
Rima Jolivet, CNM, DrPH
Maternal Health Task Force
CUGH, April 8, 2017, Washington, DC
Presentation Overview

• EPMM Strategies
  – Process and timeline
  – MMR Targets
  – Key Themes

• EPMM Global Monitoring Framework
  – Process and timeline
  – Phase I: Indicators for coverage and impact of key interventions that are closely linked to direct causes of death
  – Phase II: Policy and health system indicators for tracking social determinants
Development of the EPMM Strategies Report

2013

April
African Union Meeting: report developed to share targets

December
EPMM Working Group formed

2014

April
Stakeholder meeting in Bangkok achieves consensus on EPMM targets and top line strategic objectives

May
Every Newborn Action Plan (ENAP) is published and launched at World Health Assembly (WHA)
EPMM targets included in ENAP and ratified at WHA

June
EPMM draft report presented at the Partnership for Newborn, Maternal, and Child Health (PMNCH) Partners Forum, Johannesburg

2015

February
Publication of EPMM Strategies report on World Health Organization (WHO) website

May
EPMM report launched at WHA side event

September
Sustainable Development Goals (SDGs) launch with EPMM maternal mortality ratio target included

EPMM fed into the updated Global Strategy for Women’s, Children’s, and Adolescents’ Health (2016-2030) [Global Strategy (2016-2030)]

EPMM and ENAP strategic priorities combined in technical working paper “Ending preventable maternal and newborn deaths and stillbirths”

Global Strategy (2016-2030) launches with EPMM maternal mortality ratio target included

Projections for EPMM targets developed by measure developers and Maternal Mortality Inter-agency Estimation Group (MMEIG)

August
WHO-convened technical consultation meetings

Lancet commentary: “Ending preventable maternal deaths: the time is now”

Country-level consultations on EPMM targets and strategies

Every Newborn Action Plan (ENAP) is published and launched at World Health Assembly (WHA)
EPMM targets included in ENAP and ratified at WHA

EPMM draft report presented at the Partnership for Newborn, Maternal, and Child Health (PMNCH) Partners Forum, Johannesburg

Public and Member State comments
Systematic process to address comments and revise EPMM Strategies report
Finalization of EPMM Strategies report
GLOBAL & NATIONAL EPMM TARGETS
MMR Targets by 2030

All countries reduce MMR by at least 2/3

To reach a global average MMR of <70

No country ends with MMR >140 by 2030
Country EPMM Targets

MMR target of less than 70/100,000 live births by 2030 applies at the global level but not necessarily for individual countries.

- **For countries with MMR less than 420 at baseline**: Reduce MMR by at least two thirds

- **For countries with MMR greater than 420 at baseline**: rate of decline should be steeper so that in 2030, no country has an MMR greater than 140.

- **For countries with low MMR at baseline**: achieve equity for vulnerable populations at subnational level.
WHO is developing a tool to calculate national MMR targets—will be available April 2017.
EPMM STRATEGIES
Strategies toward ending preventable maternal mortality (EPMM)

• Direction-setting report released in 2015
• Outlines global targets and strategies for reducing maternal mortality in the SDG period
• 11 Key Themes
  o Guiding Principles
  o Cross-Cutting Actions
  o Strategic Objectives
# 11 Key Themes

## Guiding Principles
- Empower women, girls, and communities
- Integrate maternal and newborn health, protect and support the mother-baby dyad
- Ensure country ownership, leadership, and supportive legal, regulatory, and financial frameworks
- Apply a human-rights framework to ensure that high-quality reproductive, maternal, and newborn health care is available, accessible, and acceptable to all who need it

## Cross-cutting Actions
- Improve metrics, measurement systems, and data quality to ensure that all maternal and newborn deaths are counted
- Allocate adequate resources and effective health care financing

## Five Strategic Objectives
- Address inequities in access to and quality of sexual, reproductive, maternal, and newborn healthcare
- Ensure universal health coverage for comprehensive sexual, reproductive, maternal, and newborn healthcare
- Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities
- Strengthen health systems to respond to the needs and priorities of women and girls
- Ensure accountability in order to improve quality of care and equity
DEVELOPMENT OF EPMM MONITORING FRAMEWORK
Development of Monitoring Framework

