Research Article

Safe Motherhood Promotion in Bangladesh: Evidence from a NGO’s Local Level Health Monitoring and Advocacy Project

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Abstract

Introduction: Health and development partners have failed to invest seriously in safe motherhood. The issue “safe motherhood” is important because, they benefit not only the woman, but also the health of newborns and children and the well-being of entire households, societies, and nations. This paper presents the findings from an impact evaluation of the Safe Motherhood Project (SMP) conducted at the Hatibhanga Union of the Dewanganj Upazila in the Jamalpur District of Bangladesh. This project was implemented by Dhaka Ahsania Mission (DAM), a national non-governmental organization (NGO).

Objectives: The study objective was to assess whether project interventions, in particular, community-based activities, had a favorable impact on women’s access to and knowledge of maternal health care during pregnancy and childbirth.

Methods: The project impact was estimated using a number of qualitative research tools e.g., in-depth case study, focus group discussions (FGDs), key informant interviews (KII), and documentation survey.

Results: The results showed that the project successfully increased the utilization of interventions of monitoring and advocacy services, and enhanced women’s knowledge on danger signs.

Conclusion: Most of the targeted objectives were achieved within the time frame identified for the project. The project was considered comprehensive, sustainable and inclusive.

INTRODUCTION

The health system of Bangladesh relies heavily on the government or the public sector for financing and setting overall policies and service delivery mechanisms. Although the health system is facing many intractable challenges and it seems to receive little priority in terms of national resource allocation [1]. According to the World Health Organization (WHO) [2], only 3% of the Gross Domestic Product (GDP) is spent on health services. Mothers’ health has long been acknowledged to be a cornerstone of attention in public health. Of particular importance is an unacceptably high level of maternal mortality [3]. Most of the maternal deaths are due to direct obstetric causes such as hemorrhage, edampsia, sepsis, unsafe abortion and obstructed labor [4]. One of the important lacks in Bangladesh is the low of community participation in health promotion. Participation is considered an important component for securing community peoples’ decision making and equitable opportunities [5]. Community participation is the active involvement of people from communities preparing for, or reacting to, disasters. True participation means the involvement of the people concerned in analysis, decision-making, planning, and program implementation, as well as in all the activities. The community-focused programmes therefore aim to involve all members of a society in a participatory process of: assessing their own knowledge; investigating their own environmental

Bangladesh is a country with one of the highest population-density, with 1,031 people living per square kilometre. Two-thirds of the population (62.6 percent) live in rural areas, and the rest in urban area (37%). The current national population growth rate was 1.35%; the rural to urban migration rate was 21.9%; and the male-female ratio 100.3:100. The average household-size is 4.68. The life expectancy is 67.2 years (male 66.1 years and female 68.7 years). Bangladesh's population places a tremendous economic, social and environmental strain on the country's resources. Due to widespread poverty, children (40 percent) and mothers (30 percent) suffer from moderate to severe malnutrition. The Constitution ensures that health is the basic right of every citizen of the Republic, as health is fundamental to human development. The successive health plans of the country emphasize the Primary Health Care (PHC) as one key approach for improving the health status of the people. In Bangladesh, it is estimated that more than 95% of deliveries are conducted at home, and the majority of births are attended by untrained birth attendants, relatives, or neighbours that are not medically trained for delivery and every year 12,000 Bangladeshi women die due to pregnancy or pregnancy-related causes [18]. The statistics show that 29% of births in Bangladesh are delivered at a health facility, 12% in a public facility, 15% in a private facility, and 2% in an NGO facility. The likelihood of delivering in a health facility is considerably lower for women 35 years or older compared to those who are younger. Facility delivery decreases sharply as birth order increases. On the other hand, the number of women's antenatal care visits, education level and wealth status have a positive relationship with their likelihood of delivering in a health facility. For example, whereas only 11% of women with no education deliver in a health facility, the corresponding proportion for women with completed secondary education is 67%. 32% of births in Bangladesh are attended by medically trained personnel, that is, a qualified doctor, nurse, midwife, family welfare visitor (FWV), or community skilled birth attendant (CSBA). Additionally, trained traditional birth attendants assist in 11% of deliveries. However, more than half of births in Bangladesh are assisted by dais or untrained traditional birth attendants (53%), and 4% of deliveries are assisted by relatives and friends. Medically-assisted deliveries are much more common among young mothers and first order births [16].

