral and back referral systems to improve quality of maternal and newborn health services

C3.3. Regionalization of new born care services and centralization of highly specialised maternal care services according to the guideline/circulars

C3.4. Strengthen/streamline supportive services to provide essential and emergency care for women & new borns including those who are critically ill.

C3.5. Establish / strengthen public health, health education, quality and infection control units in all hospitals with specialist services

C3.6. Streamline/strengthen the supportive supervision at field and institutional level

C3.7. Streamline/strengthen regular monitoring at institutional and field level

Strategy 4

Ensure adequately staffed, teams of competent health care workers provide care during pregnancy, labour and postnatal period for every mother and baby

Major activities:

C4.1. Identify workload based cadre norms and new cadres to improve the quality of maternal and newborn health services and make carder projections for the next 10 years

C4.2. Define /redefine roles and responsibilities for health workers involving maternal and newborn health services with job descriptions and terms of reference

C4.3. Advocate for regular recruitment and deployment of necessary carders

C4.4. Streamline/ strengthen the continuous professional education through pre placement and inservice training (Refer A2.5)

C4.5. Introduce an incentive scheme to motivate and retain health workforce for maternal and newborn health services

Strategy 5

Ensure high quality medicines, equipment and appropriate technologies for maternal and newborn health services

Major activities:

C5.1. Strengthen the logistics management system for medicines, equipment and other supplies for maternal and newborn health services

C5.2. Strengthen the system of recommendation of new drugs and technologies for maternal and newborn health services (DESC, TACs)

C5.3. Address quality issues of drugs supplied to the maternal and neonatal units through the system

Strategy 6

Ensure the availability of up to date information for planning, monitoring and decision making in maternal and newborn health care

Major activities:

C6.1. Develop a common information system which facilitate routine maternal and newborn health information and surveillance systems (prenatal, infant and maternal mortality and morbidity , and birth defects)

C6.2. Link the hospital information system with the digitalized field based RHMIS

C6.3. Institutionalize the obstetric bed head tickets and new born bed head tickets to facilitate the data extraction and entry for systems.

C6.4. Establish/ strengthen the mechanism to disseminate information to all relevant stakeholders including general public.

C6.5. Generate evidence through operational research to improve maternal and newborn health services

Strategic Objective 4:

Ensure universal health coverage for comprehensive (essential and emergency) maternal and newborn health care, addressing inequities in access to quality care

Rationale

Health care delivery system of the country is responsible for the universal access to health. World Health Organization interprets universal health coverage as the ability of the citizens to access good quality health services without suffering financial hardships. It indicates everyone should have the access to appropriate care one should receive. Universal health care has three critical dimensions: who is covered, what services are covered, and how much of the cost is covered.

Universal health coverage should ensure that all people and communities are able to use promotive, preventive, curative, rehabilitative health services they need, of sufficient quality to be effective, while also that the use of these services does not expose them to financial hardship. The end result should be improved health outcomes. Universal health coverage encompasses three important aspects.

1. Everyone who needs services should have access to get them irrespective their economic or social status (equity in access).
2. Quality of health services should be good enough to improve the health of those receiving services.
3. People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

As a government policy health services in Sri Lanka is provided for free at the point of delivery both at hospital (including tertiary care) and field level. Therefore maternal and child health services are delivered through a widely distributed network of curative and preventive health service delivery points in a way that all women and children have good access at no cost. However there are areas in estate sector

and with marginalized populations with limited accessibility to health services due to difficult terrain and lack of transport. Sometimes there are unforeseen out-of- pocket expenditure (transport, day's expenses, purchase of medicines which are out of stock and cost of urgent investigations) which poor populations are unable to bear. As a result they tend to avoid care seeking even in real emergency situations.

Government's annual budget allocation for health plays a key role to ensure sustainable universal health coverage. Mobilising multiple sources of funding and resources (including community resources) are of utmost importance to fill any gaps in government allocations. In order to make maximum use of funds measures should be taken to improve efficiency of resource utilization such as appropriate use of medicines and technologies, prevent wastage and duplication of services, staff motivation, regular monitoring and supervision etc. All stakeholders should collaborate (in particular with the financial authorities at all levels) to strengthen financial and resource generation and rational utilization to improve maternal and newborn health outcomes.

Strategies

1. Ensure implementation of all the evidence based interventions on maternal and newborn health programme based on epidemiology to achieve universal health coverage for essential and comprehensive maternal and newborn care

2. Ensure quality maternal and newborn health services to reach entire target population including all underserved and hard to reach populations

3. Ensure health financing for universal health coverage in maternal and newborn health.

Strategy 1

Ensure implementation of all the evidence based interventions on maternal and newborn health based on epidemiology to achieve universal health coverage for essential and comprehensive maternal and newborn health care

Major activities:

D1.1. Review and update maternal and newborn health interventions, care packages, guidelines, protocols and circulars once in 3 years (Refer A.1)

D1.2. Strengthen/ establish a system to monitor implementation of national maternal and newborn care packages at field and institutional level

D1.3. Strengthen the supportive supervision to ensure quality implementation of maternal and newborn health interventions (Refer C3.5).

D1.4. Revise and review existing policies related to maternal and newborn health and formulate new policies to address inequities in universal coverage.

Strategy 2

Ensure quality maternal and newborn health services to reach entire target population including all underserved and hard to reach populations

Major activities:

D2.1. Identify special vulnerable groups within the defined areas (MOH/PHM) (Eg:, estate,urban slum population ,rural poor, adolescents, commercial sex workers, those in detention homes, prisons , & orphanages, lesbians ,gay , those with disabilities (restricted to home & family, domestic servants, females in armed forces, free trade zone workers, unmarried pregnant, socially stigmatized pregnancies, highest wealth quintile etc)

D2.2. Update routine information system with data in disaggregated form (sex, sector, wealth quintile, age, vulnerability) and use them to understand the situation and determinants of inequity

D2.3. Address the language barriers of the health care workers in maternal and newborn health

D2.4. Plan, design implement and monitor interventions to eliminate inequity and barriers for equity

Strategy 3

3. Ensure health financing for universal health coverage in maternal and newborn health

Major activities:

D3.1. Ensure costed national maternal and newborn health development and scaling up plans are implemented.

D3.2. Minimize Out of pocket expenditure involved in seeking quality maternal and newborn health services by the client

Strategic Objective 5:

Count every mother, fetus and newborn through measurement, programme tracking and accountability

Rationale

Measurement of progress and follow up of every individual is very essential to monitor the achievement of goals. Therefore identifying each and every person of the target population, timely data collection, analysis, and use at appropriate places is of utmost importance to ensure accountability. The information system established way back in Sri Lanka has advanced to capture the target populations, follow them up through all the important events of the life cycle in a sequential manner so as not miss out on the follow up. For instance an eligible woman when registered by a public health midwife, is followed up through her pregnancy, delivery and post-partum period and even during the inter-pregnancy period without dropping out. This ensures accountability of the system from the very beginning of a pregnancy through essential care service packages and emergency care as required. As for the newborn a similar procedure is applied to provide all appropriate services through the country's healthcare delivery system up to 5 years of age about one and a half decades ago and now up to 15 years of age.

Strategies

1. Ensure that all maternal and newborn health target groups are identified and provide appropriate services
2. Ensure that all births and deaths including still births are registered
3. Strengthens the RHMIS systems (hospital and field) for monitoring and evaluation of maternal and newborn health programme at all levels
4. Ensure that surveillance systems provide timely information for action
5. Ensure accountability for quality care and maternal and newborn health outcomes at all levels
6. Enhance monitoring/evaluation capacity and usage of data for decision making and planning at different levels

Strategy 1

Ensure that all maternal and newborn health target groups are identified and provide appropriate services

Major activities:

E1.1. Develop/strengthen a system to identify all target groups relevant to maternal and newborn health programme in the community

E1.2. Track and validate maternal and newborn health related data from various sources to monitor consistency, uniformity and quality of data

Strategy 2

Ensure that all births and deaths including still births are registered.

Major activities:

E2.1. Develop/revise clear definitions for still births, neonatal deaths, perinatal deaths, infant deaths, child deaths and maternal deaths and disseminate

E2.2. Create awareness among all marriage, birth and death registrars, coroners, and health staff on new developments in birth and death registration

E2.3. Sensitize community leaders, civil society & general public regarding their responsibility in registering of all births, still births, newborn deaths and maternal deaths and confirming the cause of death

E2.4. Strengthen linkages with registrar generals department, medical statistics unit and other relevant stakeholders to ensure quality data through validation

Strategy 3

Strengthens the RHMIS systems (hospital and field) for monitoring and evaluation of maternal and newborn health programme at all levels

Major activities:

E3.1. Revise/ strengthen the routine maternal and newborn health data system

E3.2. Implement continuous electronic tracking of all individuals from newborn, infancy, childhood, adolescent, pre pregnant, pregnant and delivery (through life cycle with continuum of care) with a unique identification number

E3.3. Create electronic applications / systems to establish linkages between hospitals and field level data and ensure availability of disaggregated data for action

E3.4. Strengthen the supervision to ensure that the eligible couples register, pregnant mothers register, expected mothers register and birth and immunization register are updated to track the target groups

Strategy 4

Ensure that surveillance systems provide timely information that would result in timely response

Major activities:

E4.1. Upgrade the maternal mortality, infant mortality, perinatal death and birth defect surveillance systems.

E4.2. Link the surveillance systems (maternal mortality, perinatal mortality, birth defects surveillance, infant death investigation) with each other and with routine information systems (IMMR, RHMIS) to ensure uniformity of data and prevent duplication (electronic/web based systems and/or paper based)

E4.3. Establish maternal and neonatal morbidity reporting system and surveillance system for severe morbidities to provide information for action.

E4.4. Disseminate information on surveillance data timely for action.

Strategy 5

Ensure accountability for quality care and maternal and newborn health outcomes at all levels

Major activities:

E5.1. Strengthen/ develop mechanisms to ensure accountability of central and provincial level policy makers and programme managers for reach targeted maternal and newborn health outcomes

E5.2. Introduce/strengthen clinical auditing systems (hospital and field) to increase accountability for quality of care and maternal and newborn health outcomes (refer A3.2)

E5.3. Develop/strengthen system to get feedback on client satisfaction both in field and hospital setup

E5.4. Introduce a system to generate community accountability to improve maternal and newborn health outcomes (through mother support groups, community, religious leaders)

Strategy 6

Enhance monitoring/evaluation capacity and usage of data for decision making and planning at different levels

Major activities:

E6.1. Develop capacity of healthcare workers at all levels to monitor and interpret data

E6.2. Establish expert panels at national and district levels to analysis and review service delivery using available data

E6.3. Conduct/strengthen regular MCH reviews, hospital progress reviews and MOH conferences to monitor service provision using data

E6.4. Disseminate data to all levels for decision making and planning

E6.5. Create intersectoral accountability and linkages to report, share and use of accurate data

E6.4 Disseminate data to all levels for decision making and planning

E6.5 Create intersectoral accountability and linkages to report, share and use of accurate data

Strategic Objective 6:

Harness the power of Individuals, families and communities in support of maternal and newborn health

Rationale

Individuals, households and communities create the demand for health and utilize the services. Thus their role is well recognized by the health sector. Initiatives that change behaviors and induce health promoting actions have been actively followed up throughout the health system in Sri Lanka.

Cultural heritage in Sri Lanka places voluntarism for community activities at a very high stake. Thus the community mobilizes for important events in the village such as cultivation related work, religious activities, sickness, funerals, and ceremonies effortlessly. Pregnancy and childbirth are also considered as important events in most villages and cultures of all ethnic groups where a pregnant woman is cared for and fed by the community and various religious activities are performed to bestow blessings on her and the baby. This practice continued even during the postpartum period to promote the health of the woman and to breast feed the baby.

With the development of the healthcare delivery system in the country, people continued their support by donating land to put up clinics and even hospitals. The informal leaders within the community play an important role in organizing the community participation and promoting these activities. Volunteers provide free labour to build the clinic in the village and later they assist in conducting clinics and in organizing community health activities. The Public Health Midwife is well assisted by the community and volunteers in carrying out her work which is based in the community to a great extent. The public health midwife need to develope good collaboration with the formal and informal leaders of the villages which was an important factor for her to function in the villages and gain the credibility of the people. With time the community gets more organized in the form of community based voluntary organizations and as women's societies and these play an important role in maternal, newborn and child health related activities in the villages supporting the work of all the field health workers.

Health sector has received much support from the clergy of all religions; Health activities are organized by temples, churches, mosques; Buddhist temples in villages have been used as the venue to train volunteers, conduct mobile clinics, weighing children under five (weighing centres) and blood donation campaigns. . Although multi-ethnic, Sri Lanka did not have cultural barriers to hinder the health sector programmes.

Community participation and support was very much evident at times of natural or other types of disasters in the country such as the tsunami in 2004 and civil war lasted for 3 decades; volunteers and groups organized mass blood donation campaigns; they donate material and free labour generated to rebuild systems. Health sector got the highest priority in these situations with pregnant women, infants ,and children related services received the attention first. The rural population (which constitute 80% of the country's population) with increasing literacy and organized health education inputs from the health care workers undoubtedly became more aware of health matters especially pertaining to women and children. When blended with the cultural practice of volunteerism this will continue be an asset for future endeavors to further improve maternal and newborn health.

Strategies

1. Ensure community awareness for maternal and newborn health.
2. Empower individuals, families and community to solve own health problems in collaboration with the health care workers
3. Ensure mobilization of community resources to achieve maternal and newborn health goals
4. Empower communities to counter domestic violence, reject disrespect and abuse towards women/girls by ensuring equal access to resources, education including sexual education and information
5. Linkages with Labour department, child secretariat, plantation human development trust to improve the service provision for mothers and newborns.

Strategy 1

Ensure community awareness for maternal and newborn health.

Major activities:

F1.1. Increase awareness on health matters of mother and new born among individuals, families and communities and mobilize their support in all activities to ensure quality maternal and new born health

F1.2. Improve the knowledge and skills of the health workers to deliver messages effectively to the individuals, families and communities

Strategy 2

Empower individuals, families and community to solve own health problems in collaboration with the health care workers

Major activities:

F2.1. Develop capacity of girls and women to stay healthy and use healthy practices related to reproductive health

F2.2. Establish mother support groups to improve health knowledge and promote desired practices and behaviors

F2.3. Strengthen male involvement in pre-pregnancy, pregnancy, postnatal care (including breast feeding support) and family planning

F2.4. Establish social support networks in the community and link with the health system & other relevant sectors such as social services, women's affairs

F2.5. I nvolve community in improving quality of home care through better interaction with healthcare workers, general practioners Community leaders (formal & informal)

Strategy 3

Ensure mobilization of community resources to achieve maternal and newborn health goals

Major activities:

F3.1. Sensitize the public to increase their demand for quality maternal and newborn health services.

F3.2. Establish mechanisms at community level to strengthen collaboration between health care workers and formal and informal community leaders to enhance maternal and newborn healthcare

F3.3. Involve the families & community to improve the quality of services in maternal and newborn health.

Strategy 4

Empower communities to counter domestic violence, reject disrespect and abuse towards women/girls by ensuring equal access to resources, education including sexual education and information

Major activities:

F4.1. Mobilize the support of the clergy, informal /formal leaders, voluntary organizations and women's organizations to ensure girls and women are protected against all forms of violence and discriminations and their human rights are safeguarded within the family and the community.

F4.2. Introduce cultural and age appropriate sexual and reproductive health education programmes in school and other settings so that all males and females become well aware about sexual and reproductive health matters and avoid unsafe sexual practices.

F4.3. Equip Individuals, families and community with knowledge and positive attitudes to empower to demand for rights, respect and quality care for girls and women from all health care delivery institutions.

F4.6. Address specific challenges to the girl child & women at home and in the society such as discrimination & violence especially during pregnancy with community participation.

Strategy 5

Linkages with Labour department, child secretariat, plantation human development trust to improve the service provision for mothers and newborn

Major activities:

F5.1. Involve/ participate for the advisory committee meetings and other technical meetings with other ministries/ agencies

F5.2. Provide technical assistance as required.

Way forward

Maternal and new born health strategic plan will be realized with visible changes in lives of women, children and families occurring in our country. Health workers and many stakeholders hold responsibility in ensuring that the plan is brought in to action and in-cooperated into service delivery.

Family Health Bureau is the National Focal point for Maternal and Newborn Health and would hold the overall responsibility of ensuring the implementation of the maternal and newborn health strategic plan. However as identified in the Activity Plan of the maternal and newborn health strategic plan (2017-2025) there are many stakeholders within the Ministry of Health and few outside who hold responsibility in implementation. All health care workers working at different levels in preventive and curative sector (hospitals) has their role to play in coordinating the service delivery, providing advocacy and implementing the plan. The provincial and district teams led by provincial director of health services and regional director of health services and guided by Provincial and District consultant community physicianss and medical officers in maternal and child health and their team at the maternal and child health cell of the district, medical officers of health and their teams carry the responsibility of obtaining the support at local level to implement the activities at the community level. In the hospitals, especially in the hospitals providing maternal and neonatal care services, the teams led by the Head of the Institution and the Consultant Obstetricians or Consultant Paediatricians/Neonatologists carry responsibility of planning and implementing the identified activities in the hospitals. In addition the preventive and curative sector has the responsibility to ensure provision of continuum of care across the systems.

The maternal and new born health strategic plan 2017-2025 accompanies a monitoring and evaluation plan. The objectives and key performance indicators are presented as an annex. A comprehensive monitoring and evaluation framework will be available as a softcopy in the Family health Bureau website to ensure timely achievement of objectives. Monitoring and evaluation plan targets national, provincial, district, hospital and divisional level health care providers and health authorities as its mainly utilized. It contains coverage targets, core indicators, indicators for the impact framework.

