Thematic Review of Safe Motherhood in Bangladesh

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MOHFW and UNFPA

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List of abbreviations

ANC	- Antenatal Clinic
AMDD	- Averting Maternal Deaths and Disability
ASRH	- Adolescent Sexual and Reproductive Health
BBS	- Bangladesh Bureau of Statistics
BCC	- Behavioural Change Communications
BDHS	- Bangladesh Demographic Health Survey
BEmOC	- Basic Emergency Obstetric Care
BMMS	- Bangladesh Maternal Health Services and Maternal Mortality Survey
BMI	- Body Mass Index
BNC	- Bangladesh Nursing Council
BRAC	- Bangladesh Rural Advancement Cooperation
CEmOC	- Comprehensive Emergency Obstetric Care
CMSD	- Central Medical Store Department
CNC	- Community Nutrition Centres
CNP	- Community Nutrition Promoter
COPE	- Client Oriented Provider Efficient
CP	- Country Programme
CPR	- Contraceptive Prevalence Rate
DGFP	- Directorate General of FP
DGHS	- Directorate General of Heath Services
DMPA	- Depo Medroxy Progestone Acetate
DSI	- Dinajpur Safe Motherhood Initiative
EmOC	- Emergency Obstetric Care
FeHA	- Female Health Assistant
FP	– Family Planning
FPCST	- FP Clinical Services Team
FWA	- Family Welfare Assistant
FWV	- Family Welfare Visitor
GoB	- Government of Bangladesh
HMIS	- Health Management Information System
HMP	- Health, Nutrition and Population project
HNPSP	- Health, Nutrition and Population Sector Programme
ICMH	- Institute of Child and Maternal Health
ICPD	– International Conference on Population and Development
IDU	- Intravenous Drug Users
IPPF	- International Planned Parenthood Federation
IUD	- Intrauterine Device
MCH	– Maternal and Child Health
MCHTI	- Maternal and Child Health Training Institute
MCWC	- Maternity and Child Welfare Centres
MDG	- Millennium Development Goals
MMR	- Maternal Mortality Ratio
MoHFW	-Ministry of Health and Family Welfare
MoLGRD	- Ministry of Local Government and Rural Development
MR	- Menstrual Regulation
MVA	– Manual Vacuum Aspiration
NGO	- Non-Governmental Organization
NNP	- National Nutrition Programme
NSV	- No Scalpel Vasectomy
O&G	- Obstetrics and Gynaecology
OGSB	- Obstetrical and Gynaecological Society of Bangladesh
PHCC	- Primary Health Care Centre
PIP	- Programme Implementation Plan
PoA	– Programme of Action
QA	- Quality Assurance
QAT	- Quality Assurance Team
QoC	- Quality of Care
RH	- Reproductive Health
RTI	– Reproductive Tract Infection
SACMO	- Sub-Assistant Community Medical Officer
SBA	- Skilled Birth Attendants
STI	– Sexually Transmitted Infection
TFR	- Total Fertility Rate
UHC	- Upazila Health Complex
UHFWC	- Union Health and Family Welfare Centres
UPHCP	- Urban Primary Health Care Project
VDRL	- Veneral Disease Research Laboratory

Summary of findings and recommendations

The health and family planning programme of Bangladesh has made remarkable progress in the last two decades as evident from the decline in fertility rate, infant and child mortality rates. The reduction in maternal mortality in the past 15 years is 22%, right on target towards Millennium Development Goal (MDG) of a 75% reduction between 1990 and 2015. However, the Maternal Mortality Ratio (MMR) is still high (320 per 100,000). Haemorrhage is the leading cause of death followed by eclampsia. Low level of awareness about complications during pregnancy, poor access to quality EmOC facilities particularly in the rural areas and economic barriers to accessing care are reported as some of the important contributory factors to the high level of maternal mortality. An important contributory factor to the high level of maternal mortality, the Total Fertility Rate (TFR), has declined to 3 after a decade of stagnation at 3.3 (Bangladesh Demographic and Health Survey (BDHS) 2004). There are marked differentials in MMR and TFR rates between the divisions, the rates being highest in Sylhet and Chittagong. The differentials between different economic quintiles are also marked. The recent data from the BDHS shows that while there is an increase in antenatal care by skilled providers, there is no improvement in proportion of deliveries conducted by skilled attendants (14%). The proportion of institutional deliveries is woefully low (10%). The data also shows that the low level of postnatal care continues. The Contraceptive Prevalence Rate (CPR) has increased to 58% (modern methods) (an increase by 4%), however the proportion of users of the long acting methods have remained stagnant and the high drop out rates continue. These findings have major implications for maternal mortality reduction programmes. The Government of Bangladesh (GoB) has developed several strategies to improve the access to skilled care and to Emergency Obstetric Care (EmOC), especially by the poor.