The access to Skilled Birth Attendants (SBAs) is strongly recommended for all the pregnant women so as to make sure a normal delivery is conducted well; related complications are recognized early and referred immediately to the appropriate healthcare facilities. Birth attendance by SBAs is considered as the 'single most important factor in preventing maternal deaths' [19]. Government of Bangladesh initiated the Community-based Skilled Birth Attendant (CSBA) program to increase accessibility to skilled delivery at home in 2003 with the target to train 13,500 government field staff as CSBAs. As of June 2014, nearly 9,000 government CSBAs have been trained. Besides, some of the development partners have also been supporting the CSBA training to the private candidates, especially to cover the hard-to-reach areas [18]. According to the Sixth Five Year Plan [20], capacity will be improved to provide care of adequate quality particularly for the poor for normal childbirth (basic essential obstetrics care) through trained (community) skilled birth attendants, community clinics, union health and family welfare
centres, upazila health complexes and facilities at and above districts including maternal and child welfare centres, and for the prevention and management of complications (comprehensive essential obstetrics care) by expanding services in more upazila health complexes and ensuring the same through all maternal and child welfare centres and district hospitals and facilities.

The Union Council is one of four-tiers of local government institutions. The union council fulfills their commitment to the villagers through 13 standing committees. These committees are accountable to the people to provide available services for which government facilities and staffs are deployed from government’s various departments. Health and Family Welfare is one of the facilities available in each Union of the country through which people can get health and family planning services. Union Council’s have the right to oversee their activities as per their manual, under the Union Council Ordinance 1983. According to the manual, seven activities are mentioned for the union council standing committee, for which members would communicate with the Union Health and Family Welfare Centre (UHFWC) or Sub-Centre (Health) or FWC staffs, and they (the service providers-staff) inform the committee of their activities. All the health facilities are poorly maintained and controlled. Medicines, logistics and supplies are not monitored for their optimal use in treating patients. Numbers of posts in different health services centres were found vacant for ages.

Research methods and data

Project location: Dewanganj is a thana of Jamalpur district, located at 25.1417°N 89.7833°E degrees. Dewanganj is a municipality with an area of 4.54 sq km. It has 9 wards and 43 mahallas. As of the 2011 Bangladesh census, Dewanganj’s population was 258,133. The literacy rate was 45.05 per cent while female literacy rate was 37.65 per cent [16]. There is one Upazila Health Complex, 8 family planning centres, and 2 satellite clinics. Dewanganj is located in the north-western part of Bangladesh, and is considered one of the worst locals for survivors of riverbank erosion and floods. These natural phenomena result in increased landlessness, pauperization, unemployment, food insecurity and forced migration [16].

Stakeholders: The stakeholders that influence safe motherhood at the Union level and their respective relationships are shown in (Figure 1). The project stakeholders are the organizations, groups and people that the project intends to work with directly. The stakeholders of this project are situated at different levels e.g., at Union level (Up health standing committees; public providers of safe motherhood facilities; private providers of safe motherhood interventions (including private for profit, informal providers, services provided by other NGOs), Community Based Organizations (CBOs), and at higher levels (Upazila Health Authorities; District Health Authorities; Ministry of Health and Family Planning at the national level; and NGOs working in health sector).

Data collection methods: The study was based on a case study approach, where multiple data collection methods such as, in-depth case study, focus group discussions (FGDs), participant observation, key informant interviews (KIIs), and documentation surveys were utilized. Project related documents such as, project concept paper, monthly reports and monitoring results were
collected and reviewed to understand the ways of introducing and implementing the Safe Motherhood project, and to assess the impact of the project activities.

**Respondents:** We took in-depth interviews of the Unit Manager of DAM in Dewanganj, Jamalpur and another five pregnant mothers. Two sets of semi-structured interview schedules were prepared for these interviews. Three groups of the respondents were selected for FGDs. One was arranged with the pregnant mothers where the total 15 mothers were participated. We selected these numbers with the consultation of the area office of DAM. Another FGD was arranged with the representatives of Union Parishad Health Standing Committee (UPHSC) and another with the Community Based Organizations (CBOs) and community leaders. All of the members of UPHSC (a total of 11 participants-7 males and 4 females) participated in the FGD sessions. From CBOs and community leaders, the total 11 people were participated from different groups e.g., school teachers, NGO workers, Union Parishad Members, and local leaders. Separate guidelines were prepared for these three FGDs. Each session took one and a half hours. Another set of guidelines was prepared for the members of CBOs.