The maternal and new born health strategic plan (2017-2025) has clearly identified strategic objectives, strategies and key activities under each of the strategy. Annex I provides a comprehensive action plan to be used at all levels. The maternal and new born health strategic plan (2017-2025) should be referred when developing the Annual Plans of the Districts and Hospitals. Activities identified in the activity plan should be included in the annuals plans to ensure effective coverage of interventions. When developing the annual plans

the time frames given under each of the activities also should be taken into consideration. In addition to the governmental organizations it is also important for non-governmental organizations, private sector, societal bodies, professional associations, health worker and community groups to follow the action plan when setting their key activity areas in 2017 -2025 time period. If all stakeholders work in a single strategic direction, there is a high success rate.

Estimated costs will be made available for activities listed in the action plan. It would enable timely and adequate allocation of financial resources to achieve the stated objectives.

Research at local level is always in encouraged. Local researchers can work on improving quality, access and coverage of interventions for pregnancy and child birth, finding approaches to deliver current evidence based interventions at all levels and engaging and enhance the community action in maternal and new born health.

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Annexes

Annex 1

Key Performance Indicators

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
Maternal Mortality Ratio	Number of maternal deaths per year during pregnancy and child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy. Defined as a death from any cause related to or aggravated by pregnancy or its management.	100,000 live births	NMMS	33.7 per 100,000 LB (2015)	15 per 100,000 LB
Neonatal mortality rate	Number of live born infants per year who die before 28 completed days of age	Total live births	NMMSS	6.6 per 1000 LB (RHMIS, 2015)	3.4 per 1000 LB
Still birth rate	Number of infants per year born with no sign of life and weighing ≥ 1000g or after 28 weeks of gestation Number of infants per year born with no sign of life and weighing ≥ 500g or after 22 weeks of gestation	1000 total live and still born births (weighing ≥ 1000g or after 28 weeks of gestation) 1000 total live and still born births (≥ 500g or after 22 weeks of gestation)	NPMSS	6.4 per 1000 births (2013) 6.1 per 1000 births (2015, RHMIS)	3.5per 1000 births
Indicators based on the objectives					
Proportion of newly married couples who received the pre-conception care package	Newly married couples who received the pre conception care package (clinic and the education session)	Estimated number of newly married couples	RHMIS	25.3% (FHB, 2015)	90%
Rubella immunization coverage	Number of pregnant women who have received rubella immunization by the time of registration	Total number of pregnancies registered in the given year	RHMIS	97.6%	99%
Proportion of pregnant women who have received pre- conceptional folic acid supplementation	Number of pregnant women who were on folic acid supplementation for 3 months by the time of pregnancy registration	Total number of pregnancies registered in the given year	RHMIS	**82.6% (FHB, 2015)**	**90%**
Unmet need of family planning	Number of eligible females who do not wish to get pregnant but not using a family planning method	Total number of eligible females under care	RHMIS	**6.6% (FHB 2015)**	**5%**
Proportion of pregnant women registering for antenatal care before 8 weeks of gestation during the last year	Number of pregnant women who have before 8 weeks of gestation	Total number of pregnant mothers registered	RHMIS	**78.5% (FHB 2015)**	**85%**
Proportion of couples who attended all three antenatal classes at the time of delivery	Number of couples who attended all three antenatal classes or sessions conducted by field health staff	Total number of births reported	RHMIS	**33.9% (FHB 2015)**	**80%**
Antenatal syphilis screening coverage before 12 weeks	Number of pregnant mothers who have received screening for syphilis (with VDRL) before 12 weeks during the current pregnancy	Total number of births reported	RHMIS	**77.2 % (FHB, 2015)**	**99%**
Proportion of pregnant women screened for HIV during pregnancy	Number of pregnant mothers who have received screening for HIV during the current pregnancy	Total number of births reported	RHMIS	**92.6% (NSACP, 2016)**	**99%**

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
Proportion of pregnant women with HIV who received ante retroviral therapy during pregnancy	Number of pregnant women with HIV positive status and who received anti retroviral therapy	Number of mothers with HIV who have delivered in the given year	NSACP	**100% (NSACP annual report, 2016)**	**100%**
% of pregnant women with VDRL positive who underwent confirmatory testing at the STD clinic	Number of pregnant women who attended for VDRL confirmatory testing at the STD clinic	Pregnant women who had VDRL screening positive reports during the last year	NSACP	**Not available**	**100%**
% of pregnant women with VDRL positive who were confirmed at the STD clinic who received treatment	No of pregnant women with VDRL positive who were confirmed at the STD clinic who received treatment	No of pregnant women with VDRL positive who were confirmed at the STD clinic	NSACP	**96.1% (NSACP, 2016)**	**100%**
Proportion of pregnant women screened for anaemia before 12 weeks of gestation	Number of pregnant women who were screened for anaemia before 12 weeks of gestation	Total pregnant mothers registered	RHMIS	**88.8% (FHB 2015)**	**98%**
Proportion of pregnant women with severe anaemia presenting in labour	Number of pregnant women who present in labour detected to have severe anaemia	Total number of deliveries reported	eIMMR	**No data**	**00%**
Proportion of pregnant women screened for hyperglycaemia during the current pregnancy before 12 weeks of gestation	Number of pregnant women who were screened for hyperglycaemia during the current pregnancy before 12 weeks of gestation	Total pregnant mothers registered	RHMIS	**76.2% (FHB, 2015)**	**95%**
Proportion of pregnant women screened for hyperglycaemia during pregnancy at or around 28 weeks of gestation	Number of pregnant women who were screened for hyperglycaemia during pregnancy at or around 28 weeks of gestation	Total pregnant mothers registered	RHMIS	**83.9% (FHB, 2015)**	**98%**
Proportion of babies weighing more than 4 kg as a marker of GDM not picked up or treated	No of babies weighing more than 4 kg at birth	Total number of births	**eIMMR**	**No data**	**00%**
Proportion of health institutions using MgSO4 for prevention and management of eclampsia to 100 % by 2025	Number of health institutions (including PMCU) with the availability of IV MgSO4 for the prevention and management of eclampsia at the time of survey	Total number of health institutions	**Special survey**	**Not available**	**100%**
Proportion of pregnant women with the risk of delivering < 34 weeks of gestation and received one dose of antenatal corticosteroids prior to delivery	All women who give birth in facility at <34 completed weeks (ultra sound confirmed) and received one dose of ACS for risk of preterm birth	Total live births at < 34weeks completed weeks of live births with ultrasound confirmed gestational age of less than 34 weeks	**eIMMR**	**No data**	**100%**
Proportion of pregnant women whose labour was monitored using the partogram	Number of pregnant women whose labour was monitored using the partogram	Total number of births	**Special survey**	**41.7% (2012)**	**100%**

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
To increase the proportion of women who have a companion of choice during labour and delivery	Number of births where a companion of choice was accompanied during the labour and delivery	Total number of births	**Special survey**	**Not available**	**100%**
Proportion of institutions following induction of labour guidelines	Number of specialist hospitals where the guidelines for labour induction are followed	Total number of specialists hospitals	Special survey	**Not available**	**100%**
Proportion of women who received pain relief during labour	Number of women who received pain relief during labour	Total number of births		**Not available**	**100%**
Primary Caesarean Section rate (LSCS rate)	Number of women who had the first LSCS	Total number of births	eIMMR / RHMIS	**34.5% (FHB – 2015)**	**25%**
Proportion of newborns who initiated breastfeeding within first one hour	Number of newborns who initiated breast feeding within the first one hour	Total number of newborns born given within the year	DHS, special survey	**91% (DHS , 2016)**	**95%**
Proportion of asphyxiated newborns who received timely resuscitation	Number of newborns in whom newborn resuscitation was initiated at the first minute	Newborns with birth asphyxiation (APGAR < 9 at birth)	eIMMR	**not available**	**100%**
Proportion of newborns who were examined by a medical officer within 24 hours of birth	Number of newborns examined by a medical officer within first 24 hours of birth	Total number of live births	eIMMR	**No data**	**100%**
% of newborns < 2000g provided with KMC	Number of newborns with birth weight less than 2000 g and initiated with Kangaroo Mother Care	Total number of newborns with birth weight less than 2000 g	eIMMR	**Not available**	**99%**
Proportion of newborns screened for congenital hypothyroidism	Number of newborns who were screened for congenital hypothyroidism	Total number of live births	eIMMR	**Not available**	**95%**
Proportion of newborns screened for critical congenital heart disease	Number of newborns screened for critical congenital heart disease before discharge from the hospitals	Total number of live births	eIMMR	**Not available**	**95%**
Proportion of newborns screened for congenital deafness	Number of newborns screened for congenital deafness before discharge from the hospital	Total number of live births	eIMMR	**Not available**	**75%**
Proportion of post partum women who had received at least 1 home visits by public health midwife during the first 10 days	Number of women who had received post partum home visits by public health midwife at least once in the first 10 days	Total number of deliveries reported	RHMIS	**92.5% (FHB, 2015)**	**98%**
Proportion of mothers who were screened for psychosis on the 5th day of the postpartum period	Number of postpartum mothers who received screening for post partum psychosis on 5th day	Total number of deliveries reported	RHMIS	**New intervention/no data**	**95%**
Proportion of postpartum women screened for post partum depression at 4 weeks	Number of postpartum women screened for post partum depression at 4 weeks	Total number of deliveries reported	special survey	36.2% (Research unit, FHB, 2014)	**95%**

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
Proportion of postpartum women who are following a modern family planning method at 6 weeks	Number of postpartum women who are following a modern family planning method at 6 weeks	Total number of births reported	Special survey	**62% (Research unit, FHB, 2014)**	**90%**
Additional indicators based on strategic objectives					
Intrapartum still birth rate	No of babies not showing signs of life at birth and but fetal heart sounds heard on admission to Labour Room	1000 total live and stillborn births	NPMSS, eIMMR	No data	
Institutional delivery rate	Women who has delivered their last pregnancy (within last 23 months) in a health institution	Total number of births	DHS	**99.5% (DHS 2016)**	**99.9%**
Skilled attendance at birth	Number of births attended by a skilled attendant (PHM, Nursing officer, doctor)	Total number of births	RH MIS	**99.9% FHB 2015**	**99.9%**
Proportion of newborns who received all 4 elements of essential newborn care	Number of newborns who have received • Initiation of breast feeding first hour • Skin to skin care • Delayed cord clamping • Delay in weighing and taking other measurements At/around birth	Total number of live births	DHS and Special survey	**Initiation of breastfeeding in the first hour 90% (DHS, 2016)** **Others not available**	**99%**
Coverage of tetanus toxoid at the time of delivery	Number of women who have received tetanus toxoid by the time of delivery	Total number of births reported	RHMIS	**99.3% (FHB, 2015)**	**100%**
% of staff (PHM, NO, MO) trained on Emergency obstetric care in the hospital	Number of PHM, NO and MOOs trained on emergency obstetric care during past 5 years or had a refresher training within past 5 years	Total number of PHM, NO and MOOs assigned to the labour room at the time of survey	Special staff survey / training database of the institute	**Not available**	**95%**
% of hospital PHM, NO, MO working in obstetric units, labour rooms and NICUs trained on Essential Newborn care four day course	Number of PHM, NO and MOOs trained on essential new born care during past 5 years or had a refresher training within past 5 years	Total number of PHM, NO and MOOs assigned to the labour room who are assigned to work in obstetric units, labour rooms and NICUs at the time of survey	Special staff survey / training database of the institute	**No data**	**95%**
% of hospital PHM, NO, MO working in obstetric units, labour rooms and NICUs trained in Neonatal Life Support one day training programme	Number of PHM, NO and MOOs trained on neonatal life support during past 5 years or had a refresher training within past 5 years	Total number of PHM, NO and MOOs assigned to the labour room who are assigned to work in obstetric units, labour rooms and NICUs at the time of survey	Special staff survey / training database of the institute	**No data**	**95%**
Percentage of specialist hospitals with Mother Baby Friendly Hospital Initiative	Number of specialist hospitals with Mother Baby Friendly Hospital Initiative at the time of survey	Number of specialist hospitals	Special survey	**No data**	**100%**
Percentage of pregnant women who had 8 or more antenatal clinic visits during the present pregnancy	Number of women with 8 or more antenatal visits who have delivered in the given year	Total number of births	RH MIS	**54.3% (FHB, 2015)**	**99%**

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
Proportion of mothers with PROM who received antibiotics within 48hrs of delivery	Number of women who had PROM and received antibiotics within 48 hours of delivery	Total number of mothers who had PROM	eIMMR		**100%**
Neonatal morbidity rate due to jaundice	Number of neonates who were diagnosed with jaundice according to the diagnosis made in the Bed Head Ticket	Total number of births reported	eIMMR	**Not available**	**<5%**
Maternal near - miss ratio	Number of maternal near-miss cases	Total number of live births	NMMS	**Not available**	
Adolescent pregnancy rate	Birth rate among girls in the age group of 15 to 19 years old age group / 1000 girls in the age group	Total number of births reported	Census data / RHMIS	**5.1% (from 16 to 19 years, RHMIS, 2015)**	**<1%**
Proportion of maternal deaths due to heart disease	Number of maternal deaths due to heart disease	Total number of maternal deaths	NMMS	**14.3% (FHB, 2014)**	-
Early neonatal death rate	Number of neonatal deaths occurred during first 7 days	Total number of live births	RHMIS	**4.9 per 1000 LB (FHB, 2015)**	-
% of hospitals covered by the neonatal retrieval system	Number of hospital with the functioning neonatal retrieval system	Number of specialist hospitals	Special survey	**No data**	**100%**
% of low BMI (18.5) pregnant mothers at registration ;	Number of mothers who had their BMI < 18.5 at the time of registration	Total number of pregnant mothers registered	RHMIS	**20.2% (FHB, 2015)**	**<10%**
% of high BMI (25) pregnant mothers at registration	Number of mothers who had their BMI > 25.0 at the time of registration	Total number of pregnant mothers registered	RHMIS	**21.3 %(FHB, 2015)**	**<10%**
% of women with hyperglycaemia < 12 weeks of gestation	Number of women with hyperglyceamia before 12 weeks of gestation	Total number of pregnant mothers registered before 12 weeks	Special survey	**4.5% (FHB, 2015)**	**<2%**
% of institutes providing method mix for family planning services	Number of health institutes which provide the method mix for family planning services Method mix include the facilities and provision of IUCD, Subdermal implants, provision of pills, condoms and injectable hormonal contraception (DMPA)	Number of health institutes in the country	Special survey	No date	100%
Proportion of maternal deaths due to obstetric hemorrhage	Number of maternal deaths due to obstetric hemorrhage in the last year	Total number of maternal deaths in the same year	NMMS	**9.8% (FHB, 2014)**	**<5%**
Low birth weight rate	Number of live born babies with birth weight less than 2500g	Total live births	eIMMR	**11.4% (RHMIS, FHB, 2015)**	**8%**
Preterm birth rate	Number of babies born alive before 37 weeks of pregnancy are completed	Total live births	eIMMR	**7.4% (WHO MCS)**	-
% of estimated budget was spent on MNH service delivery	Total amount spent on Maternal and newborn health service delivery at provincial level/ national level	Estimated budget to the implement the activities		**Not available**	-
% of specialist hospitals that have conducted regular management committee meetings throughout the year	Number of hospitals which have conducted monthly regular management committee meetings during the past 12 months	Number of specialist hospitals in the country	Special survey	**Not available**	**100%**

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
% of specialist hospitals that have conducted regular perinatal audits throughout the year	Number of hospitals which have conducted monthly regular perinatal audits during the past 12 months	Number of specialist hospitals in the country	NMMS (perinatal death audit meetings)	**Not available**	**100%**
% of maternity units with functioning Work Improvement Teams	Number of maternity units which had WIT meetings consecutively during the past 3 months	Number of specialist maternity units in the country	Special survey	**Not available**	**100%**
Number of obstetric beds for 1000 live births by the type of hospital	Number of available obstetric beds	Live births reported in the last year in the type of hospitals * Will be calculated by the type of hospital	Medical statistics unit	26.0 per 1000 births (EMOC, 2012)	
Number of NICU bed for 1000 live births by the level of care	Number of NICU beds available in level I NICU	Live births reported during last year in the hospitals where level I NICU care is provided* * Will be calculated for all levels of care	Medical statistics unit	**Not available**	
% of women with complications delivered at centers with High Dependency Units	Number of women with complications delivered at High Dependency Units	Number of women who had complications during the last pregnancy	Special survey	**Not available**	**90%**
% of specialist institutes with CEMOC facilities 24*7;	Number of hospitals with CEMOC facilities available 24*7	Total number of specialist hospitals in the country	Special survey	**Not available**	**100%**
% of hospitals with no stock outs with IV syntocinon during last one year	Number of hospitals with no stock outs with IV syntocinon during the past year	Total number of specialist hospitals in the country	Special survey	**Not available**	**100%**
% of institutions with pregnant women with obstetric BHTs at the time of survey;	Number of hospitals where all women who have delivered had received an obstetric BHT (from a sample)	Total number of specialist hospitals	Special survey	**Not available**	**100%**
% of institutions with neonates with neonatal BHTs at the time of survey;	Number of hospitals where all newborns have received neonatal BHT at the time of survey (from a sample)	Total number of specialist hospitals	Special survey	**Not available**	**100%**
% of MOH areas using e RHMIS in the functional status	Number of MOH areas which have sent the e H 509 correctly during the last quarter	Total number of MOH areas	M and E unit	**100% (FHB, 2017)**	**100%**
Percentage of PHM positions vacant at the end of the given year in the institute/ district / national level	Number of PHM vacancies available at the end of the calendar year at the institute/ district/ national level	PHM cadre at the institute / district / national level	Special staff survey	**Monitoring and evaluation unit, FHB**	**100%**
% of staff availability according to cader norms at labour rooms	Number of PHM, NO and MOOs assigned to work in the labour room	Total cadre norm for the labour room according to the number of births in occur	Special staff survey	**EMOC, 2012**	**95%**
% of staff availability according to cader norms at NICU	Number of NO and MOOs assigned to work in the labour room	Total cadre norm for the labour room according to the level of care	EMOC survey	**EMOC, 2012**	**95%**
Skilled attendance at birth (district wise)	Number of births which were attended by a skilled personal	Total number of live births	Annual report on family health	FHB, 2014	