– **Phase 1:** core set of priority, methodologically robust indicators with direct relevance for reducing preventable mortality for global monitoring and reporting by all countries
  - Timeline – mid-October 2015

– **Phase 2:** a menu of indicators to track social, political and economic determinants of maternal health and survival to be adopted by countries within their national monitoring frameworks
  - Timeline – October 2016
# EPMM Phase I Metrics

<table>
<thead>
<tr>
<th>IMPACT</th>
<th>CORE INDICATOR</th>
<th>ADDITIONAL PRIORITY INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Maternal mortality ratio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Maternal cause of death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Adolescent birth rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Four or more antenatal care visits</td>
<td>Content of antenatal care</td>
</tr>
<tr>
<td></td>
<td>5. Skilled attendant at birth</td>
<td>Content of postnatal care</td>
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<tr>
<td></td>
<td>6. Institutional delivery</td>
<td>Respectful maternity care</td>
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<tr>
<td></td>
<td>7. Early postnatal/postpartum care for woman and baby (within 2 days of birth)</td>
<td></td>
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<td></td>
<td>8. Met need for family planning</td>
<td></td>
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<tr>
<td></td>
<td>9. Uterotonic immediately after birth for prevention of post-partum hemorrhage (among facility births)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Caesarean section rate</td>
<td>Met need for EmONC</td>
</tr>
<tr>
<td></td>
<td>11. Maternal death registration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Availability of functional EmONC facilities</td>
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</tbody>
</table>
• Manuscript published August 2016 in *BMC Pregnancy and Childbirth*
• Describes the Phase I process and outcomes
Phase II Methodology

- March: ✔ Indicator mapping
- April: ✔ Technical consultations via webinar and surveys
- May: ✔ Summary technical consultation via webinar and surveys
- June: ✔
- July: ✔ Public comment period
- August: ✔ In-person meeting to finalize consensus on EPMM Phase II core indicators and additional indicators for further development
- September: ✔
Phase II Methodology: Selection Criteria

- Relevance
- Importance
- Interpretability and Usefulness
- Validity
- Feasibility and Data Availability
- Harmonization
### EPMM Phase II Core Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Equity Stratifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of laws and regulations that guarantee women aged 15-49 access to SRH care, information, and education</td>
<td>Wealth</td>
</tr>
<tr>
<td>Gender Parity Index (GPI)</td>
<td>Area of residence: urban/rural</td>
</tr>
<tr>
<td>Whether or not legal frameworks are in place to promote, enforce, and monitor equality and non-discrimination on the basis of sex</td>
<td>Area of residence: geographic region</td>
</tr>
<tr>
<td>Presence of protocols/policies on combined care of mother and baby, immediate breastfeeding, and observations of care</td>
<td>Level of education: women’s education level</td>
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<tr>
<td>Maternity protection in accordance with ILO Convention 183</td>
<td>Age</td>
</tr>
<tr>
<td>International Code of Marketing of Breastmilk Substitutes</td>
<td>Transparency Stratifier</td>
</tr>
<tr>
<td>Costed implementation plan for maternal, newborn, and child health</td>
<td>Available in the public domain</td>
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<tr>
<td>Midwives are authorized to deliver basic emergency obstetric and newborn care</td>
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<tr>
<td>Legal status of abortion</td>
<td></td>
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<tr>
<td>Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use, and RH care</td>
<td></td>
</tr>
<tr>
<td>Geographic distribution of facilities that provide basic and comprehensive emergency obstetric care (EmOC)</td>
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<tr>
<td>Presence of a national set of indicators with targets and annual report to inform annual health sector reviews and other planning cycles</td>
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<tr>
<td>Maternal death review coverage</td>
<td></td>
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<tr>
<td>Percentage of total health expenditure spent on reproductive, maternal, newborn, and child health</td>
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<tr>
<td>Out-of-pocket expenditure as a percentage of total expenditure on health</td>
<td></td>
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<tr>
<td>Annual reviews are conducted of health spending from all financial sources, including RMNCH spending, as part of broader health sector reviews</td>
<td></td>
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<tr>
<td>Health worker density and distribution (per 1,000 population)</td>
<td></td>
</tr>
<tr>
<td>Coverage of essential health services</td>
<td></td>
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<tr>
<td>If fees exist for health services in the public sector, are women of reproductive age (15-49) exempt from user fees for MH services</td>
<td></td>
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<tr>
<td>Demand for family planning satisfied through modern methods of contraception</td>
<td></td>
</tr>
<tr>
<td>Availability of functional emergency obstetric care (EmOC) facilities</td>
<td></td>
</tr>
<tr>
<td>Density of midwives, by district (by births)</td>
<td></td>
</tr>
<tr>
<td>Percentage of facilities that demonstrate readiness to deliver specific services: family planning, ANC, basic EmOC, and newborn care</td>
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<tr>
<td>Civil registration coverage of cause of death (percentage)</td>
<td></td>
</tr>
<tr>
<td>Presence of a national policy/strategy to ensure engagement of CSO representatives in periodic review of national programs for MNCAH</td>
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</tbody>
</table>
EPMM 11 Key Themes