**Research ethics:** An agreement was approved between Dhaka Ahsania Mission (DAM) and technical supporter ICDDR, B and funder Rangpur Dinajpur Rural Services (RDRS) before conducting this study. We took written consent from the Unit Manager, the representatives of Union Parishad Health Standing Committee (UPHSC), and CBOs, and community leaders. We also took verbal consent from the pregnant mothers, because of their high illiteracy. We also followed the basic ethical principles during our study.

**Data analysis technique:** The thematic approach was used to analyse data as this analysis was considered as a foundational method for qualitative analysis [21].

**RESULTS**

The ways to sensitize public and private health service providers

The public providers in Hatibangha union were sensitized on the monitoring tools and the project interventions. The project staff supported UPHSC to motivate the providers to monitor data in each month. One workshop for private health care providers was arranged with the participation of the members. The workshop attempted to motivate the private providers to comply with government rules and regulations, and refer women to needed services. The CBO members conveyed a number of messages to the pregnant women and community people. These included the importance of ante natal care (5 times) during pregnancy and post natal care (4 times) after pregnancy, the importance of using skilled birth attendance for delivery, the five signs of health risks during pregnancy, issues related to nutrition and balanced diet during pregnancy and after child birth, importance of mental peace and relaxing for some period during pregnancy, importance of exclusive breastfeeding for newborns, and that equal access to quality maternal health care is the right of every pregnant woman, and the location of public health care facilities. The CBO members arranged FGDs and one-to-one counselling to increase awareness among the pregnant women and community at large on the above issues. The community mobilization was also being fostered through DAM staff to increase the demand of maternal health services. A rally was arranged on International Mothers’ Language Day, International Women’s Day, and Safe Motherhood Day. A film show on safe motherhood was also arranged twice to sensitize the community on safe motherhood. Ten monitoring tools were used to monitor the project activities. The project field staff (Field Coordinator and Union Facilitator) supported the UPHSC to assess the service provision of providers by monitoring of all facilities in the unions on monthly basis. The monitoring reports were shared with union parishad.

**Outcomes of the DAM Interventions**

**Community awareness:** Qualitative data confirmed that DAM brought a positive change among the community people especially among the pregnant women. Hence the objectives and goal of the project were met. We verified that the Thana Health Inspector highly appreciated the positive impact of the project interventions. He mentioned that he delivered services to many pregnant patients who were referred by the CBO members and UPHSC under the project and this number increased over time. The CBO members also confirmed that community mothers were more responsive to taking health services during pregnancy. They mentioned that the cultural barriers decreased over time, and the health service demands increased. However, the CBOs and UPHSCs roles were needed to convince mothers of the importance of services. As per their role, they encouraged the use of MNH and mother tools. The office data confirmed that in Hatibangha Union, there were 141 pregnant women, 234 received anti-natal care (ANC) service, 58 women delivered by a skilled attendant and 138 received postnatal care (PNC). All mothers received MNH Information Mother Tools from January to March in 2012.

**Role of the UPHSC for enhancing safe motherhood:** According to the project guideline, the UPHSC was responsible for enhancing safe motherhood in the community. The UPHS's progress indicators were measured by a number of methods, such as proper use the monitoring tools, translating community needs into proposals for local health authority/ providers and advocating for changes, and shared monitoring results with UP. The project received reports of satisfaction by communities on how problems were addressed. For achieving the progress indicators, the UPHSC members organized regular meetings (according to schedule) to discuss monitoring results with the local community; with at least 70% participation of members providing feedback to the communities after meetings. The committee and members trained UPHSC on their mandate, used monitoring tools, facilitated regular meetings with the UP standing committee, facilitated UPSC to organise meetings with CBOs and/or civil society on the monitoring findings. The study found that in all cases progress was at 100%. Data obtained from KIs and in-depth interviews confirmed that the UPHSC and its members performed their duties accordingly and they well prepared for performance of all types of activities and performances. According to the FGD information with the UPHSC, social needs and services for the pregnant mothers increased over time. The mothers reported they did want to have their children with skilled attendants during the birth period. The UPHSCs worked under a
written plan and were encouraged to use mother tools. On the 15th of every month a meeting was held with the FWA in order to discuss the quality of services and to spread information out to the community. The UPHSCs prepared a resolution and then sent it to the UHC. They scored an average 80% of the quality of DAM services regarding this safe motherhood.