Indicator	Numerator	Denominator	Means of Verification	Baseline	Target
% of MOOH who had completed the targeted number of supervisions (based supervision reports) during the last quarter	Number of MOOH who had completed 18 supervision reports during the last quarter	Number of MOOH in the country	RHMIS		
Proportion of maternal near-misses due to primary delay in pre-identified vulnerable districts	Number of maternal near misses due to primary delay	Total number of maternal near misses in the selected districts * calculated for specified districts separately	NMMS	Not available	<5%
Out of pocket expenditure for costs in delivery and immediate postnatal care at the time of survey	Average out of pocket costs for direct and indirect expenses made by the woman and her family for the child birth, labour and immediate postnatal care		Special survey	No data	< 5%
% of pregnant mothers registered (denominator : the estimated number)	Number of pregnant mothers registered	Estimated number of pregnancies in the area	RHMIS	**91.2% (FHB, 2014)**	**100%**
% of eligible couples registered	Number of eligible couple registered	Estimated number of eligible couples living in the area	RHMIS	**105.8% (FHB, 2014)**	**100%**
% of births reported by PHMM (denominator: estimated number of births)	Number of births reported by PHM	Estimated number of births	RHMIS	**85.6% (FHB, 2014)**	**98%**
% of newborn deaths are registered from neonatal deaths reported from hospital data system	Number of neonatal deaths obtained from the Registrar General's Department	Number of neonatal deaths reported from the hospital data	Registrar General's Department and medical statistics unit (eIMMR)	**Not available**	**100%**
% of infant deaths investigated at the field level	Number of infant deaths investigated	Total number of infant deaths reported	RHMIS	**81% (FHB, 2014)**	**100%**
% of perinatal deaths investigated at the field level	Number of perinatal deaths investigated	Total number of perinatal deaths reported	RHMIS	**Not available**	**100%**
% of perinatal deaths investigated at perinatal audits at the hospital level	Number of perinatal deaths discussed at the hospital perinatal mortality meetings	Total number of perinatal deaths reported	Perinatal meeting reports / NMMS	**Not available**	**100%**
% of newborns whose families perform hand washing before handling the newborn	Number of families with a newborn where they practice hand washing before the newborn is handled	Number of families surveyed	Special survey	**Not available**	**100%**
% of PHM areas with at least one functioning mother support groups	Number of PHM areas in which at least one functioning Maw Hawla group is available	Total number of PHM areas	Special survey	**Not available**	**100%**
% of mothers (non-risk) who have received 3 antenatal home visits by PHM during the last pregnancy	Number of non-risk pregnant women who have received 3 antenatal home visits by PHM by the time of delivery	Total number of women surveyed	Special survey	.....FHB 2015	

Annex 2

Action Plan for the National Strategic Plan for Maternal and Newborn Health

		Strategic objective/ Strategy	Responsibility	Time frame			
A1	Strategy	Ensure Implementation of evidence-based interventions during pregnancy, labour and post natal period					
	Major activity	A1.1 Provide evidence based essential maternal care package (antenatal, intra-natal , postnatal) to all pregnant women and emergency care package to manage obstetric emergencies					
	Sub activities	A1.1.1 Update and adapt evidence based interventions in essential & emergency maternal and new born care packages as appropriate and scale up	FHB (MN M &E), SLCOG, PSSL		X	X	X
		A1.1.2 a. Update/ develop / distribute (disseminate) national guidelines, protocols, standards and circulars for maternal and newborn care with special focus on labour, child birth, first day and first week of life(in-utero transfer, partograph etc) . b. Take action to implement them country-wide	FHB				
		A1.1.3 a. Develop easy to use guidelines and protocols in the form of wall charts, desk references in Sinhala, Tamil and English and make them available in all antenatal wards / postnatal wards/labour rooms countrywide. b. Monitor their use by the relevant staff	FHB, PDHS, RDHS, MOMCH, HoIs	X	X	X	X
		A1.1 .4 Develop a handbook on action-oriented guidelines on the management of obstetric emergencies in non specialist hospitals (Check the one prepared earlier by Dr. Kapila Gunawardene & them. May be that needs revision)	FHB, SLCOG, SLCP, PSSL		X		
		A1.1.5 Establish a mechanism to introduce all guidelines and protocols to the unit staff by the consultant in charge of the unit and ensure implementation	HOI, Consultant In-charge of unit	X	X	X	X
		A1.1.6 Establish / strengthen multi disciplinary approach in managing complicated pregnancies (Refer to B1.4)	FHB, HOIs of THs and PGHs	X	X	X	X
		A1.1.7 Strengthen EmONC facilities to provide 24*7 services according to the standards	PDHS, RDHS, DDG BME, DDG MSD, HOIs	X	X	X	X
	Major activity	A1.2 Provide evidence based essential new born care package to all newborns and sick newborn care package to manage newborn complications					
	Sub activities	A1.2.1 Update and adapt evidence based interventions in essential & emergency new born care packages as appropriate and scale up	FHB, SLCP, PSSL	X	X	X	X
		A1.2.2 Update/ develop national guidelines, protocols, standards and circulars for newborn care with special focus on labour, child birth, first day and first week of life and implement country-wide (including new born resuscitation, APGAR score recording)	FHB, SLCP, PSSL			X	
		A1.2.3 Develop easy to use guidelines and protocols in the form of wall charts, desk references in Sinhala, Tamil and English to every postnatal / neonatal unit and labour room	FHB, SLCP, PSSL			X	
		A1.2.4 Distribute and ensure availability of guidelines and protocols in the form of wall charts, desk references in Sinhala, Tamil and English in every postnatal / neonatal unit and labour room	FHB, PDHS, RDHS, HOIs			X	
		A1.2.5 Develop a handbook on action-oriented guidelines on the management of neonatal emergencies in non specialist hospitals	FHB, SLCP, PSSL		X		
		A1.2.6 Develop checklists for baby at labour room targeted to monitor vital signs, temperature, respiratory rate, heart rate and early feeding	FHB, SLCP, PSSL	X			
		A1.2.7 Strengthen documentation of APGAR score	HoI, WITs of ward, MOMCH, FHB	X	X	X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	A1.3 Monitor, evaluate and strengthen evidenced based practices related to delivery and immediate postnatal care					
	Sub activities	A1.3.1 Develop/revise tools and indicators to monitor and evaluate evidence based practices at delivery & immediate post natal care	FHB, SLCOG, SLCP, PSSL		X		
		A1.3.2 Strengthen the use of partograph,and MEWS chart in monitoring labour in all institutions	HoI, WITs of ward, MOMCH, FHB	X	X	X	X
		A1.3.2a.Train a pool of master trainers from every district on maintenance of partogram and MEWS chart using WHO module and essential newborn care (ENC).	FHB, MOMCH, SLCOG, SLCP, PSSL	X	X		
		A1.3.2b. Conduct regular in service training programs at institution / ward level or at regional level for refreshing the knowledge on recording the progress of labour on the partogram and their interpretation, use of MEWS chart and ENC	HoIs, WITs, MOMCH,	X	X	X	X
		A1.3.2c. Conduct regular (at least monthly) audits on the use of the partogram, MEWS chart and ENC practices at unit level	WITs, HoIs	X	X	X	X
		A1.3.2d. Include the partogram to the newly introduced obstetric formats as an essential component of the BHT of a woman for whom delivery care is provided	FHB	X			
		A1.3.2e. Examine the partogram in maternal death and “near miss” investigations as well as in perinatal mortality surveillance	FHB, HoIs, RDHS, MOMCH, SLCOG	X	X	X	X
		A1.3.3 Conduct regular supervisions and monthly reviews at hospital level with the objective of rectifying the gaps in providing care	HoIs, WITs, MOMCH	X	X	X	X
	Major activity	A1.4. Protect, promote and support breast feeding practices in all settings					
	Sub activities	A1.4.1.Revisit the Baby Friendly Hospital Initiative as Mother Baby Friendly Hospital Initiative (Refer A3.3)	FHB	X	X		
		A1.4.2. Update all the hospital and field staff on BF code of Sri Lanka	FHB, PDHS, RDHS, MOMCH, HoIs	X	X	X	X
		A1.4.3. Continue the training on lactation management for hospital and field staff.	HoIs, RDHS, MOMCH, FHB	X	X	X	X
		A1.4.4. Monitor the implementation of SriLanka code for BF					
A2	Strategy	Ensure adequate, competent human resource with appropriate skill mix to provide high quality MNH services					
	Major activity	A2.1. Establish an HRH policy for MNH or ensure that human resources for MNH addressed in health sector HR policy (Refer C4.1)					
	Sub activities	A2.1.1. Develop/revise MNH staffing norms for each level and competency mix for MNH teams,	DDG PHS II, DDG MS I & II, DDG Admin, FHB	X	X		
		A2.1.2. Define roles and responsibilities for each member of the MNH team	DDG PHS II, DDG MS I & II, DDG Admin, FHB, SLCOG	X	X		
		A2.1.3. Project the staff requirements for different categories for next 10-15 years based on utilization patterns and MN mortality and morbidity patterns.	DDG PHS II, DDG MS I & II, DDG Admin, DDG Planning, FHB, SLCOG	X	X		
		A2.1.4. Establish a data base on HR for MNH by mapping staff requirements and update regularly	DDG PHS II, DDG MS I & II, DDG Admin, DDG Planning, FHB				
		A2.1.5. Advocate for regular recruitment and training of health staff related to MNH services	DDG PHS II, DDG MS I & II, DDG Admin, DDG Planning, FHB	X	X	X	X
	Major activity	A2.2. Establish training centers where needed and strengthen existing centers (NIHS, NTSs, RTSs) to support basic and in-service training					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Sub activities	A2.2.1. Conduct a detailed assessment of training centers / facilities/trainer capacity/ training guides and materials etc.	DDG ET&R, NIHS	X	X		
		A2.2.2. Improve facilities in training centers based on the assessment to provide an enabling environment for trainers and trainees. (Skills lab, models, Manikins, IT facilities)	DDG ET&R, PDHS, RDHS, FHB	X	X	X	X
		A2.2.3. Develop a system that all the district training programmes are facilitated through regional training centers	DDG ET & R, PDHS, DMCH	X	X		
	Major activity	A2.3 Establish training facilities for essential regular skill development in hospitals					
	Sub activities	A 2.3.1 Identify and develop training leads for standard training programmes at hospital level	HoI, RDHS	X			
		A 2.3.2 Conduct activities to maintain high levels of skill development to provide MNH services	HoI, RDHS	X	X	X	X
		A2.3.3 Provide facilities for regular essential skill development in hospital	HoI, RDHS	X	X	X	X
		A 2.3.4. Develop district teams of master trainers for all standard training programme led by district CCP (e.g.: EMOC, ENC, NALS, Breast feeding counselling, Facility based sick new born care)	FHB, HoI, RDHS, SLCP, SLCOG	X	X	X	X
		A 2.3.5 Train and certify all categories of neonatal care staff and assign function of Level 3 and 3+ institutions within a Province					
		A 2.3.6 Conduct training programmes on essential newborn care (WHO and FHB), neonatal advanced life support, facility based sick newborn care (SDF and FHB), breast feeding counselling (WHO, UNICEF and FHB) and emergency obstetric care (LSTM and FHB)	HoIs, RDHS, training leads of hospitals, MOMCH	X	X	X	X
		A2.3.7. Maintain a training data base at each unit/ institution/ district	HOIs, Mos in-charge of training	X	X	X	X
		A2.3.8. Develop and implent annual training calendars at institutional and district level for competence based in-service training	MOMCH, HOIs, Mos in-charge of training	X	X	X	X
		A2.3.9. Advocate for linking In-services training/portfolio with increments and/or renewal of registration	DGHS, DDG MS I & II		X		
	Major activity	A2.4. Increase the number of trainers and strengthen their capacity to conduct training related to MNH					
	Sub activities	A2.4.1. Recruit adequate number of qualified/experienced staff as trainers in Sinhalese and Tamil medium regularly	FHB, MOMCH, SLCOG, SLCP, PSSL	X	X	X	X
		A2.4.2. Improve their capacity particularly to conduct skill based training using innovative methodologies regularly.	FHB, MOMCH, SLCOG, SLCP, PSSL	X	X	X	X
		A2.4.3. Develop and distribute updated trainer guides including all aspects of quality of care (theory& practical) and trainee assessment tools.	FHB, SLCOG, SLCP, PSSL		X	X	X
		A2.4.4. Assess the capacity of trainers periodically using trainer assessment tools	FHB, SLCOG, SLCP, PSSL		X	X	X
	Major activity	A2.5. Update/develop curricula/in-service training packages to incorporate new evidence based interventions/ competencies / skills focusing on labour, delivery and care of newborn on first day and first week of life among all staff providing MN care					
	Sub activities	A2.5.1. Revise and update curricular, training manuals, guides for the training of nurses, midwives, MOHs and others to ensure that training covers all aspects of quality MNH care in Sinhalese and Tamil medium	DDG ETR, D/ Training, D/ Nursing Training, D/NIHS, FHB		X	X	X
		A2.5.2. Include modules/ activities to training programmes to develop client friendly attitudes, practices and sense of accountability among trainees.	DDG ETR, D/ Training, D/ Nursing Training, D/NIHS, FHB		X	X	X
		A2.5.3. Improve and update medical undergraduate training curricular focusing on quality aspects & skill development to cater to the needs of the MNH services	Heads of Departments of Obstetrics, Paediatrics and Com Medicine		X	X	X
		A2.5.4. Update the post graduate medical curricular and training courses to cater to current needs of MNH	Chairpersons of BOS in Obstetrics, Paediatrics and Com Medicine		X	X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	A2.6 Conduct regular Pre-placement training					
	Sub activities	A2.6.1. Define essential packages of pre placement training programme / frequency of refresher training for each category of staff at different levels working in different departments					
		A2.6.2. Introduce a system of competency certification at specific intervals of time (3-5 years) for MNC staff at all levels (doctors, nurses and mid wives).					
		A2.6.3. Develop and implement institution based compulsory skills and competency based training for all grades/ categories of staff based on the defined essential training packages.	FHB, Heads of Training Institutues		X	X	X
		A 2.6.4 Regularly update training packages based on the new evidence	FHB, D/Training/SLCOG, SLCP, PSSL		X	X	X
		A 2.6.5 Identify centers for preplacement training in MNH	DDG ETR, D/Training		X		
	Major activity	A2.7. Regularly improve and update knowledge and skills of GPs & private hospital staff providing MNH care					
	Sub activities	2.7.1 Establish a mechanism to update all full time and part time GPs on new developments in maternal and newborn care through MOH system.	FHB, RDHS, MOMCH, SLCFP	X	X		
		2.7.2. Establish a system to train MNH staff in private hospitals through professional colleges.	FHB, D/Private Sector Development, SLCOG, SLCP , PSSL	X	X		
A3	Strategy	Ensure quality care during pregnancy, labour and post natal period					
	Major activity	3.1. Implement a uniform sustainable, quality assurance system on Pre-pregnancy care, ANC, INC, PNC and New born care at institutional and field level					
	Sub activities	A3.1.1. Develop/ Update/ Distribute standards, protocols, guidelines for quality maternal and new born care with special focus on labour, child birth and first day and week of life (ref	FHB, SLCOG, SLCP, PSSL			X	
		A3.1.2. Develop and distribute quality assessment tools for MNH services.	FHB, D/HQ & S	X	X		
		A3.1.3. Develop and introduce appropriate quality indicators for Pre-pregnancy care, ANC, INC, PNC, NBC and include them in the MIS (field & hospital).	FHB, D/HQ & S		X		
		A3.1.4. Introduce quality assurance systems for maternity units/labor rooms/ neonatal care units including regular unit meetings.	FHB, D/HQ & S, HOI, Consultants in-charge of wards		X	X	
		A 3.1.5 Monitor quality assessment and quality assurance at the regular unit meetings and management committee meetings under the chairmanship of the Institutional Head and at regular intervals (internal assessment)	HOIs, Consultants in-charge of units		X	X	X
		A3.1.6. Establish a client feedback system to monitor quality of care at field and institutional level coupled with client education on quality of care.	FHB, RDHS, MOMCH, MOOH, HOIs, Sister in-charge of wards		X	X	X
		A 3.1.7 Conduct external assessment of quality of MNH care at field and institutional level	FHB, D/HCQ &S, RDHS, MOMCH,				
		A 3.1.8 Discuss and take corrective action for issues identified at management committee meeting and follow them up in subsequent meeting	HOIs		X	X	X
		A3.1.9 Develop / update standards, norms and guidelines on MNH care to the field MNH activities	FHB		X		
		A 3.1.10 Develop quality tools for pre pregnancy, ANC, PNC and newborn care for the field level	FHB		X		
		A3.1.11 Implement quality tools for field base MNH care	FHB, MOOMCH			X	X
	Major activity	A3.2. Introduce clinical audits as quality improvement procedure at institutional and field level					
	Sub activities	A3.2.1. Develop guidelines and tools to conduct clinical audit based on national standards guidelines and protocols	FHB, SLCOG, SLCP, PSSL		X		
		A3.2.2. Establish teams to conduct clinical audits of MNH services at field and institutional level.	FHB, RDHS, MOMCH, SLCOG, SLCP, PSSL			X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
		A3.2.3. Train the identified staff/ teams to conduct clinical audits.	FHB, RDHS, MOMCH, SLCOG, SLCP, PSSL			X	X
		A3.2.4. Establish a mechanism for regular monitoring of clinical audits and identify gaps and take action to improve service quality (through unit or management committee meetings).	FHB, RDHS, MOMCH, SLCOG, SLCP, PSSL			X	X
		A3.2.5 Advocate for in cooperation of conducting clinical audits for performance appraisal	FHB, DDG MS I & II			X	X
	Major activity	A3.3. Introduce a system for accreditation of hospitals as Mother Baby Friendly (M/BFHI) - link to 1.3.1.					
	Sub activities	A3.3.1. Develop criteria for certification of institutions as Mother Baby Friendly with special focus on practices during labor, delivery and first day and first week of life	FHB, SLCOG, SLCP, PSSL	X	X		
		A3.3.2. Incorporate the MBFHI assessment in to the routine quality assessment tools for the maternal and neonatal units and make it part of the quality assurance process	FHB, SLCOG, SLCP, PSSL	X	X		
		A3.3.3. Re-launch the Baby Friendly Hospital Initiative including additional components of Baby Friendly concept such as Mother Friendly Hospitals, baby friendly NICU and SCBU	FHB		X		
		A3.3.4. Regularly (monthly /Quarterly) monitor MBF status of accredited hospitals by a team lead by Head of Institution to maintain MBFHI status	HOI		X	X	X
		A3.3.5 Develop suitable indicators to assess MBFHI status and include it to the hospital MIS.	FHB	X	X		
		A3.3.6. Monitor MBF status at central, provincial and district level at NHDC, HDC and Hospital Director's meetings with other MNH indicators	DGHS, DDG Planning, FHB		X	X	X
		A3.3.7 Train all staff in maternal and neonatal units on WHO and FHB conducted BFHI 20-hour course	FHB, RDHS, MOMCH, HOIs, Consultants in-charge of units		X	X	X
		A 3.3.8 Accredit hospitals as mother baby friendly by the Accreditation Council in every 3 years	DGHS, FHB		X	X	X
		A3.3.9. Annually certify hospitals as mother-baby friendly (accreditation by the Accreditation Council)- 2025	DGHS, FHB		X	X	X
	Major activity	A3.4 Introduce a rewarding system related to implementation of standards and guidelines at different levels					
	Sub activities	A 3.4.1 Design and introduce a rewarding system for implementing standards and guidelines at different levels	DGHS, FHB		X	X	X
A4	Strategy	Ensure women in child bearing age and their partners receive a comprehensive package of pre pregnancy care					
	Major activity	A4.1. Strengthen the implementation of service package for newly married couples.					
	Sub activities	A4.1.1. Review/ evaluate the implementation status and components of the service package for newly married couples	FHB, RDHS, MOMCH	X			
		A4.1.2. Revise the package based on the findings of the review/ evaluation.	FHB, RDHS, MOMCH		X		
		A4.1.3 Create awareness among pre-pregnant women, families and community regarding the importance of pre-pregnancy care	FHB, RDHS, MOMCH, MOOH	X	X	X	X
		A 4.1.4 Establish counselling services to the couple and their parents with regard to pregnancy related risk factors (including genetic counselling)	FHB, RDHS, MOMCH, MOOH	X	X		
		A4.1.5 Establish referral, back referral system and follow up services at hospital & field level to implement appropriate interventions for women with pre-pregnancy risk factors.	FHB, RDHS, MOMCH, MOOH	X	X		
		A4.1.6 Identify indicators to monitor pre-pregnancy care and include them in the MIS and MCH reviews.	FHB	X			
	Major activity	A4.2. Develop/ introduce service delivery package for inter pregnancy period					
	Sub activities	A4.2.1. Develop and implement a service delivery package for couples in inter pregnancy period coupling with family planning and well women programmes	FHB, SLC OG	X	X		
		A4.2.2 Update and maintain the Eligible Couples Register so that the clients in the interpregnancy period could be identified	MOOH, PHNS, PHM	X	X	X	X
		A4.2.3 Develop indicators to monitor inter-pregnancy care include them to RHMIS	FHB	X			