The main objective of the thematic review of the quality of safe motherhood services is to identify areas for future programme strengthening to create an enabling environment for improved utilisation of services by the poor. The framework for the review focused on rights of clients and needs of providers. Key elements that are critical for enabling the realisation of the rights, especially by poor women, such as policy framework, decentralisation, quality assurance mechanisms and human resource development and the role of NGOs and private sector have also been reviewed.

The summary of findings and recommendations are given below.

1. Policy framework

The National Maternal Health Strategy is built on rights framework and is based on the 'three delays' model. Reduction of maternal mortality is one of the major goals of the Poverty Reduction Strategy and Health, Nutrition and Population Sector Programme (HNPSP) indicating the commitment of the GoB. However, there are gaps in terms of resource allocation for EmOC.

Recommendations

- Using the digitised enumeration maps developed by Bangladesh Bureau of Statistics (BBS) (with UNFPA assistance under the Sixth Country Programme (CP), the current and planned availability and distribution of EmOC facilities should be reviewed. The information should be used for planning of facilities.
- Consideration should be given to increasing budget allocations to meet the gaps in number and distribution of EmOC facilities to ensure access within a maximum time of two hours.
- The HNPSP human resource development plan should pay special attention to availability of doctors and nurses trained in EmOC (see more under section 3.4 'human resource development).

2. Decentralisation and local level planning

The current efforts at decentralisation of the HNP sector include activities for maternal mortality reduction.

Recommendations

- Advocacy efforts should be directed at the HNP service development committees to
  - increase budgetary allocations for EmOC facilities
  - improve human resource availability for safe motherhood (including Family Planning (FP) and Reproductive Tract Infections (RTI) / Sexually Transmitted Infections (STI). This should contribute to achieving the targets in reduction of maternal and infant mortality. With increasing number of women especially the poor having access to facilities, equity and gender equality should also improve.
- The management skills of the District and Upazila health managers should be strengthened which should contribute to improving the efficiency of the health system and thereby the efficiency of the EmOC services, as it is inextricably linked to the former.

3. Quality assurance (QA) systems

Various quality assurance mechanisms are being implemented by the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) as well as by the Urban Primary Health Care Project (UPHCP). Maternal death audits and clinical audits are being practised by some of the Medical Colleges. However, the systems need strengthening.

Recommendations

The following recommendations are made in the context of the HNP Sector Investment Plan that promotes a health system that is more responsive to clients' needs, efficient and effective in reaching the services to the poor.

- HMIS
  - The proposed strengthening of the Health Management Information System (HMIS) by the DGFP and DGHS under HNPSP should provide an opportunity to institute mechanisms to ensure that the reports are reviewed and appropriate actions are taken. This is also important for performance planning as envisaged under the HNPSP.
  - The labour room and client records should be reviewed to add columns or subtitles to ensure that relevant information is collected. In addition, the maternity ward registers, death records and general statistical records of female patients should be reviewed and modified appropriately. The Maternal and Child Welfare Centres (MCWC) reports should include information on complications (linked to recommendations on HMIS under section 3.9 'right to continuity of care').
  - The reporting on EmOC indicators developed under the 'Women's right to life and health' project should be strengthened. It is important to ensure that the definitions are well understood by the institutions.
- Review of the QA instruments and system should be done to ensure regularity and follow up actions based on the findings of the monitoring visits.
- The quality and coverage of the maternal death reviews should be strengthened with the ultimate objective of reducing maternal deaths and improving the quality of care and not for punitive action. Perinatal death reviews also should be instituted. Training programmes should be instituted to systematically introduce facility-based maternal death and perinatal death reviews[1]. Since substantial number of maternal deaths takes place at home, a system of verbal autopsy should be introduced (ICDDR, B is an excellent resource). The community based SBAs should be trained in the technique. 'Near miss audits' introduced under the 'Women's right to life and health' project should be strengthened. Clinical audits should be instituted in health facilities (see details under section 3.6. 'right to safe services') based on the gaps identified during maternal death reviews.

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[1] Facility-based maternal death review is a "qualitative, in-depth investigation of the causes of, and circumstances surrounding, maternal deaths which occur in health care facilities". Source: Beyond the numbers. Reviewing Maternal Deaths and Complications to Make Pregnancy Safer. WHO, Geneva.

- Community audits of maternal deaths by women's groups should be encouraged to monitor the quality of care provided at institutions or at home. Such audits also build accountability of the health system.
- The composite score used under the urban project should be reviewed.
- As part of the monitoring process being developed under HNPSP and the decentralisation process, quality assurance circles (building on the existing ones) should be developed. These circles will ensure the quality of various service components of safe motherhood. This will also help to bring accountability as the HNP service development committees include community stakeholders.
- All activities on QA should be linked to the QA system being developed under the HNPSP.