Performance of public providers for safe motherhood at union level: The performance of the public health providers were measured through a number of indicators such as, to disclose their plan and budget to the public, deliver health care as per the plan and budget, maintain a standard protocol (government rules and regulations), have a positive attitude towards patients, refer mothers timely and properly to adequate facility levels, provide more counselling services to patients, use the existing MIS, and meet regularly with UPHSC. In order to fulfill these performances, the UPHSCs arranged workshops on the monitoring tools (including advocacy) with the Health and Family Planning officials, supported health service providers to fill out the monitoring tools, and facilitated consultation meetings between UP standing committees and Health and Family Planning officials for sharing monitoring findings. These qualitative performances were achieved at satisfactory levels except to advocate for solutions in case of constraint. According to the results provided by the local office, one Refresher Training of Union Parishad Education Health and Family Planning Standing Committee (UPEHPFSC) was arranged on monitoring tools, 12 UPEHPFSC organized regular monthly meetings to monitor analysis of data, 3 UP EFHPSC organized meetings with CBO’s and/or civil society platforms on the findings quarterly, 3 UPEHPFSC arranged quarterly consultation meetings with Health and Family Planning officials for sharing monitoring findings, and 12 meetings occurred between CBO and public providers. According to our qualitative data, the achievement was highly satisfactory.

Private providers have been sensitized for enhancing safe motherhood: As per project objectives, the formal private providers had knowledge about the government rules and regulations. In this regard, they supported UPHSC to map private providers in the union. DAM organised the workshops for private providers. Data showed that there was one meeting arranged to support UPHSC in organizing workshops for private providers, and 3 meetings were done to support UPEHPFSC in organizing workshops for private providers on monitoring findings. The performance was highly satisfactory. The study team asked a number of questions to the private service providers including CBO members. By which the team was fully convinced that both formal and informal private providers have sufficient knowledge about the present government rules and regulations related on safe motherhood.

Create partnership and replicate of the project: One of the objectives of the project was that the Ministry of Health and Family Planning (at upazila, district and national levels) would take initiative to improve health service provisions for safe motherhood with NGOs so that it would replicate the plans at unions and upazila levels. It was found that the policy makers in the local areas participated at high levels in meetings to discuss monitoring findings. They showed a positive attitude towards the project during these meetings, took action to solve concrete problems (problems were effectively solved), and promoted replication of the project interventions in other areas. The project attempted to build partnerships with other communities, NGOs, union and upazila authorities. In addition, the UPHSCs visited the project activities - in their upazila, discuss their plan with the implementing UPHSC, and request replication in upazila meetings. The main activities for these performances supported CBOs to work with the UPSCs to document and analyse monitoring findings and translate findings into feasible and concrete recommendations.

DISCUSSION

The main objective of this study was to show whether the project interventions, in particular, community-based activities, had a favorable impact on women’s access to and knowledge of maternal health care during pregnancy and childbirth. The above discussion clarified that DAM used a wide range of interventions under the safe motherhood project and achieved positive results on different components of the project. The main limitation of our study was that we could not compare our result within the same level of the respondents in the same community to justify the impact of DAM interventions as it was based on a case study method [16]. With considering this limitation, the study found that DAM had made the UPHSC functional with the formation of CBOs, providing training to them, arranged regular meetings of CBOs and HSC, and intensive monitoring and supervision of project activities against selected indicators. It facilitated organizing regular meetings to identify local problems, to find out probable solutions, and to decide courses of action. It encouraged 100% participation of members at the HSC meetings every month, while more than 75% of the members attended the CBO meetings. We found that that the proportion of deliveries by SBAs was similar to the estimates of nationally representative survey findings though the proportion of women received any ANC was higher. The finding of this study is compared with Islam et al. [22], DAM provided feedback to the communities after the meetings and monitoring results were also shared with the local community. DAM staff members made these possible through their hard work and commitment towards achieving the goals. They (FC and UP) had the flexibility in decision making and there was no bureaucracy in communication among central and local level. FC and UP received support from the central level as they required.