		Strategic objective/ Strategy	Responsibility	Time frame			
		A4.2.4 Establish a system to monitor women with diagnosed medical or mental conditions through out the reproductive years	FHB	X			
A5	Strategy	Promote client friendly care during pregnancy, childbirth and postnatal period					
	Major activity	A5.1. Provide respectful kind courteous care to all women, newborns and their families					
	Sub activities	A5.1.1. Create awareness among MNH staff on the rights of patients	FHB, SLCOG, MOOMCH, MOOH, HOIs, Public Health MOO	X	X	X	X
		A5.1.2. Provide MNH services (Including verbal interactions) securing privacy, confidentiality, dignity and cultural values of the women, newborns and their families without discrimination.	Heads of Units, Ward in-charge nurse, MOOH, HOIs, Public Health MOO	X	X	X	X
		A5.1.3. Conduct regular audits on respectful behavior among staff members and provide feedback for improvement.	HOI, Ward in-charge nurses		X	X	X
		A5.1.4 Educate women and family members to make health related decisions and make healthy choices with regard to MNH	MOOH, PHMM, Ward Staff		X	X	X
		A5.1.5. Improve physical facilities in OPD, wards, labour room etc. (labour room guideline) to support privacy and rights of women, spouses and families.	PDHS, RDHS, HOIs, In-charge nurses	X	X	X	X
	Major activity	A5.2. Develop a system to support informed decision making for the management to be carried out on the baby or mother during pregnancy, delivery and post-partum period					
	Sub activities	A5.2.1. Develop a system to Inform any important decisions/ procedures pertaining to the mother/baby during pregnancy, child birth or postpartum period to the husband or family members by the most senior staff member.	FHB	X			
		A5.2.2. Develop and distribute all communication, educational & instruction material and publications in both languages pertaining to informed decision making	HEB, FHB		X	X	
	Major activity	A5.3. Encourage the participation of a birth companion during labour and childbirth					
	Sub activities	A5.3.1 Develop a circular on the participation of a companion at birth and labour in government institutions	FHB	X			
		A5.3.2 Develop guidelines for companions at birth indicating their code of conduct during child birth and their limitations while in the labour room.	FHB, SLCOG, PSSL	X			
		A5.3.3 Develop a system to institutionalize the practice of allowing a female companion of choice at child birth and labour	FHB, SLCOG, PSSL				
		A5.3.4 Introduce the practice of female companion of choice at child birth to pre-service and in-service training of field health staff	D/NIHS, D/Training, FHB	X	X		
		A 5.3.5 In cooperate a session on the importance of a female companion of their choice to support at the time of delivery in to antenatal sessions and at parent crafting classes	FHB, MOOMCH, MOOH	X	X	X	X
		A5.3.6 In cooperate a session on female companion of choice at child birth and labour to the obstetric care training package	FHB, SLCOG	X			
		A5.3.7. Create awareness among the institutional and filed staff on the birth companion allowed during labour and childbirth.	FHB, HOIs, Consultants in-charge of wards, Ward in-charge nurses	x	X	X	X
		A5.3.8. Make mothers aware that a female companion of their choice to support them at the time of delivery is allowed.	MOMCH, MOOH. PHHM	x	X	X	X
		A5.3.9. Take action to ensure rights of the medical personnel and avoid any interference by the birth companion in carrying out proper medical management	HOIs	x	X	X	X
		A5.3.10. Organize observation visits to units that allow a female companion to discuss the perceived problems and see how they have been overcome	FHB	X	X		

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	A5.4. Update and/or develop national guidelines for induction of labour and decision making for caesarean section and assisted vaginal deliveries					
	Sub activities	A5.4.1 Conduct a national in depth study on both health and non health determinants, care provision and cost assessment of Caesarian deliveries in government and private hospitals	FHB, SLCOG, PSSL	X	X		
		A5.4.2. Develop / update National guidelines for (elective/ emergency) LSCS indications and induction of labour.	FHB, SLCOG, PSSL			X	
		A5.4.3. Create awareness on national policies and guidelines on the induction of labour and caesarean section among MNH healthcare workers including private sector	FHB, MOOMCH, MOOH SLCOG, SLCP, PSSL	X	X		
		A5.4.4. Create awareness among women, their spouses and families regarding the harmful consequences of demanding LSCS delivery without a justifiable indication.	FHB, MOOMCH, MOOH SLCOG, SLCP, PSSL	X	X	X	X
		A5.4.5. Monitor implementation of guidelines on labour induction and caesarean section as per unit and institutional level	HOI, Consultant In-charge of unit, FHB		X	X	X
	Major activity	A5.5. Strengthen positive birth care practices including pain relief during labour					
	Sub activities	A5.5.1 Create a culture of pain relief at labour and at post delivery through a process of sensitization and capacity development of staff	FHB, SLCOG, SLCA, HOIs, Consultant in-charge of units	X	X	X	X
		A5.5.2. Create awareness among health workers and clients on possible positions for delivery and possibility of taking clear fluids or light meals during labour and implement the guideline.	FHB, MOOMCH, MOOH, PHM	X	X	X	X
		A5.5.3. Create awareness among health workers and clients on skin to skin care (even during cord clamping and episiotomy suturing) and rooming-in/ bedding-in and implement such practices according to the guideline.	FHB, MOOMCH, MOOH, PHM	X	X	X	X
		A5.5.4. Develop a system of regular clinical auditing of important interventions at the time of birth (refer A3.2)	FHB	X	X		
	Major activity	A5.6. Reduce over-medicalization of pregnancy and childbirth					
	Sub activities						
B	Strategic objective 02	Address all causes of maternal, perinatal and neonatal mortality and morbidity					
B1	Strategy	Ensure prevention, early Identification and management of direct and indirect causes of morbidities and mortalities to ensure optimal maternal, perinatal & neonatal outcomes.					
	Major activity	B1.1.Strenghten the health services available for prevention and early identification and proper management of conditions that may lead to adverse maternal and neonatal outcomes.					
	Sub activities	B1.1.1 Strengthen the school health, child health and prepregnancy care programmes to identify conditions (heart disease, connective tissue disorders, obesity etc.) which may lead to adverse maternal and neonatal outcomes and follow up of identified cases	FHB	X	X	X	X
		B1.1.2.Develop guidelines and establish a system to provide a permanent method of contraception for girls with conditions where pregnancy is contraindicated with adequate counselling (patient and/or family) at the time of diagnosis.	FHB, SLCOG	X	X		
		B1.1.3. Develop guidelines and establish a system to obtain multidisciplinary opinion and advice for women with medical conditions when decided to get married or get pregnant.	FHB, SLCOG	X	X		
	Major activity	B1.2 Introduce a case based auditing system for severe maternal morbidities and mortalities and perinatal deaths at the field and hospital level					
	Sub activities	B1.2.1. Develop auditing tools for common causes of severe maternal and perinatal morbidity and mortality based on national standards, guidelines and protocols.	FHB, SLCOG, PSSL	X	X		
		B1.2.2. Implement the auditing system as describe in strategic direction A3.2					
	Major activity	B1.3. Develop regionalized Highly specialized centers to manage women with severe obstetric complications e.g.: placenta accreta, eclampsia, heart disease complicating pregnancies etc.					
	Sub activities	B1.3.1. Establish highly specialized centers at DMH, TH Kandy and TH Anuradhapura (refer ..)					

		Strategic objective/ Strategy	Responsibility	Time frame			
		B1.3.2. Develop and implement admission criteria, human resource norms, functioning guidelines for Obstetric ICUs and highly specialized centers	FHB, SLCOG	X	X	X	X
		B1.3.3.Strengthen ICU Bed availability system to support Obstetric patients with complication	FHB, D/Information, ICU bed availability system	X	X		
		B1.3.4 Allocate funds, human resources and infrastructure to highly specialized centers	Chief Accountant, DDG MS I & II, DDG Administration, DDG BME		X	X	X
		B.1.3.5 Develop criteria for levels of management of complications along with guidelines for decision making and referrals	FHB, SLCOG, PSSL	X	X		
	Major activity	B1.4. Develop / strengthen Multi disciplinary teams / clinics to manage obstetric complications and medical disorders complicating pregnancy with continuum of care					
	Sub activities	B1.4.1. Establish multi disciplinary teams/ clinics to manage complicated maternity cases according to the circular.	HOIs, PDHS, RDHS	X	X		
		B1.4.2. Develop and disseminate a list of experts with contact details to provide clinical guidance for management of complicated cases when required.	FHB, SLCOG, PSSL	X	X		
		B1.4.3. Establish rapid response teams within institutions to deal with emergencies	HOIs, PDHSs, RDHSs, MOMCH, MO Public Health	X	X	X	X
	Major activity	B1.5. Strengthen Referral, back referral systems and follow up of pregnant and post partum women e.g.: common pregnancy record - single record for a mother, communication system					
	Sub activities	B1.5.1. Develop and implement the common pregnancy record (all the service providers can keep notes on the single record) to strengthen the proper management of maternity cases.	FHB, SLCOG	X			
		B1.5.2. Compile and disseminate updated directory with contact details of hospital and field staff engage in MNH care to facilitate the communication (based on the draining area for the district).	FHB	X	X		
		B1.5.3. Conduct training programmes to Improve the writing of management plans and other advice in pregnancy record.	FHB, SLCOG	X	X	X	X
	Major activity	B1.6. Create awareness among health workers, pregnant women, spouses, families and the community on the need to prevent complications and to seek timely health care for any abnormality detected during pregnancy or postpartum period.					
	Sub activities	B1.6.1. Provide all instructions in a language well understood by the women & family members providing care for them.	FHB, RDHSs, MOMCH	X	X	X	X
		B1.6.2. Implement a BCC package to address cultural, social & financial barriers to seek timely appropriate care for mothers with complications	FHB, HEB, SLCOG	X	X	X	X
	Major activity	B1.7. Update / Develop/ implement national guidelines, protocols and standards for management of medical diseases complicating pregnancies and obstetric emergencies					
	Sub activities	B1.7.1. Develop and disseminate management guidelines for heart disease and respiratory disease complicating pregnancies (leading causes of maternal deaths)	FHB, SLCOG	X	X		
		B1.7.2. Review the existing guidelines and identify the conditions which need to develop guidelines and which need to update.	FHB, SLCOG		X		
		B1.7.3. Update the mobile application for MNH guidelines and promote it among medical and other related professionals.	FHB, SLCOG, UOM		X	X	
		B1.7.4. Develop and introduce antenatal screening for mental conditions during pregnancy	FHB, SLCOG, D/Mental Health		X	X	
		B1.7.5. Develop auditing tools based on the national standards, guidelines and protocols (refer A3.2)					
	Major activity	B1.8. Establish a mechanism to follow up women with pregnancy related medical or mental health problems with necessary counselling & interventions during inter-pregnancy period					
	Sub activities	B1.8.1 Establish a mechanism to follow up women with pregnancy related medical or mental health problems with necessary counselling & interventions during inter-pregnancy period	FHB, SLCOG, D/Mental Health		X	X	

		Strategic objective/ Strategy	Responsibility	Time frame			
		B1.8.2 Scale up the mechanism to follow up women with pregnancy related medical or mental health problems with necessary counselling & interventions during inter-pregnancy period	FHB, D/Mental Health, RDHSs, MOOMCH, MOOH			X	X
	Major activity	B1.9 Strengthen the linkages among Family Health Bureau, Epidemiology Unit, HEB and stakeholders for early identification and prompt action on epidemics such as influenza, dengue other communicable diseases.					
	Sub activities	B1.9.1 Establish information flow to enable immediate notification of suspected outbreaks to relevant stakeholders such as FHB and HEB	FHB, Epid Unit, HEB, D/ Information	X	X		
		B1.9.2. Create awareness on such situations among field health care workers providing antenatal care, GPs, VOGs immediately and disseminate management guidelines.	FHB, Epid Unit, HEB		X	X	X
		B1.9.3. Ensure the supply of necessary medicines in adequate stocks E.g.. Oseltamivir)	D/MSD, FHB, RDHSs, MOOMCH	X	X	X	X
		B1.9.4 Develop guidelines for inpatient care including a case definition	FHB, SLCOG		X	X	
		B1.9.5 Establish an outbreak response team to address and manage epidemics affecting maternal and newborn health	DMU, FHB, HEB, SLCOG, SLCP, PSSL	X			
	Major activity	B1.10 Strengthen identification of HIV and STIs and care during pregnancy, labour and postnatal period to prevent mother to child transmission of HIV and STIs					
	Sub activities	B1.10.1Update guidelines to screen HIV and STIs among pregnant women and management	FHB, NSACP, SLCOG		X		
		B.1.10.2 Strengthen screening and management of HIV / STIs during pregnancy	FHB, NSACP, MOOMCH, Regional STD clinics		X	X	X
		B.1.10.3 Support mothers with HIV and STIs with infant feeding as per national guidelines	FHB, NSACP, MOOMCH, MOOH	X	X	X	X
		B.1.10.4 Establish facilities for counselling for women with families with HIV and STIs	FHB, NSACP, MOOMCH, HOIs, MOOH	X	X		
B2	Strategy	Ensure early Identification and management of causes of morbidities and mortalities in all newborns					
	Major activity	B2.1. Strengthen existing Newborn screening programmes such as congenital hypothyroidism, critical congenital heart diseases and introduce screening for congenital deafness					
	Sub activities	B2.1.1. Prepare a national plan for neonatal screening with new developments, time line and costing.	FHB, SLCP, PSSL, SLCOL, D/MRI, Karapitiya University	X			
		B2.1.2 Strengthen and improve the quality of the new born screening programme for congenital hypothyroidism	FHB, D/MRI, Karapitiya Uni, HOIs, Consultants of respective units, MOOMCH	X	X	X	X
		B2.1.3 Scale up the already started screening programme for critical heart diseases	FHB, HOI, Consultants of respictive units, DDG BME,	X	X	X	X
		B2.1.4 Initiate and scale up the newborn screening for congenital deafness	DDG PHS II, FHB, SLCOL, DDG BME, DDG MSD, Consultants at screening centres and referal centres	X	X	X	X
		B2.1.5 Advocate for adequate and uninterrupted funding for neonatal screening programmes.	Chief Accountant, DGHS	X	X	X	X
	Major activity	B2.2. Strengthen regionalization of new born care by establishment and implementation of levels of newborn care according to the Circular FHB / INBU/ 2014/03					
	Sub activities	B2.2.1. Advocate the central, provincial and district level health authorities on rationale and plan for regionalization of newborn care	FHB, SLCP, PSSL	X	X		