1. Empower women, girls, families and communities
2. Integrate maternal and newborn care, protect and support the mother-baby dyad
3. Prioritize country ownership, leadership, and supportive legal, regulatory and financial mechanisms
4. Apply a human rights framework to ensure that high-quality reproductive, maternal, and newborn health care is available, accessible, and acceptable to all who need it
5. Improve metrics, measurement systems, and data quality
6. Prioritize adequate resources and effective health care financing
7. Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care
8. Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care
9. Address all causes of maternal mortality, reproductive and maternal morbidity and related disabilities
10. Strengthen health systems to respond to the needs and priorities of women and girls
11. Ensure accountability to improve quality of care and equity
The **25 indicators and 6 stratifiers** from Phase II can be grouped into these maternal health topic areas:

- **Universal Health Coverage**: 8 indicators
- **Human Rights**: 16 indicators
- **Health System Strengthening**: 22 indicators
- **Empowering Women, Girls & Communities**: 10 indicators
- **Improving Measurement & Metrics**: 4 indicators

*Areas of interest are not mutually exclusive*
Phase II Indicators and Human Rights

- **Participation**
  - Core: 2 indicators

- **Equity & Non-discrimination**
  - Core: 11 indicators
  - 5 stratifiers

- **Transparency**
  - Core: 4 indicators

- **Accountability**
  - Core: 1 indicator
  - 1 Stratifer
Tying EPMM In with Other Efforts in MNH Measurement

EPMM

Countdown to 2030

WHO Quality of Care

ENAP

Lancet Maternal Health Series
Phase II Indicators and Harmonization

- 42 total indicators in Goals 3 & 5
- 60 total key indicators

Global Strategy Indicator
- 60 total key indicators
- 5 key indicators

SDGs
- 11 indicators
- 42 total indicators

EPMM Phase II Core Set
- 5 indicators
- 5 stratifiers

Countdown to 2015
- 6 indicators
- 70+ indicators

Additional Indicators for Further Development with Research Recommendations
EPMM Comprehensive Monitoring Framework: Concept for Use

Phase I
- A core set of MH indicators with direct causal link to mortality for global monitoring and reporting by all countries

Phase II
- A robust menu of well-vetted, research-validated monitoring options for tracking key system drivers and social determinants of MH
- A menu/pick-list that countries can select from, while ensuring that standard definitions and meta data will allow cross-country comparisons and national benchmarking
THANK YOU!

For questions about EPMM, please contact Rima Jolivet at rjolivet@hsph.harvard.edu.

Dr. Chibugo Okoli
Senior Maternal Health Advisor, MCSP Nigeria

Presented at:
CUGH 2017 Conference | Washington DC, USA
Nigeria’s fiscally decentralized government structure and large rural population challenges health care systems, service delivery and outcomes

Administratively, Nigeria is divided into:

- **36 states**
- A Federal Capital Territory (FCT)
- **774 Local Government Areas (LGAs)**
- **9,565 wards**
- **Six geopolitical zones** (North Central, North East, North West, South East, South South, South West)

With a population of **167 million** and:

- **31 million women** of child bearing age
- **28 million children** under the age of five
- An estimated **6 million births** annually