The reduction of maternal mortality has now become one of the leading global health agendas emphasized in Millennium Development Goal 5 [5]. In this regard, the study finding indicated that DAM’s contribution was helpful to achieve this agenda. Like Islam et al. [22], our study found that maternal occupation, parity, complications during pregnancy and antenatal check-up (ANC) by SBAs was the significant determinants of delivery by SBAs. Through activating CBOs along with community mobilization activities (e.g., rally, film show), DAM contributed in creating trust among pregnant mothers and community people that maternal care is available in public facilities, and using public facilities leads to safe delivery and reduced maternal mortality arising from child birth related complications. Before the initiation of the project, perceived poor quality of care at public facilities led to low utilization of public facilities for maternal
health care. DAM was successful in breaking that myth to a great extent, and created demand among pregnant women for ANC, PNC and safe delivery. This finding can be compared with Kamiya et al., [4]. They have found from a Japanese aid-funded project that the project exerted positive effects on the utilization of ANC and postpartum EmOC services, as well as on the improved knowledge of danger signs during pregnancy and delivery. DAM project ensured better functioning of public facilities through creating awareness among providers and creating a bottom up pressure from community people. All this resulted in improved health outcomes in Hatibhangla. The project had been widely appreciated by all stakeholders, including the community, the CBO and HSC members.

The research team agreed that DAM project had a number of strengths. The team concluded that the project was comprehensive, inclusive and sustainable. The project was able to consider all of the relevant local partners/stakeholders within the project. These partners (both GO and NGO) helped to ensure successful operation of the safe motherhood project. DAM was able to deliver numerous activities by using local resources where participation was very high. Though the project achieved considerable progress over a short period of time, but several challenges remained there. Like the findings of Islam and Biswas [1], and WHO [2], we believe that the lack of decentralization and low amount of public health budget are major challenges in health system in Bangladesh. Our finding also compared with another finding of WHO [6], we found that apathy and disempowerment, conflict and division, poverty and cynicism were main barriers for community participation in health promotion. In addition, this study noted that due to the shortage of staff many services were not possible to deliver to the pregnant mothers at the grassroots levels. Almost all of the stakeholders mentioned 'no incentive' and 'long distance' for participation as threats and weaknesses of the project. Most of the CBOs and GO-NGO service providers mentioned that one major problem is the non-availability of delivery services in FWC. Distance of the upazila health complex from the homes of pregnant mothers discouraged them to utilize the delivery services from modern facilities. Though the project has contributed to improved availability of health workers in public facilities, this is still not enough to meet the local needs. In many cases we discovered that the staff members failed to secure effective community participation. Like Bath and Wakerman, we perceived that community participation is associated with improved health outcomes [23]. Unavailability of health care providers at public facilities was identified as a major constraint in accessing quality maternal care in public facilities in Dewangang. The major problems identified in accessing maternal care were inadequate supplies of medicine, vacant post of health workers in public facilities, lack of measurement instruments, and lack of urine examination instruments, lack of delivery instruments, lack of breast examination machines, and lack of vasectomy and ligation systems.

CONCLUSION

The objective of the health monitoring and advocacy of safe motherhood project was to empower pregnant women through capacity building to utilize health services in their community. The project was considered successful based on the overall response to the activities, workshops, and trainings by participants. Most of the targeted objectives were achieved within the time frame identified for the project. The project was considered comprehensive, sustainable and inclusive; however, there was a consensus from the participants that the overall situation of safe motherhood in Bangladesh is currently not good. We also agreed that there were good examples of what can be achieved with appropriate intervention methods to secure safe motherhood. We acknowledged the comments of AbouZahr [3] that the activities of both grassroots organizations and international health and development agencies have helped to build political will and momentum. We found that many problems were related to the composition of the community both geographical and local as many people came from long distances to cover the project outcomes. Due to natural disasters such as flood and rain, lack of transportation, poor socio-economical conditions of the people and shortages of health services at union and upazila health complex, the project could not achieve the overall desired expectations. In considering the overall limitations, this study provides a number of recommendations, which included i) to arrange a mid-term orientation meeting for the members of UPHSC, CBOs, public and private service providers in order to aminate about the project objectives; ii) to form a 'husband-group' in order to obtain family support; iii) to arrange refresher training for the CBOs to enhance their knowledge on safe motherhood; iv) to develop an effective partnership so that the beneficiaries, community, implementing agency, and development partners can work together, and monitor the project activities closely; v) to strengthen the referral mechanism for reducing the delays in accessing services from FWC/ UHC; vi) to develop an appropriate management information system (MIS) in the local community; and vii) to supply printed documents, such as posters, stickers, leaflets can be distributed for community awareness.

ACKNOWLEDGEMENTS

The authors acknowledge to three organizations: Dhaka Ahsania Mission (DAM) for operation of this study, ICDDR, B for technical support, and Rangpur Dinajpur Rural Services (RDRS) for funding support. The authors also gratefully acknowledge the generosity of those women, community people, and staff members of the DAM local office who participated in interviews for this study.

Funding

This study was funded by the Rangpur Dinajpur Rural Services (RDRS).

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