		Strategic objective/ Strategy	Responsibility	Time frame			
		B2.2.2. Prepare a development/ upgrading plan for new born care units with human resource development plan.	FHB, SLCP, PSSL, PDHSs, RDHSs, HR Unit MoH+D212 D212:J217	X	X		
		B2.2.3 Allocate funds, human resource and infrastructure to newborn care units according to norms	CA, DDG MS I & II	X	X	X	X
	Major activity	B2.3. Scale up neonatal retrieval system by establishing retrieval teams in all provinces					
	Sub activities	B2.3.1. Develop a plan to scale up neonatal retrieval system with HR, other infrastructure and cost	DDG PHS II, FHB, DDG BME, DDG MS I & II, D/ Transport	X	X		
		B2.3.2. Establish neonatal retrieval centers by identifying the neonatal networks with a Level III+/III unit as a lead according to the plan.	DDG PHS II, FHB	X	X		
		B2.3.3. Institutionalize and strengthening of the guideline and training on neonatal retrieval	FHB, SLCP, PSSL, D/ Training	X	X	X	X
		B2.3.4. Advocate infrastructure, human resource and funding for neonatal retrieval	FHB	X	X		
		B2.3.5. Establish an information system on neonatal retrieval	FHB, D/Information, MSU	X	X		
	Major activity	B2.4. Establish a national neonatal care Bed availability system to facilitate care for critically ill newborns					
	Sub activities	B2.4.1. Strengthen the NICU/SCBU bed availability monitoring system	DDG MS I, DDG PHS I, FHB, D/Information,	X	X	X	X
		B2.4.2. Create awareness on the NICU/SCBU bed availability system among relevant institutions.	FHB, PSHSs, RDHSs, MOOMCH	X	X	X	X
		B2.4.3 Link neonatal retrieval system with NICU/SCBU bed availability system.	FHB, D/Information	X			
		B2.4.4 Establish a system to review the neonatal care bed availability system	FHS, D/MS, D/Information	X	X		
	Major activity	B2.5. Establish Neonatal intensive care surveillance system to improve quality of advanced newborn care					
	Sub activities	B2.5.1. Establish a web based information system for NICUs	FHB, DDG MS I, D/ Information, PDHS, RDHSs, HOI	X	X		
		B2.5.2 Strengthen infrastructure a trained human resources for neonatal care information system	DDH BME, DDG MS I & II, D/ Information, FHB, NeoNICUS	X	X		
		B2.5.3 Establish a monitoring system (outcome, processes, cost) based on the information system	FHB, NeoNICUs		X	X	
	Major activity	B2.6. Introduce a case based auditing system for severe neonatal morbidities and mortalities at the field and hospital level					
	Sub activities	B2.6.1 Develop auditing tools for common causes of neonatal morbidity and mortality based on national standards, guidelines and protocols	FHB, SLCP, PSSL		X	X	
		B2.6.2. Implement the auditing system as describe in strategic direction A1. 3.2.					
	Major activity	B2.7. Strengthen the care and management of the sick new born and follow up					
	Sub activities	B2.7.1. Review the existing guidelines to manage sick newborns and develop/ update necessary guidelines and protocols.	FHB, SLCP, PSSL		X	X	
		B2.7.2. Update the mobile application for MNH guidelines and create awareness among medical professionals regarding the application.	FHB, SLCP		X		
		B2.7.3. Introduce early development care package to all parents of sick newborns	FHB, SLCP			X	
		B2.7.4. Introduce a follow up plan with shared care (with hospital and field) for all sick newborns up to their preschool years	FHB, SLCP, PSSL		X	X	

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	B2.8. Create awareness among health workers, mothers, families and the community on the need to prevent and seek timely health care for any illness in the newborn					
	Sub activities	B2.8.1. Introduce a system for risk identification in all newborns using standardized observation charts with specific plans for management	FHB, SLCP, PSSL		X	X	
B3	Strategy	Ensure health and nutrition of women using life cycle approach enabling them to go through pregnancy, labour & postnatal period safely					
	Major activity	B3.1. Strengthen implementation of national programmes to improve the health and nutritional status of every girl child from birth to adulthood/ reproductive age.					
	Sub activities	B3.1.1. Strengthen the implementation of Infant and young child feeding, growth monitoring and promotion, nutrition supplementation and immunization with special emphasis on care of preterm, low birth weight and sick babies	FHB, Epid Unit, RDHSs, MOOMCH, MOOH	X	X	X	X
		B3.1.2Implement interventions to improve nutritional status (anemia, underweight, over weight and obesity) specially among girls	FHB, D/Nutrition, D/Estate & Health Sector, MOOMCH, MOOH	X	X	X	X
		B3.1.3 Strengthen follow up of children with medical conditions identified at SMI	FHB, MOOMCH, MOOH, HOIs	X	X	X	X
		B3.1.4 Establish a link between Peadiatric care and obstetric services to follow up girls with cardiac diseases with continuum of care	FHB, SLCOG, SLCP, HOIs	X	X		
		B3.1.5 Establish a system to screen and identify girls with cardiac disease and establishing the risk of becoming pregnant	FHB, SLCOG	X	X		
		B3.1.6 Strengthen the family counseling for children with medical conditions specially with regard to girls	FHB, HEB, MOOMCH, MOOH	X	X	X	X
		B3.1.7 Strengthen micro nutrient supplementation and anthelminthic treatment programmes and ensure complete immunization as per schedule for children and adolescents in and out of the schools.	FHB, RDHSs, MOOMCH, MOOH	X	X	X	X
		B3.1.8 Develop a programme to reach girls /adolescents & youth who are out of school and in different settings (domestic servants, detention homes, employees etc.) and identify health and nutritional problems among them and manage appropriately.	FHB, D/Nutrition, HOIs		X	X	
		B3.1.9.Establish Adolescent and Youth friendly health services to cater health, nutritional and psycho special issues of adolescents and youths.	FHB, SLCP, HOIs	X	X	X	X
		B3.1.10 Strengthen the implementation of national maternal care programme according to the guidelines to improve nutritional and health status of pregnant and lactating women with special emphasize on micronutrient supplementation for lactating women.	FHB, RDHSs, MOOMCH, MOOH	X	X	X	
		B3.1.11 Strengthen the micronutrient supplementation programme for pregnant and lactating women	FHB, RDHSs, MOOMCH, MOOH	X	X	X	X
		B3.1.12 Continue the Implementation of prepregnancy and interpregnancy programmes and carry out the developments as describe in section A4.1 and A4.2.					
		B3.1.13 Identify nutritionally disadvantaged geographical pockets by mapping and implement special targeted interventions to improve nutritional status of girls and women	FHB, D/Nutrition, D/Nutrition Coordination, D/Estate Health		X	X	
		B3.1.14 Coordinate all nutrition intervention programs implemented by various organizations to avoid duplication and improve quality for pregnant and lactating women	D/Nutrition Coordination	X	X	X	X
		B3.1.15 Monitor & evaluate all nutrition programmes using uniform indicators to follow up progress.	D/Nutrition Coordination	X	X	X	X
	Major activity	B3.2. Implement appropriate BCC programmes on MNH and nutrition targeting all stages of the life cycle.					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Sub activities	B3.2.1. Develop and implement a costed comprehensive BCC plan to address issues related to MNH with time line (issues to address, means of communication etc.)	HEB, FHB	X	X		
		B3.2.2. Advocate to mobilize funds for the developed plan	HEB, FHB		X		
		B3.2.3 Develop stories/ dramas on maternal deaths on medically contraindicated pregnancies and publish widely to make aware the public.	HEB, FHB		X	X	
B4	Strategy	Enable all couples / individuals optimally time and space their pregnancies while preventing unintended conceptions					
	Major activity	B4.1. Strengthen pre pregnancy, interpregnancy and maternal care programmes to empower couples for appropriate use of contraception to plan pregnancies.					
	Sub activities	B4.1.1. Develop appropriate IEC material on "Planning a family" to use for classes for newly married couples and antenatal classes.	FHB, HEB	X	X		
		B4.1.2. Develop/update comprehensive training package for health workers on contraception including skill development for counseling.	FHB, HEB	X	X		
		B4.1.3. Include training on contraception to all mandary in-service training programmes for MNH staff	FHB, HEB	X	X		
	Major activity	B4.2. Ensure the implementation of circular ..... on providing contraceptive services in the health sector with appropriate method mix					
	Sub activities	B4.2.1. Monitor the implementation of the circular through MCH reviews and hospital directors meeting with appropriate indicators.	FHB, D/Planning	X	X	X	X
		B4.2.2. Develop a costed plan to establish/upgrade contraceptive services in the country.	FHB, SLCOG	X	X		
		B4.2.3. Expand the PPIUD and laparoscopic LRT services with infrastructure and training	FHB, SLCOG, BME	X	X	X	
		B4.2.4.Establish a system to provide FP commodities to private sector and getting returns from them (As for vaccines) to improve accessibility and affordability.	FHB	X	X		
	Major activity	B4.3. Generate client demand for contraceptive services					
		B4.3.1. Develop a comprehensive IEC/ BCC plan to increase demand for contraceptive services with costing and implementation plan	HEB, FHB		X	X	
		B4.3.2.Develop uniform set of messages to use for social marketing campaigns (rebranding).	HEB, FHB		X	X	
		B4.3.3.Revise the reading material (leaflets and posters) on contraceptive methods and print and disseminate them adequately.	HEB, FHB, RDHS, MOOMCH	X	X	X	X
		B4.3.4 Establish / strengthen family planning clinic services 7 days a week in all specialist / all hospitals	HOI, FHB, RDHSs, MOOMCH	X	X	X	X
	Major activity	B4.4.Establish/strengthen contraceptive services for high risk groups such as those with medical contraindications for pregnancy (heart disease, malignancies), sexually active single individuals including adolescents and widows.					
	Sub activities	B4.4.1. Link the cardio thoracic surgical units, cardiology units and medical units with Obstetricians to provide appropriate contraception methods for women who are the risk of medically contraindicated pregnancies	DDG MS I & II, FHB, SLCOG, SLCP, SLCS		X	X	
		B4.4.2.Monitor the implementation of such linkages through hospital management committees and hospital director's meetings	D/Planning, FHB		X	X	X
		B4.4.3 Develop a system and Link the post abortion women/ couples with appropriate contraceptive services at the hospital or field.	FHB, RDHSs, MOOMCH, MOOH, HOIs		X	X	X
	Major activity	B4.5. Strengthen services for sub fertile couples.					
	Sub activities	B4.5.1. Review/ evaluate the services available for sub fertile couples in the country.	FHB, SLCOG	X			

		Strategic objective/ Strategy	Responsibility	Time frame			
		B4.5.2. Develop a costed plan to expand services for sub fertile couples based on the findings of the review/evaluation.	FHB, SLCOG		X		
		B4.5.3. Advocate for funding for the costed plan based on the scaling up plan.	FHB, SLCOG		X		
C	Strategic objective 03	Strengthen health systems to respond to the needs and priorities of women, newborns and their families					
C1	Strategy	Ensure governance and leadership for MNH					
	Major activity	C1.1.Advocate to revive the National Health Council to monitor and address Health related issues including MNH target achievement					
	Sub activities	C1.1.1 Advocate to monitor and address health related issues including MNH targets	DDG PHS II, FHB (M & NB)	X	X	X	X
		C1.1.2. Advocate and create awareness on MNH including targets among parliamentarians, policy makers and central & provincial administrators.	DDG PHS II, FHB (M & NB)	X	X	X	X
	Major activity	C1.2.Strengthen National committee on Family Health, Technical Advisory Committees on Maternal Health and Family Planning (TACMHFP) and Newborn and Child Health (TACNCH)					
	Sub activities	C1.2.1. Ensure participation of all appointed members for the committee meetings.	DDG PHS II	X	X	X	X
		C1.2.2. Create awareness among all stakeholders on the role of TACs.	DDG PHS II, FHB (M & NB)	X	X	X	X
	Major activity	C1.3. Advocate for MNH/FP related issues as agenda items at the Provincial Health Minister's meetings, National Health Development Committee (NHDC), Health Development Committee (HDC) and Hospital Directors Meeting					
	Sub activities	C1.3.1. Request to allocate a regular time slot to discuss issues related to MNCAH.	FHB (P), D/Planning	X			
		C1.3.2. Develop lists of indicators/activities to be monitored at each meeting and introduce a reporting mechanism.	FHB (M,N,C, A, S, PreP, FP, P, M&E)	X			
		C1.3.3. Present the proposed strategic plans, development plans and targets at these meeting to ensure commitment for implementation and achieving targets.	FHB (P)	X	X	X	X
	Major activity	C1.4.Ensure the implementation and monitoring of MNH NSP at central, provincial , district and divisional levels.					
	Sub activities	C1.4.1. Establish a national coordinating mechanism to ensure implementation of NSP (2017-2025) & monitor progress	DDG PHS II, FHB (P)	X			
		C1.4.2. Monitor the progress of annual implementation plan of MNH strategic plan at TACs as routine agenda item.	DDG PHS II (M, N)	X	X	X	X
		C1.4.3. Train the provincial and district level staff who are responsible on MNH services on planning for implementation and facilitate and guide them accordingly	FHB (P, M, N)	X	X	X	X
		C1.4.4. Develop, implement and monitor annual operational plans based on the MNH strategic plan of the strategy at provincial and district level	FHB (P, M, N), RDHSs, MOOMCH	X	X	X	X
		C1.4.5 Strengthen the collaboration between central, provincial, district level healthcare delivery systems to plan, implement and monitor NSP	FHB (P, M, N), RDHSs, MOOMCH	X	X	X	X
	Major activity	C1.5. Develop a national master plan for improving MNH services while ensuring equity, universal health coverage, accountability & transparency					
	Sub activities	C1.5.1. Develop a national master plan for improving MNH services in the country including infrastructure development, HR and technology placement	DDG PHS II, FHB (M & N), DDG MS, DDG BME	X	X		
		C1.5.2. Advocate and create awareness regarding the plan to health authorities at central, provincial and district level.	DDG PHS II, FHB (M & N)		X	X	X
	Major activity	C1.6. Strengthen the national focal point (FHB) to plan, coordinate, monitor and provide technical guidance and direction to the national MNH programme					
	Sub activities	C1.6.1. Define roles and responsibilities and terms of reference of the staff allocated for the units	DDG PHS II, DDG MS I & II, FHB (M & N),	X	X		