SOURCE: Nigeria Population Census 2006
In addition to high maternal and child mortality rates, health system challenges are exacerbated by inadequate supply and low demand for low quality services

- **Maternal mortality** rate is 576/100,000 live births = 33,000 women each year
- 1 in 9 maternal deaths worldwide
- **Contraceptive prevalence rate** = 15.1

- **Infant mortality** rate is 69/1,000
- 8% of the global total
- An estimated 70% of these deaths are preventable

- **Child mortality rate** is 128/1,000
  - = ~1 million deaths per year
  - ~10% of the global total

- **Health facilities** (~23,000) (estimated 14,000 PHCs) but with different levels of functionality
- Poor quality of care
- Shortage of critical human resources

- **Supply challenges**
  - Inadequate power or water supply
  - Commodity stock-outs
  - Equipment inadequacy
  - Inadequate number of trained service providers

- **Demand** for critical services very low, largely driven by a loss of confidence in the system e.g.
- Only 38% of women have skilled births
  - Only 61% attend ANC

**SOURCE:** Nigeria Demographic and Health Survey, 2013
Access to MNH Services Higher in Urban than Rural Areas - 2013 NDHS

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of women with 4 ANC Visits</td>
<td>74.50%</td>
<td>38.20%</td>
<td>51.10%</td>
</tr>
<tr>
<td>% of women delivering at health facilities</td>
<td>61.70%</td>
<td>21.90%</td>
<td>35.80%</td>
</tr>
<tr>
<td>% of mothers &amp; babies with PNC within 2 days</td>
<td>59.10%</td>
<td>29.00%</td>
<td>39.60%</td>
</tr>
</tbody>
</table>
Inequitable Access to MCH Services by Wealth Quintiles

The poorest 20% of Nigerian women have significantly less access to maternal and child health services than richer women.

**Multiple antenatal care (ANC) visits**
- % of pregnant women
  - Poorest 20%: 31%
  - Richest 20%: 91%

**Skilled attendant at birth**
- % of live births
  - Poorest 20%: 13%
  - Richest 20%: 85%

**Contraceptive prevalence**
- % of women of reproductive age
  - Poorest 20%: 4%
  - Richest 20%: 21%

SOURCE: World Bank: Socio-economic Differences in Health, Nutrition, and Population within Developing Countries
Priorities for Maternal, Newborn and Child Health Improvement in Nigeria

- Mobilization and deployment of unemployed Midwives and CHEWs to rural areas (Midwives Service Scheme)
- Systematic Training and continuous support of Doctors/Midwives/CHWs to improve competencies and health outcomes
- Quality Improvement and regular tracking of MNH measures by key actors (facility, district (LGA), State MOH)
- Provision of supplies, life-saving drugs, commodities, and midwifery kits to health facilities
- Building Partnerships with States, LGAs, Development Partners, NGOs, and other stakeholders
- Building Community Ownership through the Ward Development Committees

National Health Strategic Development Plan, RMNCAH Strategy (Reflects EWEC, EPMM etc)
MNH QoC Strategy
A CASE STUDY: MCSP Quality Improvement Work in Two States

- Primary purpose is to **improve the quality and utilization of maternal and newborn and Child Health interventions** including PPFP in order to improve health outcomes and experience of care for mothers and their children.

- The country has adapted the WHO MNCH Quality of Care Framework

- MCSP supports quality work at both the National and Sub National level:
  - National MNCH Quality Policy Development
  - 2 States: Quality Improvement (QI) Teams established in selected health centres, hospitals – measurable improvement aims, work plans, priority quality measures

