

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



Family Health Bureau
Ministry of Health- Sri Lanka



National Strategic Plan

Maternal and Newborn Health

(2017 -2025)



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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, fetuses 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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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.

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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 per 100,000 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, fetuses 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 attendance 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 heart 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 are currently being established within the system.



Key Points

Maternal mortality surveillance has been 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

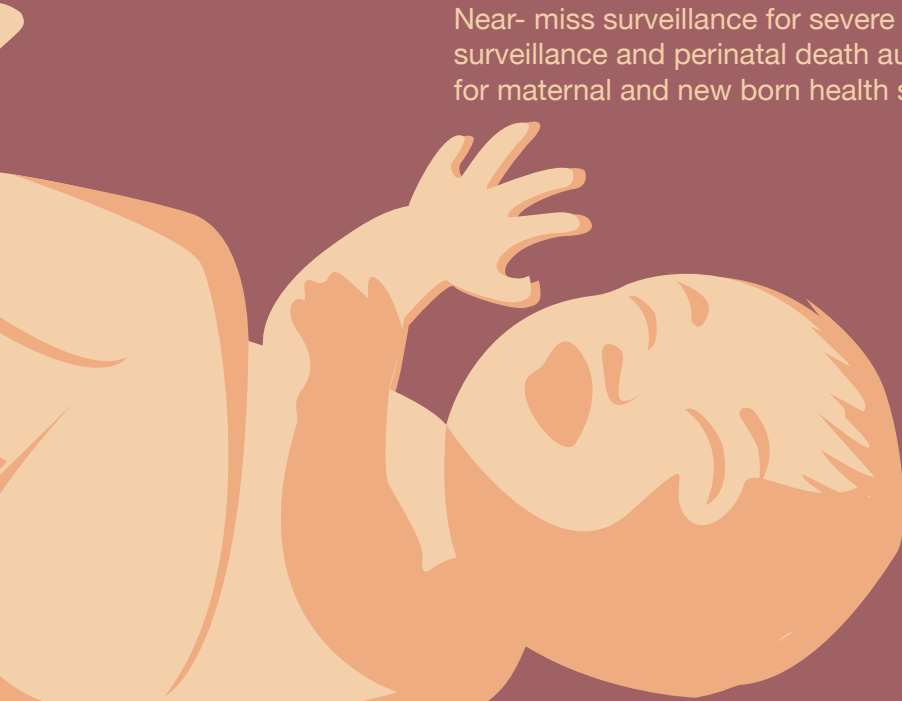
congenital anomalies (41%)

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 newborn 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.

Anemia 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 Thihe 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 Perinatology), 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 for 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. The 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, 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, fetuses 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 formulated for the years 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 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-conceptual 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 antiretroviral 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 MgSO₄ 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 (2017-2025) 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 is 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 the 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 information systems, regular recruitment procedures, training programmes and a 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 of 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 a human resource policy for maternal and newborn health or ensure that human resources for MNH are 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 Increase 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 practioners & 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 regarding 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 19 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.

In 2012 WHO revised the categorization of maternal deaths by application of ICD-10 to deaths which occur during pregnancy, childbirth, and the puerperium. 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 puerperium) are categorized as direct causes

of maternal death. Therefore Sri Lanka needs to adopt this system and work towards prevention.

More efforts should be focused on counting maternal morbidity especially near misses and follow up the long term effects on RH and future pregnancies of 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. Strengthen the health services available for prevention, 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 to prevent 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 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 care 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 newborn 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 & newborns 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 that 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 facilitates 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

The health care delivery system of the country is responsible for 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, and 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 service 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 certain marginalized populations which have 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 to 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 out the country's healthcare delivery system up to 5 years of age 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 supervision to ensure that the eligible couples register, pregnant mothers register, expectant 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 analyse 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



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 these 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.

The cultural heritage in Sri Lanka holds voluntarism for community activities very high esteem. 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 all ethnic groups, and 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 needs to develop good collaboration with the formal and informal leaders of the villages which is 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 such 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 that 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 receiving 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. Involve community in improving quality of home care through better interaction with healthcare workers, general practioners and 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 in 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 a 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 hospitals, especially in 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 the responsibility of planning and implementing the identified activities. 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. the 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 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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05

Annexes

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 \geq 1000g or after 28 weeks of gestation Number of infants per year born with no sign of life and weighing \geq 500g or after 22 weeks of gestation | 1000 total live and still born births (weighing \geq 1000g or after 28 weeks of gestation) 1000 total live and still born births (\geq 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 | <p>Number of newborns who have received</p> <ul style="list-style-type: none"> • Initiation of breast feeding first hour • Skin to skin care • Delayed cord clamping • Delay in weighing and taking other measurements <p>At/around birth</p> | Total number of live births | DHS and Special survey | <p>Initiation of breastfeeding in the first hour 90% (DHS, 2016)</p> <p>Others not available</p> | 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 newborn 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 hyperglycaemia 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, Hols | 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 | Hol, 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 | Hols, 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, Hols | 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, Hols, 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 | Hols, 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, Hols | X | X | X | X |
| | | A1.4.3. Continue the training on lactation management for hospital and field staff. | Hols, 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 | Hol, RDHS | X | | | |
| | | A 2.3.2 Conduct activities to maintain high levels of skill development to provide MNH services | Hol, RDHS | X | X | X | X |
| | | A2.3.3 Provide facilities for regular essential skill development in hospital | Hol, 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.: EMOG, ENC, NALS, Breast feeding counselling, Facility based sick new born care) | FHB, Hol, 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) | Hols, 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 Institutes | | 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/HQ & 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 Accredite 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, PSSSL | 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, PSSSL | | | | |
| | | 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 field 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.Strengthen 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, PSSSL | 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, PSSSL | 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 | B1.10.1 Update 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 respective 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 referral 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, PSSSL, 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, PSSSL, 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, PSSSL | | 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, PSSSL | | 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, PSSSL | | 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 |
| | | B3.1.2 Implement 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 Paediatric 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 anthelmintic 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 mandatory 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 expertise 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 3.5.1 Define 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/ malfunctioning 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 eMMR 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 eMMR. | 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 (Researchy) | 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, PSSSL | | 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 an 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 supervision 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 | PDHSSs, RDHSSs, 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, Hols, 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, PDHSSs, RDHSSs | 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 | RDHSSs, 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, PDHSSs, RDHSSs, 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, PDHSSs, RDHSSs, 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), PDHSSs, RDHSSs, HOIs, Provincial CCPs, MOOMCH, MOOH | X | X | X | X |
| | Sub activities | E 6.5.1 Develop a mechanism to creast intersectoral accountability and linkages to report and use accurate data | D/Information, DMCH, FHB (M & E), PDHSSs, RDHSSs, 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. Priyane 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

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|-------------------------|--|
| 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

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|-------------------------------|--|
| 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)

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|-------------------------------|-------------------------------------|
| 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 Intrant 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)

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|-------------------------------|--|
| 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 Abeyssekera | - 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 Irohsha 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 |