		Strategic objective/ Strategy	Responsibility	Time frame			
		C1.6.2. strengthen the national focal point with providing human resources and infrastructure according to norms	DDG MS I & II, D/MS	X	X	X	X
		C1.6.3.Ensure regular capacity building of National Programme Managers on updating MNH services	FHB (DMCH, M, N)	X	X	X	X
		C 1.6.4 Strengthen linkages with other programmes such as Women's Health/ Family Planning, Adolescent and school health, NSACP, NCD, Mental Health and HEB.	FHB (DMCH, M, N)	X	X	X	X
		C 1.6.5 Web based system to share information, provide guidance and direction to MNH stakeholders	FHB (M&E)	X	X	X	X
	Major activity	C1.7. Strengthen collaboration to improve MNH outcomes with professional colleges, private sector, development partners and community as appropriate.					
	Sub activities	C 1.7.1 Develop strategies to strengthen collaboration to improve MNH outcome with above parties	FHB (M & N)	X	X		
C2	Strategy	Ensure financial security for MNH service delivery					
	Major activity	C2.1.Strengthen the separate budget line for MCH and closely monitor for regular cash flow to implement planned MNH activities at all levels.					
	Sub activities	C2.1.1. Secure adequate funds for contraceptive commodities, micronutrients, MN investigations and training	FHB (DMCH)	X	X	X	X
		C2.1.2. Advocate to secure regular funds for MNH services and training in district and institutional plans	FHB (M & N), PDHSs, RDHSs, MOOMCH	X	X	X	X
		C2.1.3. Establish a monitoring mechanism between the FHB and the financial division of the MoH to ensure uninterrupted cash flow.	DDG PHS II, FHB (P), DDG Finance	X	X		
		C 2.1.4 Ensure separate financial allocation for Labour Rooms and neonatal units as per level of care at institution/district level with audit of the usage of such accounts	DDG PHS II, FHB (P), DDG Finance	X	X	X	X
		C 2.1.5Ensure dedicated funding for in-service training in maternal and newborn care at District level	DDG PHS II, FHB (P), DDG Finance	X	X	X	X
	Major activity	C2.2. Cost all the interventions and the annual MNH plans well ahead of the financial deadlines.					
	Sub activities	C2.2.1. Develop costed plans: annual plans, development plans, scaling up plans etc.	FHB (M & N), RDHSs, MOOMCH	X	X	X	X
		C2.2.2.Conduct cost-effectiveness analysis when introducing new interventions to optimize resource utilization	FHB (M &N)	X	X	X	X
		C2.2.3. Establish a system to review costs and financing options when introducing new interventions or procedures.	FHB (M &N)	X	X		
	Major activity	C2.3. Strengthen collaboration with development partners and other stakeholders to generate additional resources (financial & other) to strengthen MNH services & address inequity.					
	Sub activities	C2.3.1. Develop plans to be shared with development partners based on MNH strategic plan and implementation plan	FHB (M, N, P)	X	X	X	X
		C2.3.2. Maintain a good relationship/ communication and monitoring mechanism with development partners to mobilize funds and to obtain technical expertize as required,	FHB (M, N, P)	X	X	X	X
		C2.3.3. Develop guidelines for ethical practices in resource mobilization for MNH related activities	FHB (P)	X	X	X	X
	Major activity	C2.4. Establish a mechanism to involve financial authorities in the planning , monitoring & evaluation processes of the programme at central, provincial &district levels					
	Sub activities	C2.4.1. Establish a close coordination with national planning unit at finance ministry and planning unit at Ministry of Health	FHB (P)	X	X	X	X
		C2.4.2. Communicate strategic plan and annual implementation plans at nation level to them.	FHB (P)	X	X	X	X
C3	Strategy	Streamline the MNH service delivery system					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	C3.1. Establish Clinical governance system for MNH					
	Sub activities	C3.1.1.Develop indicators to monitor the implementation of national guidelines and in cooperate in to the routine MIS and monitoring mechanisms (MCH review, NHDC, HDC, Hospital director's meeting).	FHB (M, N, M & E)	X	X		
		C3.1.2. Develop clinical auditing tools based on the national standards, guidelines and protocols (ref A3.2).					
		C3.1.3. Strengthen/establish the clinical review mechanisms such as clinical audits, death reviews and morbidity reviews	FHB (M, N, MM Survei)		X	X	X
	Major activity	C3.2. Strengthen shared care, referral and back referral systems to improve quality of MNH services					
	Sub activities	C3.2.1. Initiate discussions at district level to minimize the duplication and overcrowding of MNH services through implementation of shared care model according to guidelines.	FHB (M), RDHSs, MOOMCH, HOI	X	X	X	X
		C3.2.2. Establish a telephone based communication system (to hospital to filed and vise versa) to manage and follow up women and newborns with complications and risks.	FHB (M & E)	X	X		
		C3.2.3 Utilize divisional hospitals to support MNH services as required (hospital to home)	FHB (M & E)	X	X	X	X
		C3.2.4 Strengthen/ streamline the procedures of transferring/referring maternity cases and newborns (communication, initial management, accompanying staff etc.) (refer B.1.5).					
	Major activity	C3.3. Regionalization of new born care services and centralization of highly specialized maternal care services according to the guideline/circulars					
	Sub activities	C3.3.1 Needs assessment according to standards and guidelines	FHB (N)		X	X	
		C3.3.2 Establish highly specialized centers in DMH, TH Kandy and TH Anuradhapura to manage highly complicated cases (Refer) .	FHB (M), HOIs of respective hospitals	X	X	X	
		C3.3.3. Establish / strengthen Neonatal units - level I, II. III. III+ in the country according to the circular.	HOIs, Consultants of respective units	X	X	X	X
		C3.3.4 Use technology such as GIS mapping (delivery pattern, case load, transfer patterns, staff availability) periodically to identify places to establish / upgrade MNH services	FHB (M, N, M & E)	X	X	X	X
		C3.3.5 Develop a linked system of communication (e.g.. ICU bed availability) using modern technology to avoid delays in providing care .	DDG MS I, FHB, ICU Bed availability System, NeoNICS	X	X		
		C3.3.6. Provide round the clock transport services with inbuilt facilities to provide care during transport (transport incubators, oxygen etc.)	DDG PHS II, FHB (n) , D/ Transport	X	X	X	X
		C3.3.7 Develop guidelines for referral of mothers and babies to higher levels of care to receive timely specialized care	FHB (M, N), SLCOG, SLCP, PSSL	X	X		
	Major activity	C3.4. Strengthen/streamline supportive services to provide essential and Emergency care for women & new borns including those who are critically ill.					
	Sub activities	C3.4.1.Establish high dependency units at every specialist obstetric unit in the country	FHB (M), HOIs, PDHS, RDHSs	X	X	X	X
		C3.4.2. Establish MBCs and LMCs in all specialist hospitals	FHB (N), HOIs, PDHS, RDHSs	X	X	X	X
		C3.4.3. Provide 24*7 services: blood transfusion, radiology, laboratory, Theatre services in all specialist hospitals	HOIs, PDHS, RDHS	X	X	X	X
		C 3.4.4 Provide 24*7 laboratory services with facilities for essential investigations to manage maternal and new born emergencies available in all specialist hospitals	HOIs, PDHS, RDHS	X	X	X	X
		C3.4.5 Establish dedicated obstetric operating theaters based on the case load in selected institutions or have designated theater tables for obstetric emergencies in other institutions	HOIs, PDHS, RDHS	X	X	X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
		C3.4.6. Establish effective communication systems using modern technology to coordinate and strengthen supportive services between hospitals (including private hospitals) in MNH service delivery	HOIs, PDHS, RDHS	X	X	X	X
		C3.4.7. Establish linkages with nearby hospitals in providing supportive services as back up methods	HOIs, PDHS, RDHS	X	X	X	X
		C3.4.8. Strengthen ambulance facilities to avoid delays in providing MNH care.	D/Transport, HOIs, PDHS, RDHS	X	X	X	X
	Major activity	C3.5 Establish / Strengthen public health, health education, quality and infection control units in all hospitals with specialist services					
	Sub activities	C 3.5.1Define specific roles and responsibilities related to MNH in the public health, health education, quality and infection control units	DDG MS I, DDG PHS II, FHB (M, N, P)	X	X		
		C 3.5.2 Develop indicators to monitor the functions of public health, health education, quality and infection control units of hospitals	DDG MS I, DDG PHS II, FHB (M, N, P)	X	X		
		C 3.5.3 Review functions of the above units at regular reviews for the institutions	DDG MS I, DDG PHS II, FHB (M, N, P)	X	X	X	X
		C 3.5.4 Strengthen the practice of universal precautions	HOI	X	X	X	X
		C 3.5.5 Establish / strengthen quality assessment and quality assurance in hospitals in MNH units (Refer A 3.1)					
	Major activity	C3.6. Streamline/strengthen the supportive supervision at field and institutional level					
	Sub activities	C3.6.1. Revise supervision check list for field staff and define/streamline the supervision hierarchy	FHB (P)		X	X	
		C3.6.2. Develop supervision check list for institutional staff and define supervision norms and hierarchy.	DDG MS I, DDG PHS II, FHB (M, N, P)		X	X	
		C3.6.3. Evaluate indicators related to supervision to routine reporting and monitoring systems where relevant	FHB (P). MSU	X	X	X	
	Major activity	C3.7. Streamline/strengthen regular monitoring at institutional and field level					
	Sub activities	C3.7.1. Include monthly performance monitoring of PHM on selected indicators as a routine activity in the monthly conference.	FHB (P), MOOH	X	X	X	X
		C3.7.2. Develop a mechanism to monitor the performance of maternity and newborn units monthly with selected indicators at the hospital level	FHB (P, M, N)	X	X		
		C3.7.3. Evaluate the MCH review mechanism to improve the outcome	FHB (P)		X	X	
C4	Strategy	Ensure adequately staffed, teams of competent health care workers provide care during pregnancy, labour and postnatal period for every mother and baby					
	Major activity	C4.1. Identify workload based cadre norms and new cadres to improve the quality of MNH services and make carder projections for the next 10 years					
	Sub activities	C4.1.1. Develop cadre norms for all categories of staff in MNh services based on the case load.	HR Unit MoH	X	X		
		C4.1.2. Identify new cadres e.g. counselors, social workers, health information assistants, new sub specialties for MNH services	HR Unit MoH	X	X		
		C4.1.3. Develop cadre projections for next 10 years and plan recruitment and training accordingly.	HR Unit MoH	X	X		

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	C4.2. Define /redefine roles and responsibilities for health workers involving MNH services with job descriptions and terms of reference					
	Sub activities	C4.2.1 Define roles and responsibilities of each category of staff based on place of work, type of services delivered	FHB (P), HR Unit MoH	X	X		
		C 4.2.2 Introduce task shifting for all staff categories	DDG MS I & II, DDG PHS II		X	X	
		C4.2.3 Develop terms of reference for each category based on the place of work and service delivery.	DDG MS I & II, DDG PHS II		X	X	
	Major activity	C4.3. Advocate for regular recruitment and deployment of necessary carders					
	Sub activities	C4.3.1. Develop and implement a recruitment plan based on cadre projections and capacity of the training centers.	DDG MS I & II, DDG PHS II		X	X	
		C4.3.2. Develop a data base for Human resources for ministry of Health and maintain a subdata base for MNH related carders at FHB	HR Unit MoH, FHB (P)	X	X		
		C4.3.3. Develop deployment plans for all categories including specialist to maintain the transparency and equity.	DDG MS I & II, DDG PHS II	X	X		
		C4.3.4. Establish a staff allocation criteria for all institutions and field level	DDG MS I & II, DDG PHS II	X	X		
	Major activity	C4.4. Streamline/ strengthen the continuous professional education through pre placement and in-service training (Refer A2.5)					
	Sub activities	C4.4.1. Define a essential packages of pre placement and in-service trainings and frequency of refresher training for each category of staff at different levels and different departments	DDG ET&R, DDG PHS II, FHB (M, N, P)		X	X	
		C4.4.2. Develop and maintain training data based for units, institutions and districts.	FHB (M, N, P), RDHSs, HOIs	X	X	X	X
		C4.4.3. Conduct annual training needs assessments and prepare and implement training calendar accordingly.	FHB (M,N,P)	X	X	X	X
	Major activity	C4.5. Introduce an incentive scheme to motivate and retain health workforce for MNH services					
	Sub activities	C4.5.1. Introduce incentive system to staff working in preventive health sector in difficult areas and units with high case loads.	DDG PHS II, DDG MH I & II, DMCH	X	X	X	X
		C4.5.2. Advocate and identify a system to retain the highly trained staff in NICUs and ICUs.	DDG PHS II, DDG MH I & II, DMCH	X	X		
		C4.5.3. Provide opportunities for staff in NICUs and ICUs to get exposure to centers in developed countries.	DDG PHS II, DDG MH I & II, DMCH	X	X	X	X
C5	Strategy	Ensure high quality medicines, equipment and appropriate technologies for MNH services					
	Major activity	C5.1. Strengthen the logistics management system for medicines, equipment and other supplies for MNH services					
	Sub activities	C5.1.1. Maintain a computerized equipment database at the national, district and institutional level BME units.	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X	X	X
		C5.1.2. Establish a system to replace when a piece of equipment is removed for repair	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X		
		C5.1.3. Prepare procurement plans based on replacements and broken/ malfunctional equipment.	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X	X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
		C5.1.4. Establish/strengthen centralized procurement systems with SOPs to facilitate the maintenance	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X		
		C5.1.5. Establish universal specification system with regular updating	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X		
		C5.1.6. Establish a mechanism to repair and maintenance of equipment (with SOPs, checklists and appointing staff)	DDG BME, Provincial District BMI Units, BMI units in Institutions	X	X		
		C5.1.7. Update periodically the norms for drugs and equipment for MNH at institutions and field level	DDG BME, Provincial District BMI Units, BMI units in Institutions, FHB (M, N), SLCOG, SLCP	X	X		
	Major activity	C5.2. Strengthen the system of recommendation of new drugs and technologies for MNH services (DESC, TACs)					
	Sub activities	C5.2.1. Institute health Technology Assessment (HTA) mechanisms at ministry level for new drugs , equipment and interventions	D/CDDA,	X	X		
		C5.2.2. Strengthen the Drugs evaluation sub Committee (DESC) and Technical advisory committees.	D/CDDA,	X	X		
	Major activity	C5.3. Address quality issues of drugs supplied to the maternal and neonatal units through the system					
	SSub activities	C5.3.1. Improve the quality control process for drugs and commodities through strengthening the National Drug Quality control Laboratory (NDQL) with necessary equipment and human resources.	Chairman NDQL, DDG BME, DDG MS I & II	X	X	X	X
		C5.3.2 Strengthen reporting system of adverse events following drug administration	Chairman NDQL, HOIs	X	X		
C6	Strategy	Ensure the availability of up to date information for planning, monitoring and decision making in MNH care					
	Major activity	C6.1. Develop a common information system which facilitate routine MNH information and surveillance systems (prenatal, infant and maternal mortality and morbidity , and birth defects)					
	Sub activities	C6.1.1. Review/ evaluate the current information and surveillance systems to assess the degree of duplication and possibilities for integration.	FHB (M & E, MM Surveillance)	X	X		
		C6.1.2. Develop computer based health information system linking field and institutional MNH/ health services with inbuilt feed back mechanism.	FHB (M & E, MM Surveillance)	X	X		
		C6.1.3. Advocate for appointing for appointing officers to manage data at ward level	DGHS, DDG Administration	X	X		
	Major activity	C6.2. Link the hospital information system with the digitalized field based RHMIS					
	Sub activities	C6.2.1 Digitalize the hospital based information system	FHB, Medical Statistician, D/ Information	X	XX	X	
		C6.2.2 Develop and implement web based information system for field based RHMISlinking with hospital based system.	FHB (M & E), MSU, D/ Information	X	X		
		C6.2.3 Link the data systems within the hospital digitally	HOI		X	X	X
		C6.2.4 Develop costed plans for development and scaling up of such system (equipment, training, etc.)	FHB (M & N)	X	X		
		C 6.2.5 Establish / strengthen the system to include maternal and neonatal data to electronic Indoor Mortality and Morbidity Return	MSU, FHB (M, N, M & E)	X	X		
	Major activity	C6.3. Institutionalize the obstetric BHT and newborns BHT to facilitate the data extraction and entry for systems.					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Sub activities	C6.3.1 Introduce and strengthen use of obstetric and neonatal BHTs in all institutions providing maternal and neonatal care	FHB (M, N), HOI	X	X	X	X
		C6.3.2 Establish the information follow from the obstetric and newborn BHTs through eIMMR to the center	MSU, HOIs	X	X	X	X
		C6.3.3 Train the hospital staff, Medical records officers on the use of and data extraction from BHTs to the eIMMR.	MSU, FHB (M, N, M & E)	X	X	X	X
	Major activity	C6.4. Establish/ strengthen the mechanism to disseminate information to all relevant stakeholders including general public.					
	Sub activities	C6.4.1 Ensure timely publication of annual health bulletin and annual report on family health	DDG Planning, D/Planning, DMCH, FHB (M & E)	X	X	X	X
		C6.4.2. Establish and publish the National Policy on Data Sharing	DDG Planning	X	X		
	Major activity	C6.5. Generate evidence through operational research to improve MNH services					
	Sub activities	C6.5.1. Establish a mechanism to allocate funds for research in support of MNH	CA, DDG Finance, DMCH	X	X		
		C6.5.2. Establish a local research data base and ensure its appropriate use.	FHB (Researcy)	X	X		
		C6.5.3. Apply local research findings to improve service delivery & service utilization.	FHB (M, N)	X	X	X	X
		C6.5.4. Identify research areas as relevant for MNH programme through the advisory committees (Maternal, Newborn health) and other collaborative organizations.	FHB (M N)	X	X	X	X
		C6.5.5.Encourage and support postgraduate students and other researchers to undertake relevant research in the area of MNH	FHB (M N)	X	X	X	X
		C6.5.6. Organize an annual event to present research findings, success stories and new innovations related to MNH.	FHB (M N)	X	X	X	X
D	Strategic objective 04	Ensure universal health coverage for comprehensive (essential & emergency) maternal and newborn health care, addressing inequities in access to quality care					
D1	Strategy	Ensure implementation of all the evidence based interventions on MNH based on current epidemiology to achieve UHC for essential and comprehensive MNH care					
	Major activity	D1.1. Review and update MNH interventions, care packages, guidelines, protocols and circulars once in 3 years (Refer A.1)					
	Sub activities	D1.1.1. Review and revise the maternal care package	FHB (M), SLCOG		X	X	
		D1.1.2. Develop and disseminate protocols, flow charts, wall charts, desk top guides etc. as required to facilitate the implementation of guidelines.	FHB (M, N), SLCOG, SLCP, PSSL		X	X	X
		D1.1.3. Ensure availability of all the guidelines, protocols and circulars as relevant to different levels of health care both electronically (mobile application, websites etc.) and printed forms.	FHB (M, N), HOIs, MOOMCH, MOO Public Health	X	X	X	X
	Major activity	D1.2.Strengthen/ establish a system to monitor Implementation of national maternal and newborn care packages at field and institutional level					
	Sub activities	D1.2.1. Develop suitable indicators and incorporate into the existing reporting and monitoring mechanisms to monitor the implementation of guidelines.	FHB (M, N, M &E)		X	X	
		D1.2.2. Develop and implement clinical auditing tools based on national guidelines and protocols (Refer A 3.2).					
	Major activity	D1.3. Strengthen the supportive supervision to ensure quality implementation of MNH interventions (Refer C3.5).					
	Major activity	D1.4 Revise and review existing policies related to MNH and formulate new policies to address inequities in universal coverage.					
	Sub activities	D 1.4.1 Revise and review existing policies related to MNH and formulate policies to ensure universal coverage	FHB (M, N)			X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
D2	Strategy	Ensure quality MNH services to reach entire target population including all underserved and hard to reach populations					
	Major activity	D2.1. Identify special vulnerable groups within the defined areas (MOH/PHM)E.g.:, Estate, urban slum population ,rural poor, adolescents, commercial sex workers, those in detention homes, prisons , & orphanages, lesbians ,gay , those with disabilities (restricted to home & family, domestic servants, females in armed forces, free trade zone workers, Unmarried pregnant, socially stigmatized pregnancies, highest wealth quintile etc.					
	Sub activities	D2.1.1. Mapping of target populations against intervention package coverage and morbidity and mortality rates (selected indicators) up to GN level to identify gaps in coverage and outcomes.	FHB (M, N, M & E)		X	X	X
		D2.1.2.Update the eligible couple register and maintain a special register for vulnerable groups in each PHM area.	FHB (M&E)		X	X	X
		D2.1.3. Identify causes/barriers for disparity in access and address them appropriately.	FHB (M, N, M & E)		X	X	X
	Major activity	D2.2. Update routine information system with data in disaggregated form (sex, sector, Wealth quintile, age, vulnerability) and use them to understand the situation and determinants of inequity					
	Sub activities	D2.2.1. Introduce electronic data system to enter data at the point of generation e.g.. At PHM level, clinic, ward or labour room.	FHB (M, N, M & E), HOI, D/ Information		X	X	X
		D2.2.2. Introduce web based system for data management with inbuilt analysis and report generating facilities.	FHB (M & E)		X	X	X
		D2.2.3 Develop indicators to monitor implementation of the programme to ensure equity	FHB (M, N, M & E)	X	X		
	Major activity	D2.3. Address the language barriers of the Health care workers in MNH					
	Sub activities	D2.3.1. Map the staff vacancies in the MNH services and fill the vacancies prioritizing the areas with vulnerable populations.	FHB (M & E), PDHS, Provincial CCP, RDHS, MOOMCH		X	X	X
		D.2.3.2 Prioritize in appointing health care workers based on the language requirement of the area	PDHS, Provincial CCP, RDHS, MOOMCH	X	X	X	X
		D2.3.3 Develop and implement in-service programme to improve language skills of health care workers	PDHS, Provincial CCP, RDHS, MOOMCH	X	X	X	X
	Major activity	D2.4. Plan, design implement and monitor interventions to eliminate inequity and barriers for equity					
	Sub activities	D2.4.1. Conduct Short programme reviews in every two years at MOH/ district level to identify inequities in the service provision and monitor the progress.	FHB (P), Provincial CCP, MOOMCH	X	X	X	X
		D2.4.2. Identify the issues of accessibility using GIS mapping	FHB (P), Provincial CCP, MOOMCH	X	X	X	X
		D2.4.3. Address issues identified in D2.4.1. and D2.4.2)					
		D2.4.4 Identify and implement community strategies to increase demand for services in these areas & populations (Maternal and newborn care practices)	FHB (M, N), MOOMCH, MOOH		X	X	X
		D 2.4.5 Develop a plan to address avoid any form of discrimination barriers to communication (ethnic, language, cultural, social, financial, religious , mental or physical disability, HIV, STIs, etc.) which may cause delays in seeking care	FHB (M, N), MOOMCH, MOOH		X	X	X
		D 2.4.6 Provide all instructions in a language that is well understood by the women and their spouses & family members	FHB (M, N), MOOMCH, MOOH	X	X	X	X
		D 2.4.7 Implement a strong BCC package to address cultural, social & financial barriers to seek timely appropriate care.	FHB (M, N), HEB, MOOMCH, MOOH	X	X	X	X
		D 2.4.8 Increase awareness among vulnerable groups to seek care during pre-pregnancy and pregnancy	FHB (M, N), HEB, MOOMCH, MOOH	X	X	X	X