- Learning platforms under development for QI teams to share results and accelerate improvements in MNH care.
<table>
<thead>
<tr>
<th>S/N</th>
<th>EPMM Phase 1 Indicators</th>
<th>Nigeria’s DHIS2, HMIS Registers &amp; QoC Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IMPACT Maternal Mortality Ratio</td>
<td>DHIS2</td>
</tr>
<tr>
<td>2</td>
<td>Maternal Cause of Death</td>
<td>DHIS2</td>
</tr>
<tr>
<td>3</td>
<td>Adolescent Birth Rate</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>COVERAGE Four or More Focused ANC Visits</td>
<td>DHIS2, HMIS</td>
</tr>
<tr>
<td>5</td>
<td>Skilled Birth Attendant</td>
<td>DHIS2, HMIS</td>
</tr>
<tr>
<td>6</td>
<td>Institutional Delivery</td>
<td>DHIS2, HMIS</td>
</tr>
<tr>
<td>7</td>
<td>Early Post Natal Visits for Mother and baby</td>
<td>DHIS2, HMIS</td>
</tr>
<tr>
<td>8</td>
<td>Met need for Family Planning</td>
<td>HMIS</td>
</tr>
<tr>
<td>9</td>
<td>Uterotonic Immediately after Birth for prevention of PPH</td>
<td>HMIS &amp; QoC</td>
</tr>
<tr>
<td>10</td>
<td>Caesarean Section Rate</td>
<td>DHIS2</td>
</tr>
<tr>
<td>11</td>
<td>INPUT Maternal Death Registration</td>
<td>QoC</td>
</tr>
<tr>
<td>12</td>
<td>Availability of Functional EmOC facilities</td>
<td>-</td>
</tr>
</tbody>
</table>
Challenges with Measurements & Health Programmes in Nigeria

• Primary data not available in DHIS2 for every EPMM Phase 1 Indicator
• Quality of data available
• Use of data for decision making is weak (e.g. MMR, maternal cause of death not analyzed regularly)
• Non Standardized patient data (e.g. lack of individual patient record) – hinders clinical case management and calculation of quality measures
• Challenges with some health facilities infrastructure and frequent stock out of commodities
• Availability and retention of skilled human resources for health at the health facility level
Conclusion

• Nigeria is working towards ending preventable maternal mortality through its 5 year Reproductive maternal, newborn, child and adolescent health (RMNCAH) strategy

• Nigeria is one of the nine “phase one” countries in the WHO MNCH quality of care network: Quality Improvement road map developed to halve institutional maternal mortality in 5 years

• MNH quality measures prioritized by health system level; dashboards under creation – State MOH, LGA (district), primary health centers (PHC), hospitals

• Nigeria needs to scale up initiatives to attain these goals

• Leadership, political commitment and an enabling environment is also essential to achieve these goals
Thank you for Listening!

Making Pregnancy and Child Birth Safer!!
How is the Bangladesh health system aligned with the EPMM indicators?

Dr. Mahbub Elahi Chowdhury
Scientist
Health Systems and Population Studies Division
icddr,b
Trend in maternal mortality reduction in Bangladesh (1990-2015)
Trend in increase of contraceptive prevalence rate and reduction of TFR in Bangladesh (1975-2014)
Adequate coverage of health facilities for comprehensive and basic EmONC services by administrative divisions in Bangladesh

No. of EmONC facilities per 500,000 popon.

- Public facilities designated for CEmOC
- Public facilities designated for BEmOC
- Private nfp facilities
- Private fp facilities
Lack of readiness of the health facilities for EmONC signal functions in Bangladesh
Poor quality of care for pregnancy and delivery related services in Bangladesh.
Lack of Human Resource (HR) in public facilities for EmONC services

![Bar chart showing HR availability index (%) for different categories of staff in district hospitals and mother and child welfare centres.](chart.png)

- **Medical doctors**: District hospital - 45%, Mother and child welfare centre - 30%
- **Nurses/FWVs**: District hospital - 65%, Mother and child welfare centre - 55%
- **Other technical staff**: District hospital - 75%, Mother and child welfare centre - 65%
- **Other support staff**: District hospital - 85%, Mother and child welfare centre - 75%
All EPMM Indicators by Groups

- Total indicators (37)
  - Policy (13)
  - Health system financing (7)
  - Coverage (14)
  - Impact (3)
### Status of EPMM policy indicators in Bangladesh