		Strategic objective/ Strategy	Responsibility	Time frame			
D3	Strategy	Ensure health financing for Universal Health Coverage in MNH					
	Major activity	D3.1. Ensure costed national MNH development and scaling up plans are implemented.					
	Sub activities	D3.1.1. Communicate the costed plans with planning units at MoH and Finance Ministry before the national budget every year.	FHB (P)	X	X	X	X
		D3.1.2. Advocate to ensure routine funds for MNH at district and institutional level	FHB (M, N), Provincial CCP, MOOMCH, MOOH	X	X	X	X
		D3.1.3. Discuss new interventions and procedures with cost analysis at TACs and obtain concurrence before implementation	DDG PHS II, FHB (M, N)	X	X	X	X
	Major activity	D3.2. Minimize Out of pocket expenditure involved in seeking quality MNH services by the client					
	Sub activities	D3.2.1. Streamline the referral from the field to higher centers for USS and investigations with clear guidelines and systems to prevent duplication and repeated visits.	FHB (M), MOOMCH, MOOH	X	X	X	X
		D3.2.2. Establish a system with MSD to monitor MNH commodities to prevent stock outs and maintain the quality	DMCH, DMSD	X	X		
		D3.2.3. Establish local systems to prevent duplication of clinic attendance and investigations	CCP Province, MOOMCH, MOOH, HOIs	X	X		
E	Strategic objective 05	Count every mother, fetus and newborn through measurement, programme tracking and accountability					
E1	Strategy	Ensure that all MNH target groups are identified and provide appropriate services					
	Major activity	E1.1. Develop/strengthen a system to identify all target groups relevant to MNH programme					
	Sub activities	E1.1.1 Strengthen the registration of eligible couples and maintain the eligible couple register by PHMs	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
		E1.1.2. Develop and implement care package for pre-pregnancy couples/ inter pregnancy couples (Refer A 4.1)					
		E1.1.3. Streamline/ strengthen the programme for newly married couples for facilitate eligible couple and pregnant women registration.	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
		E1.1.4 Strengthen identification of postnatal mothers at PHM level	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
		E1.1.5. Monitor the pre-pregnancy, interpregnancy and postnatal care at PHM level as a routine item of the monthly conference.	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
	Major activity	E1.2 Track and validate MNH related data from various sources to monitor consistency, uniformity and quality of data					
	Sub activities	E1.2.1 Develop /revise the indicators to track the MNH intervention coverage of target groups	FHB (M, N, M & E)	X	X		
		E1.2.2. Maintain a Red Book for pregnant women in danger	FHB(M), MOOMCH, MOOH	X	X	X	X
		E1.2.3 Monitor the population coverage of interventions by Including necessary information to RHMIS, eIMMR, DHS survey, census and other surveys to gather data	FHB (M, N, M & E), MSU, D/ Information	X	X	X	X
		E1.2.4 Revisit and revise the MCH review indicator list and include/ revise indicators as required.	FHB (M & E)	X	X		
		E1.2.5 Define the variables and indicators of MNH to ensure the uniformity of information collected (e.g.: DHS, Annual health bulletin, Reports of various organizations, Ministry of Health, Registrar General)	FHB (M, N, M & E), MSU, D/ Information	X	X		
		E1.2.6 Establish am annual review system to institutions to review MNH service delivery with selected indicators at the hospital level	FHB (M,N, M & E)		X	X	

		Strategic objective/ Strategy	Responsibility	Time frame			
E2	Strategy	Ensure that all births and deaths including still births are registered.					
	Major activity	E2.1. Develop/revise clear definitions for still births, neonatal deaths, perinatal deaths, infant deaths, child deaths and maternal deaths and disseminate					
	Sub activities	E2.1.1. Lobby for policies on timely registration of maternal deaths, stillbirths, neonatal and infant deaths.	FHB (MM Surveillance)	X	X	X	X
		E2.1.2. Validate the registration of deaths and births with hospital data system and surveillance system	FHB (MM Surveillance)	X	X	X	X
		E2.1.3. Produce a quarterly report on neonatal / perinatal data from the hospitals to support policy and practice	FHB (MM Surveillance)	X	X	X	X
	Major activity	E2.2. Create awareness among all marriage, birth and death registrars, coroners, and health staff on new developments in birth and death registration					
	Sub activities	E2.2.1. Conduct training programmes for newly appointed House officers on ICD classification and importance of writing of correct diagnosis and cause of deaths during good-intern program	MSU	X	X	X	X
		E2.2.2. Conduct training programmes for all coroners and marriage, birth and death registrars periodically on new developments of Birth and death registration	MSU	X	X	X	X
	Major activity	E2.3. Sensitize community leaders, civil society & general public regarding their responsibility in registering of all births, still births, newborn deaths and maternal deaths and confirming the cause of death					
	Sub activities	E.2.3.1 Conduct advocacy programmes for general public on importance and benefits through print and electronic media	FHB (MM Surveillance)	X	X	X	X
	Major activity	E2.4. Strengthen linkages with registrar generals department, medical statistics unit and other relevant stakeholders to ensure quality data through validation					
	Sub activities	E 2.4.1 Strengthen linkages with registrar general and medical statistics unit through regular meetings	MSU	X	X	X	X
		E 2.4.2 Ensure quality of data by cross validation of data from difference sources	FHB (MM Surveillance), MSU	X	X	X	X
E3	Strategy	Strengthens the RHMIS systems (hospital and field) for monitoring and evaluation of MNH programme at all levels					
	Major activity	E3.1. Revise/ strengthen the routine MNH data system					
	Sub activities	E3.1. 1.Review and revise all data entry records, formats and returns originating from hospital and field (PHM/MOH/clinics) to ensure data quality and to suit the present and future needs of MNH.	FHB (M & E)	X	X		
		E3.1.2. Introduce and ensure implementation of obstetric formats	FHB (M)	X	X	X	X
		E3.1.3 Streamline and strengthen the implementation of newborn formats	FHB (N)	X	X	X	X
	Major activity	E3.2. Implement continuous electronic tracking of all individuals from newborn, infancy, childhood, adolescent, pre pregnant, pregnant and delivery (through life cycle with continuum of care) with a unique identification number					
	Sub activities	E3.2.1 Expand the system with HIN number (computer/ web based system).	D/Information	X	X		
		E3.2.2 Strengthen the electronic information system from labour room	FHB (M & E)	X	X		
		E3.2.3 Develop and establish linkages with newborn information system	FHB (M & E)	X	X		
	Major activity	E3.3 Create electronic applications / systems to establish linkages between hospitals and field level data and ensure availability of disaggregated data for action					
	Sub activities	E3.3.1. Advocate to Identify and place a designated officer at ward level to manage data related to MNH with necessary training and infrastructure	DDG PHS II, DDG MS I & II, FHB (M & N),	X	X		
		E3.3.2. Introduce a computer based/ web based system to field level officers (PHMs/ clinics) to enter data at the point of generation	FHB (M & E)	X	X	X	

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	E3.4. Strengthen the supervision to ensure that the eligible couples register, pregnant mothers register, expected mothers register and birth and immunization register are updated to track the target groups					
	Sub activities	E 3.4.1 Develop strategies to strengthen supervison to ensure tracking of target groups	FHB (M & E)	X	X		
E4	Strategy	Ensure that surveillance systems provide timely information for action					
	Major activity	E4.1. Upgrade the maternal mortality, infant mortality, perinatal death and birth defect surveillance systems.					
	Sub activities	E4.1.1. Revise the surveillance formats to cater the new information need for planning and monitoring.	FHB (MM Surveillance)	X	X		
		E4.1.2. Develop/ install data base with auto analysis and report generating capacity at the central level	FHB (MM Surveillance)	X	X		
		E4.1.3. Scale up the birth defect surveillance system addressing the issues identified during each stage of scaling up.	FHB (MM Surveillance)	X	X		
		E4.1.4. Conduct in-depth analysis of existing data using Gap mapping, modelling and new indicators.	FHB (MM Surveillance)	X	X	X	X
		E4.1.5 Establish a mechanism to ensure follow up of recommendations of the audit	FHB (MM Surveillance), M,N	X	X	X	X
	Major activity	E4.2. Link the surveillance systems (maternal mortality, perinatal mortality, birth defects surveillance, infant death investigation) with each other and with routine information systems (IMMR, RHMIS) to ensure uniformity of data and prevent duplication (electronic/web based systems and/or paper based)					
	Sub activities	E4.2.1. Review the surveillance systems and formats to see the possibility of developing a single system linking it with e IMMR.	FHB (MM Surveillance), M,N		X	X	X
	Major activity	E4.3. Establish maternal and neonatal morbidity reporting system and surveillance system for severe morbidities to provide information for action.					
	Sub activities	E4.3.1. Incooperate necessary information to e IMMR and ICU systems.	FHB (M, N), MSU, D/ Information	X	X	X	
		E4.3.2. Streamline/ strengthen the severe maternal morbidity surveillance system with necessary guidelines, monitoring and supervision.	FHB (MM Surveillance), SLCOG	X	X	X	
		E4.3.3. In cooperate NICU surveillance to ICU monitoring system.	FHB (M, N), NeoNICS, D/ Information	X	X		
	Major activity	E4.4. Disseminate information on surveillance data timely for action.					
	Sub activities	E 4.4.1 Strengthen / Develop mechanisms to disseminate information on surveillance to ensure timely action	FHB (MM Surveillance)	X	X	X	X
E5	Strategy	Ensure accountability for quality care and MNH outcomes at all levels					
	Major activity	E5.1. Strengthen/ develop mechanisms to ensure accountability of central and provincial level policy makers and programme managers for reach targeted MNH outcomes					
	Sub activities	E 5.1.1 Strengthen/ develop mechanisms to ensure accountability of central and provincial level policy makers and programme managers for reach targeted MNH outcomes	DGHS, DDG PHS II, DDG MS I & II	X	X		
	Major activity	E5.2. Introduce/strengthen clinical auditing systems (hospital and field) to increase accountability for quality of care and MNH outcomes (refer A3.2)					
	Major activity	E5.3. Develop/strengthen system to get feedback on client satisfaction both in field and hospital setup					
	Sub activities	E5.3.1 Develop/strengthen system to get feedback on client satisfaction both in field and hospital setup	FHB (M, N, M & E), HoI, MO Public Health		X	X	
	Major activity	E5.4. Introduce a system to generate community accountability to improve MNH outcomes (through mother support groups, community, religious leaders)					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Sub activities	E5.4.1 Advocate community leaders / general public on their role in MNH care	PDHSs, RDHSs, Provincial CCPs, MOOMCH, MOOH	X	X	X	X
		E5.4.2 Create awareness on the community accountability in MNH care	ProvincialCCPs, MOOMCH, MOOH	X	X	X	X
E6	Strategy	Enhance monitoring/evaluation capacity and usage of data for decision making and planning at different levels					
	Major activity	E6.1 Develop capacity of healthcare workers at all levels to monitor and interpret data					
	Sub activities	E6.1.1. Organize a skill development sessions to all levels of health staff in both field and hospital to analyze and interpret data	FHB (M & E), Provincial CCPs, MOOMCH, HoIs, MO Public Health		X	X	X
		E6.1.2. Develop a guide/ module on analysis and interpretation of data on MNH to be used by health workers.	FHB (M, N, M&E)		X	X	
	Major activity	E6.2 Establish expert panels at national and district levels to analysis and review service delivery using available data					
	Sub activities	E6.2.1. Identify suitable panel in national/ district level to analyze and review data on MNH regularly	DDG PHS II, DMCH, PDHSs, RDHSs	X	X	X	X
		E6.2.2. Review/ analyze data annually and provide their recommendations to the TAC or RDHS/MOMCH	FHB (M, N, M & E)	X	X	X	X
		E 6.2.3 Identify a panel at district level to monitor data at the district with representatives from the grass root level	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
		E 6.2.4 Conduct regular meetings at each districts and provide recommendations to MOMCH with a copy to FHB	RDHSs, MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
	Major activity	E6.3 Conduct/strengthen regular MCH reviews, hospital progress reviews and MOH conferences to monitor service provision using data					
	Sub activities	E6.3.1. Develop guidelines, formats and indicators for hospital MNH reviews (Refer E1.2)					
		E6.3.2. Allocate regular time slot in monthly conference to monitor MNH performances at PHM level.	MOOMCH, MOOH, RSPHNO, PHNSS	X	X	X	X
		E6.3.3. Review the district MCH review process to improve efficiency and effectiveness (Refer E1.2)					
	Major activity	E6.4 Disseminate data to all levels for decision making and planning					
	Sub activities	E 6.4.1 Strengthen usage of data for decision making and planning MNH programmes at different levels	FHB (M, N), Provincial CCPs, PDHSs, RDHSs, MOOMCH, MOOH, HOIs	X	X	X	X
		E6.4.2 Use SPR methodology to identify gaps and use planning for implementation of program techniques to develop MNh plans at all the levels.	FHB (M, N), Provincial CCPs, PDHSs, RDHSs, MOOMCH, MOOH, HOIs	X	X	X	X
	Major activity	E6.5 Create intersectoral accountability and linkages to report, share and use of accurate data	D/Information, DMCH, FHB (M &E), PDHSs, RDHSs, HOIs, Provincial CCPs, MOOMCH, MOOH	X	X	X	X
	Sub activities	E 6.5.1 Develop a mechanism to creast intersectoral accountablity and linkages to report and use accurate data	D/Information, DMCH, FHB (M &E), PDHSs, RDHSs, HOIs	X	X		
F	Strategic objective 06	Harness the power of Individuals, families and communities in support of MNH					
F1	Strategy	Ensure community awareness for maternal and newborn health.					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Major activity	F1.1. Increase awareness on health matters of mother and new born among individuals, families and communities and mobilize their support in all activities to ensure quality maternal & new born health					
	Sub activities	F1.1.1.Develop appropriate communication strategies for maternal and newborn care concurrently with program plans	HEB, FHB (M, N)	X	X	X	X
		F1.1.2. Use all forms of appropriate media including social media to provide information for the public and engage with the parents and civil society as a platform to raise concerns	HEB, FHB (M, N)	X	X	X	X
		F1.1.3. Maximize the power of parents voices, civil society, mass media and social media to provide information and change norms	HEB, FHB (M, N), Provincial CCPs, MOOMCH, MOOH	X	X	X	X
		F1.1.4. Create public awareness on the right to health, right to know the causes of illness and death in maternal and newborn health.	HEB, FHB (M, N), Provincial CCPs, MOOMCH, MOOH	X	X	X	X
		F1.1.5. Utilization of occupational, industrial and educational settings to deliver maternal and newborn health messages to the public	HEB, FHB (M, N), Provincial CCPs, MOOMCH, MOOH	X	X	X	X
		F1.1.6. Develop and display health education material at general medical, cardiology, neurological and other clinics in hospitals indicating the risk the importance of controlling the disease and risks associated with unplanned pregnancies while having medical conditions	HEB, FHB (M, N), Provincial CCPs, MOOMCH, HOIs	X	X	X	X
		F1.1.7 Share information between health professionals and the public using modern technology as social media, media, hotlines, mobile phones	HEB, FHB (M, N)	X	X	X	X
	Major activity	F1.2. Improve the knowledge and skills of the health workers to deliver messages effectively to the individuals, families and communities					
	Sub activities	F1.2.1. Review the capacity of training programmes on improving communication and health promotion skills of for health care workers.	HEB	X	X		
		F1.2.2. Develop standard and uniform training modules and training system to train/develop communication skills among grass root level health workers and hospital staff.	HEB	X	X		
		F1.2.3. Conduct training programmes for grass root level health workers to deliver target oriented, relevant and uniform health messages on MNBH using appropriate communication skills and material.	HEB	X	X	X	X
		F1.2.4. Ensure standard and uniform training is provided to all public health midwives through well developed training modules	HEB, FHB, RDHS, MOOMCH, MOOH	X	X	X	X
		F1.2.5.Ensure regular awareness on maternal and newborn health is provided at all encounters with the community	HEB, FHB, RDHS, MOOMCH, MOOH	X	X	X	X
F2	Strategy	Empower individuals, families and community to solve own health problems in collaboration with the health care workers					
	Major activity	F2.1.Develop capacity of girls and women to stay healthy and use healthy practices related to reproductive health					
	Sub activities	F2.1.1.Increase individual, family and community awareness of the high value of girls and women in the society	HEB, FHB, RDHS, MOOMCH, MOOH	X	X	X	X
		F2.1.2. Create awareness in the family and community to value mother baby relationship & importance of providing/ receiving care together as one unit	RDHS, MOOMCH, HEO, MOOH	X	X	X	X
		F2.1.3. Advocate to establish day care facilities at institutions for working mothers from 6 months	FHB, HEB, PDHSs, RDHSs, HOIs, MOOMCH	X	X	X	X
	Major activity	F2.2. Establish mother support groups to improve health knowledge and promote desired practices and behaviors					
	Sub activities	F2.2.1. Establish mother support groups at each PHM level	HEB, RDHSs, MOOMCH, HEO, MOOH	X	X	X	X
		F2.2.2. Conduct monthly meetings with mother support group by the PHM	MOOH, PHNSs	X	X	X	X
		F2.2.3. Establish a mechanism to share experiences of mother support groups.	MOOMCH, MOOH, PHNSs	X	X		