<table>
<thead>
<tr>
<th>Category</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laws and regulations in place for access to SRH</td>
<td>Regulations in place for RH. Services on sexual health is still not streamlined.</td>
</tr>
<tr>
<td>Gender Parity Index</td>
<td>Used only for education</td>
</tr>
<tr>
<td>Legal frameworks in place for non-discrimination based on sex</td>
<td>Has policy on advancement of women but legal framework does not exist.</td>
</tr>
<tr>
<td>Protocols/policies in place for combined maternal and baby care</td>
<td>Emphasis given but policies does not exist</td>
</tr>
<tr>
<td>Maternity protection in accordance with ILO</td>
<td>Policy in place for public servants only</td>
</tr>
<tr>
<td>International Code of Marketing Breastmilk Substitutes</td>
<td>Policy exists, revised in 2010</td>
</tr>
<tr>
<td>Costed implementation plan for MNCH</td>
<td>Available under the current sector program</td>
</tr>
<tr>
<td>Midwives authorized to deliver basic EmONC</td>
<td>The midwifery cadre has been introduced to provide maternity and basic EmONC</td>
</tr>
<tr>
<td>Legal status of abortion</td>
<td>Abortion not legal but menstrual services are available up to the grassroots level</td>
</tr>
<tr>
<td>Annual reporting on indicators to inform health sector reviews and planning cycles</td>
<td>Results Framework available. However, more emphasis needed on system indicators</td>
</tr>
<tr>
<td>Exception from user fees for MH-related services</td>
<td>MH-related services are free in public facilities but service availability is as issue</td>
</tr>
<tr>
<td>Policy/strategy for engagement of civil society in national review of MNCAH programs</td>
<td>Representatives of civil society are involved in the health facility committees but suffers from lack of empowerment</td>
</tr>
<tr>
<td>Annual reviews conducted on RMNCH health spending</td>
<td>Annual reviews conducted</td>
</tr>
</tbody>
</table>

- **Fully implemented**
- **Partially implemented**
### Status of EPMM health system indicators in Bangladesh

<table>
<thead>
<tr>
<th>Availability of EmONC facilities</th>
<th>Bangladesh has adequate number of health facilities for EmONC services. However, facility readiness is poor.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic distribution of EmONC facilities</td>
<td>Geographic distribution of the health facilities is also reasonably good. About 80% and 75% of the population has accessibility to comprehensive and basic EmONC facilities with 2 and 1 hour travel time respectively</td>
</tr>
<tr>
<td>Health worker density and distribution (per 1000 population)</td>
<td>5 physicians and 2 nurses for every 10,000 population. Current doctor-nurse ratio is 1:0.4 which is reverse of the WHO recommended ratio is 1:3</td>
</tr>
<tr>
<td>Midwife density (per birth)</td>
<td>Government has introduced 3 years diploma in midwifery course since 2012. Currently 1500 midwives are being produced annually from 53 institutions</td>
</tr>
<tr>
<td>Facility readiness to delivery RMNCH services</td>
<td>Despite having an adequate number of facilities, the readiness of the facilities for RMNCH services is poor.</td>
</tr>
<tr>
<td>Total health expenditure on RMNCH</td>
<td>Per capita Government expenditure on health in Bangladesh was US$27 in 2012, whereas the same for India and Nepal was US$61 and US$36 respectively</td>
</tr>
<tr>
<td>Out-of-pocket expenditure as % of total expenditure on health</td>
<td>Out-of-pocket expenditure on health is high 64%</td>
</tr>
</tbody>
</table>

- **In expected direction**
- **Not in expected direction**
Summary Findings

• Bangladesh has made reasonably good progress in the reduction of maternal mortality. The country has also attained the replacement level of fertility.

• Although Bangladesh has adequate health infrastructural set-up, readiness of the health facilities is a major issue, mainly due to unavailability of providers. Quality of MNH care services is also poor.

• Regarding the EPMM policy level indicators, the country has already implemented some, and the rest either have been partially implemented or are in the process of implementation by taking into account the local context.
Successful implementation of the EPMM Phase II indicators, particularly those related to health system strengthening, may have impact in service availability and improvement of quality of care that will help further reduction of maternal mortality in Bangladesh.

Initiative should be taken to inform and engage the relevant stakeholders about the EPMM Phase II indicators and incorporate those in the national health indicator list for periodic monitoring and review.
Ending Preventable Maternal Mortality

For more information, visit:

World Health Organization
who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/

Maternal Health Task Force
www.mhtf.org/projects/ending-preventable-maternal-mortality/