		Strategic objective/ Strategy	Responsibility	Time frame			
		F2.2.4 Utilize community based mother support groups to educate the community on the danger signs during pregnancy, postpartum and the neonatal period, provide support to risk women and parents especially those with small and sick infants, to alleviate common myths around pregnancy, child birth and neonatal care and promoting, protecting and supporting in breastfeeding.	MOOH, PHNSs	X	X	X	X
		F2.2.5 Monitoring the activities of mother support groups at PHM level	MOOH, PHNSs	X	X	X	X
	Major activity	F2.3.Strengthen male involvement in pre-pregnancy, pregnancy, postnatal care (including breast feeding support) and family planning					
	Sub activities	F2.3.1. Strengthen the existing parent craft classes with special emphasis on participation of fathers	FHB (M), MOOMCH, MOOH	X	X	X	X
		F2.3.2. Emphasis on involvement of extended family members in maternal and newborn care as per traditional practices in our country	FHB (M), MOOMCH, MOOH	X	X	X	X
		F2.3.3. Provide Structural facilities and other resources to accommodate the husband in clinic setting and visiting the ward	RDHSs, MOOH	X	X	X	X
		F2.3.4. Engage the husband in all healthcare activities pertaining to pre-pregnancy care, ANC, INC and postnatal care	MOOMCH, MOOH, PHNSs	X	X	X	X
		F2.3.5. Engage family members including males as supporters and change agents to improve health of mother and new born at home hospital, clinic and community settings.	MOOMCH, MOOH, PHNSs	X	X	X	X
	Major activity	F2.4.Establish social support networks in the community and link with the health system & other relevant sectors such as social services, women's affairs					
	Sub activities	F2.4.1. Identify mothers and families who need social support at the MOH level	MOOH, PHNS, PHMM	X	X	X	X
		F2.4.2. Identify currently available social support networks in the community.	MOOH, PHNS, PHMM	X	X	X	X
		F2.4.3. Establish a mechanism to link these families with health system and other sectors	RDHSs, MOOMCH, MOOH	X	X		
	Major activity	F2.5. Involve community in improving quality of home care through better interaction with healthcare workers, GPs Community leaders (formal & informal)					
	Sub activities	F2.5.1. Involve locally practicing GPs and other medical practitioners at community stake holder meetings	RDHSs, MOOMCH, MOOH	X	X	X	X
		F2.5.2. Conduct regular meetings between field health care workers, local hospitals and General practitioners and other medical practioners	RDHSs, MOOMCH, MOOH	X	X	X	X
F3	Strategy	Ensure mobilization of community resources to achieve MNH goals					
	Major activity	F3.1. Sensitize the public to increase their demand for quality MNH services.					
	Sub activity	F3.1.1. Use media & other means to create awareness among the public on elements of quality and to increase the demand for quality care at government and private health institutions.	HEB, FHB, RDHSs, MOOMCH	X	X	X	X
	Major activity	F3.2. Establish mechanisms at community level to strengthen collaboration between health care workers and formal and informal community leaders to enhance MNH care					
	Sub activities	F3.2.1. Establish a forum in the community to discuss maternal and newborn health between field health workers and formal and informal community leaders	RDHSs, MOOMCH, HEO, MOOH		X	X	
		F3.2.2. Advocate community level organizations relevant organizations to act promptly on abandoned newborns and vulnerable women who need support.	RDHSs, MOOMCH, HEO, MOOH	X	X		
		F3.2.3. Identify and mobilize resources in the community (including human resources) to improve MNH care and services	HEB, FHB, RDHSs, MOOMCH	X	X		
	Major activity	F3.3. Involve the families & community to improve the quality of services in Maternal and newborn health.					

		Strategic objective/ Strategy	Responsibility	Time frame			
	Sub activities	F3.3.1. Develop / Utilize client Feed back mechanism to improve the quality of service	HEB, FHB		X	X	
		F3.3.2. Assess the client and community expectations on MNBH periodically	HEB, FHB		X		X
		F3.3.3. Identify gaps and strengthen front end maternal and newborn health services	HEB, FHB		X		X
F4	Strategy	Empower communities to counter domestic violence, reject disrespect and abuse towards women/girls by ensuring equal access to resources, education including sexual education and information					
	Major activity	F4.1. Mobilize the support of the clergy, informal /formal leaders, voluntary organizations and women's organizations to ensure girls and women are protected against all forms of violence and discriminations and their human rights are safeguarded within the family and the community.					
	Sub activities	F4.1.1 Advocacy to clergy, informal /formal leaders, voluntary organizations and women's organizations on protection against violence, discrimination and human rights of women and girls	DDG PHS II, FHB (WH), Ministry of Women's Health	X	X	X	X
		F4.1.2 Increase awareness on violence, discrimination and human rights of women and girls among clergy, informal / formal leaders, voluntary organizations and women's organizations	RDHSs, MOOMCH, MOOH, PHNSs	X	X	X	X
		F4.1.3 Establish a forum in the community to discuss and address on violence and discriminations and human rights of women and girls	RDHSs, MOOMCH, MOOH	X	X		
	Major activity	F4.2. Introduce cultural & age appropriate SRH education programmes in school and other settings so that all males and females become well aware about SRH matters and avoid unsafe sexual practices.					
	Sub activities	F4.2.1 Introduce culturally acceptable and age appropriate SRH educational programmes to school and other settings	FHB (SH, AH)		X	X	
		F4.2.2 Increase awareness on SRH matters in schools and other settings	HEB, HEO, FHB (SH, AH), RDHSs, MOOMCH, MOOH	X	X	X	X
		F4.2.3 Increase awareness on harmful/ unsafe sexual practices at school and other settings	HEB, HEO, FHB (SH, AH), RDHSs, MOOMCH, MOOH	X	X	X	X
	Major activity	F4.3 Equip Individuals, families and community with knowledge and positive attitudes to empower to demand for rights, respect and quality care for girls and women from all health care delivery institutions.					
	Sub activity	F4.3.1. Conduct a media campaign through regular programmes to raise public awareness to demand the right for quality health care	HEB, FHB	X	X	X	X
	Major activity	F4.4. Address specific challenges to the girl child & women at home and in the society such as discrimination & violence especially during pregnancy with community participation.					
	Sub activities	F4.4.1.Initiate awareness programmes in school settings through the curriculum as appropriate and develop skills of the girl child and empower them to resist harassment and violence at different places.	FHB (SH, AH)		X	X	X
		F4.4.2. Focus programmes on the male children (boys schools) and make them understand that girls are equal and they should have mutual respect and prevent violence (mental or physical)against girls & women at home, school, work place or in the community.	HEB, FHB (SH, AH), HEO, MOOMCH, MOOH	X	X	X	X
		F4.4.3. Conduct special seminars and workshops awareness programmes targeting youth in universities, work places, forces etc.	HEB, FHB (SH, AH), HEO, MOOMCH, MOOH	X	X	X	X
F5	Strategy	Linkages with Labour department, child secretariat, PHDT to improve the service provision for mothers and newborn					
	Major activity	F5.1. Involve/ participate for the advisory committee meetings and other technical meetings with other ministries/ agencies					
	Sub activity	F 5.1.1 Develop linkages with other ministries and agencies and ensure membership in relevant technical advisory committees	DDG PHS II, DMCH	X	X	X	X
	Major activity	F5.2. Provide technical assistance as required.					
	Sub activity	A5.2.1. Promote autonomy of females over their own SRH matters & power to decide and select choices.	HEB, FHB (SH, AH), HEO, MOOMCH, MOOH	X	X	X	X

Annex 3

Resource persons contributed under each of the SO in the large scale stakeholder workshop;

Strategic Objective 1: Strengthen and invest in improving quality of maternal and newborn care, particularly during labour, birth and the first day and week of life	
Dr. S. Dhanapala	Acting Director - MCH
Dr. Priyanee Senadheera	Director – Teaching Hospital – Mahamodara
Dr. Dhammica Rowel	CCP/FHB, NPM (Intranatal and Newborn Care)
Prof. D. Gunasekara	Consultant Paediatrician, University of Sri Jayawardenapura
Dr. Gamini Perera	VOG – CSHW
Dr. U. D. P. Rathnasiri	VOG – CSHW
Dr. N. Saravanabhavan	VOG – DGH Kilinochchi
Dr. Y. Weerasekara	CCP – Southern Province
Dr. P. K. D. C. Perera	Senior Registrar in Community Medicine – FHB
Mrs. H. M. C. M. Herath	Chief Special Grade Nursing Officer – De Soysa Maternity Hospital

Strategic objective 2 Address all causes of maternal, perinatal and neonatal mortality and morbidity	
Dr. C. de Silva	Director – Mental Health Unit
Dr. S. Godakandage	CCP/FHB, NPM (Family Planning)
Dr. Heshan Jayaweera	Senior Lecturer- Faculty of Medicine, University of Peradeniya
Dr. Deepa Gamage	Consultant Epidemiologist – Epidemiology Unit
Dr. I. Pinnaduwa	MOH – Homagama
Dr. K. G. S. De Silva	MOH - Polgahawela
Dr. M. A. C. U. Fazal	MOMCH – Kalmunai
Dr. Nadeeka Chandrarathne	Registrar in Community Medicine – FHB
Mrs. B. N. Rathnayake	PHNS – MOH office , Polgahawela

Strategic Objective 3:	
Strengthen health systems to respond to the needs and priorities of women, newborns and their families	
Prof. H. Senanayake	Professor of Obstetrics and Gynaecology, FOM, Colombo
Dr. N. Hemachandra	National Professional Officer – WHO
Dr. Ramya De Silva LRH	Consultant Paediatrician, In charge of the Neonatal Intensive Care unit,
Dr. Deepika Attygalle	Health specialist, UNICEF
Dr. H. M. Roshan Sampath	Acting CCP – North Central Province
Dr. Umanga Sooriarachchi	CCP – Education, Training and Research Unit
Dr. Saman Kumara	Consultant Neonatologist, CSHW
Dr. P. J. Arumapperuma	Registrar in Community Medicine – FHB

Strategic Objective 4:	
Ensure universal health coverage for comprehensive (essential and emergency) maternal and newborn health care, addressing inequities in access to quality care	
Prof. Sujeewa Amarasena	Professor of Paediatrician, Faculty of Medicine, University of Ruhuna
Dr. Janaki Karunasinghe	VOG – CSTH
Dr. I. Nilaweera	CCP/FHB, NPM (Maternal Care)
Dr. W. K. Migara Epa	Deputy Director (DMH)
Dr. S. J. Senanayake	Registrar in Community Medicine – FHB
Dr. D. Jeyakumaran	Registrar in Community Medicine – FHB
Mrs. Daya Amarasinghe	RSPHNO – RDHS, Mathara

Strategic Objective 5:	
Count every mother, fetus and newborn through measurement, programme tracking and accountability	
Dr. Kapila Jayarathne	CCP/FHB, NPM (Maternal and Child Morbidity and Mortality Surveillance)
Mrs K.A.S. Kodikara	
Dr. Sandhya Bandara	Deputy Director, Medical Statistics Unit
Consultant Paediatrician, In charge of the Neonatal Intensive Care Unit, Teaching Hospital, Peradeniya	
Dr. Ajitha Wijesundare	VOG – Sri Lanka College of Obstetricians and Gynaecologists
Dr. Indika Pathiraja	CCP – North Western Province
Dr. Nalin Gamaathige	Consultant Neonatologist – De Soya Maternity Hospital
Dr. R. B. Dayarathna	Medical Officer (Health Information) – Medical Statistics Unit
Mrs. H. M. Wimalarathne	RSPHNO – RDHS office, Monaragala

Strategic Objective 6:	
Harness the power of Individuals, families and communities in support of MNH	
Prof. A. Kaluarachchi	Professor of Obstetrics and Gynaecology, FOM, Colombo
Dr. Sampatha Gunawardena	Senior Lecturer – Faculty of Medicine, University of Sri Jayawardenapura
Dr. S. Perera	Consultant Paediatrician, In charge of Neonatal Intensive Care unit, Kethumathi Maternity Hospital
Dr. R. D. S. Ranasinghe	CCP- Sabaragamuwa Province
Dr. Amanthi Bandusena	CCP - HEB
Dr. N. V. J. Thenuwara	CCP/FHB, Head Planning Unit, FHB
Dr. A. D. P.P. Chandradasa	MOH – Kahathuduwa
Dr. L. W.C. N. Ranaweera	MOH – Yatawathatha
Dr. H. Jayakody	Registrar in Community Medicine – FHB
Dr. J. H. Dassanayake	Registrar in Community Medicine – FHB
Dr. E. Rajapakshe	Medical Officer, Primary Health Service Unit
Mrs. H. B. G. N. Madhubashini	DO – Primary Health Service Unit

Annex 4

Technical Advisory Committee on Maternal, Women's Health and Family Planning (2015/2016)

Dr.R.R.M.L.R.Siyambalagoda	DDG(PHS11)
Dr. Sapumal Dhanapala	Acting Director MCH
Dr.R.D.F.C.Kanthi	Director/HEB
Dr.Suranga Dolemulla	Director/TCS
Mrs.R.L.S.Rajapaksha	D/Nursing PHS(MOH)
Dr.JanithaTennakoon	RDHS/Badulla
Dr.Migara Epa	DD /DMH
Dr Deepthi Perera	PDHS/ Western Province
Dr R.M.S.K.Ratnayake	Director/TH Kandy
Dr. Ajitha Wijesundara	Representative of SLCOG
Dr. Gamini Perera	President / SLCOG
Dr. Harsha Attapattu	Secretary/SLCOG
Dr. Kapila Gunawardene	Past president/ SLCOG
Dr.Sampatha Gunawardena	Representative CCPSL
Prof Dulani Gunasekera	Perinatal Society of Sri Lanka
Dr.Janakie Karunasinghe	VOG/CSTH
Dr.U. D. P. Rathnasiri	VOG/CSHW
Dr. C.Mathota	VOG/FHB
Dr. Sardha Hemapriya	VOG, TH Kandy
Dr.Amanthi Bandusena	CCP/HEB
Dr. Umanga Sooriyarachchi	CCP/ ET&R
Dr.Irosha Nilaweera	CCP/NPM/Maternal care
Dr. S.S.P.Godakandage	CCP/NPM/Family Planning
Dr.Dhammica Rowel	CCP/NPM Intrantal and Newborn Care
Dr.Kaushalya Kasthuriarachchi	CCP/ Head, Monitoring & Evaluation
Dr. NethminiThenuwara	CCP/ Head, Planning, FHB
Dr. Kapila Jayaratne	CCP/ NPM/MM surveillance
Dr. Nethanjalee Mapitigama	CCP/NPM/Women's Health
Dr. S Kumaravel	MOMCH/Jaffna
Dr. Gamini Jayakody	UNICEF, NPO
Dr. Nilmini Hemachandra	National Professional Officer / WHO
Mr. Jayan Abeywickrama	NFPA, NPO

Annex 5

Technical Advisory Committee on Newborn and Child Health (2015/2016)

Dr R R M L R Siyambalagoda	- DDG PHS II - Chairman
Dr Sapumal Dhanapala	– Acting Director MCH
Dr R.D.F.C. Kanthi	- Director / Health Education and Publicity
Dr Pabha Palihawadana	- Chief Epidemiologist
Dr Priyantha Atapattu	- Director MS
Dr Suranga Dolamulla	- Director / TCS
Dr W. K. Wickramasinghe	- Director /LRH
Dr Darshini Abeysekera	– Deputy Director /CSTH
Dr Sudath Dharmaratne	– RDHS Gampaha
Mrs M.G.C. Samanmali	- Director Nursing /MS
Mrs L Abeygunawardena	- Director Nursing / PHS
Dr Ramya de Silva	- President / SLCP
Prof Dulani Gunasekera	- President PSSL
Prof Sujeewa Amarasena,	- Professor of Paediatrics
Dr Sandya Bandara	- Consultant Paediatrician
Dr Surantha Perera	- Consultant Paediatrician
Dr Nishani Lucus	- Consultant Neonatologist
Dr Saman Kumara	- Consultant Neonatologist
Dr Nalin Gamethige	- Consultant Neonatologist
Dr M.A.C.Perera	- Consultant Obstetrician and Gynaecologist
Dr Heshan Jayaweera	- Senior Lecture in Paediatrician ,University of Peradeniya
Dr Irohsa Nilaweera	- CCP / NPM (Maternal Care)
Dr Dhammica Rowel	- CCP / NPM (Intranatal and Newborn Care)
Dr Hiranya Jayawickrama	- CCP / NPM (Child Nutrition)
Dr Neil Thalagala	- CCP / NPM (Child Development and Special Needs)
Dr Kapila Jayaratne	- CCP/ NPM (Maternal and Child Morbidity and Mortality Surveillance)
Dr Kaushalya Kasthuriarachchi	- CCP / Head of Monitoring and Evaluation, FHB
Dr. Nethmini Thenuwara	- CCP/Head of Planning Unit, FHB
Dr Indika Pathiraja	- Provincial CCP, NWP
Dr Badrika Gunawardena	- MOMCH / Colombo
Dr Nilmini Hemachandra	- WHO/National Professional Officer- MNCAH
Dr Gamini Jayakody	- UNICEF/NPO, Health and Nutrition
Mr Jayan Jayaweera	- UNFPA/NPO

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