These recommendations reinforce the action plans of maternal health strategy.

4. Human resource for safe motherhood

The national maternal health strategy includes a human resource plan to support safe motherhood services. Although the action plans of DGHS and DGFP under HNPSP recognises reduction in maternal mortality as one of the focus areas, the human resource development planning has no specific focus on human resources for safe motherhood. As per the strategy, several categories of providers from the peripheral facilities have been trained in EmOC. Currently the training of community based Skilled Birth Attendants (SBAs) and training in midwifery of the Family Welfare Visitors (FWVs) are underway.

Recommendations

- Decision should be taken on the duration of the EmOC training of Doctors.
- The excellent training materials developed for the four months course training and the methodologies should be used for training, irrespective of the final decision on the duration of training.
- Regulation on scope of practice of various categories of providers should be clearly defined. The Bangladesh Nursing Council (BNC) should take a lead on this issue.
- Quality assurance in training through follow up and clinical audits should be developed (see also under section 3.3 'quality assurance').
- See recommendations for SBA training and FWV training under section 3.11 on 'staff need for information, training and development'.
- An updated human resource plan for safe motherhood should be developed and should be part of the HNPSP plan (as recommended under the 'policy framework'). The plan should include the proposed posting of junior specialists in Upazila Health Complexes (UHCs).

5. Client's right to information

Information contributes to empowering women to participate in decision-making and enable them to exercise their right to care. The GoB has implemented several strategies to increase awareness about FP and safe motherhood and it has paid dividends as evident from the increase in knowledge levels. However, there are still information gaps on key issues such as the awareness about danger signs during pregnancy and birth preparedness plan, critical for overcoming the delay in seeking care and delay in reaching a health care facility. Other critical information gaps are knowledge about side effects of contraceptives (a major reason for high drop out rates), dual protection with condoms and STIs.

Recommendations

Stimulating demand for services is one of the seven challenges/ strategies identified under the HNP Sector Investment Plan.

- The information campaigns should be complemented with evidence based strategies for BCC for <u>key decision makers</u> in the family and community (using ongoing effective strategies or developing new ones). The aim is to make " every pregnancy special" and ensure that a woman's right to safe pregnancy and delivery is ensured. These efforts should be linked with the various BCC activities being undertaken by various agencies and the proposed Behavioural Change Communication strategy with UNFPA assistance. The focus of these should be on complications

of pregnancy, birth preparedness planning (see details below), skilled birth attendants at delivery and gender-based violence particularly during pregnancy.

- The capacity of the BCC workers under the UPHCP in interpersonal communication should be strengthened. A system should be developed through which the BCC workers discuss with families the information provided under the public information campaign.
- Regular health education in ANC, maternity wards and postnatal clinics on care of mother and newborn, birth planning, FP and STI/HIV and gender based violence should be provided (as appropriate).
- The health education sessions should ensure "two way communication' to enable clients to clarify doubts. Such an approach will also help health educators to assess whether the clients understood the messages. Consider including the topic during training.
- Posters and leaflets on topics identified above especially on danger signs during pregnancy, skilled birth attendants at delivery, side effects of contraceptives and dual protection, presented in a manner that is easily understood by an illiterate person, should be made available in all health facilities. Such health education material should be displayed in community facilities (as appropriate) as well as in groups organised by women's development programmes.
- The knowledge of the Family Welfare Assistants (FWAs) and Female Health Assistants (FeHAs) (in wards and villages where no community based SBAs are available) and FWVs and Nurses in UHCs, Upazila Health and Family Welfare Complexes (UHFWCs) and UPHCP centres should be improved to promote birth preparedness planning (The training of community based SBAs does include information on birth preparedness planning). The birth preparedness plan should identify the skilled birth attendant, preparation for home delivery, transport, emergency funds and location of EmOC facility.
- During home visits, the field workers should hold sessions on birth preparedness planning that includes the key decision makers in the family. The planning should ideally include the birth attendant the family traditionally uses and the practitioner (if applicable) to ensure their support in referral of cases during complications (this is important as often the birth attendants/ practitioners delay the referral in case of complications).
- The lessons learned from the CARE Dinajpur Safe Motherhood Initiative and other similar community mobilization initiatives for safe motherhood should be reviewed and replicated elsewhere. Linkages should be established with the existing women's groups to foster partnership with them to help women realize their right to safe pregnancy and delivery. Such a partnership will help women to access information on topics identified above and access services.

6. Clients' right to informed choice

The quality of FP counselling is poor and it is difficult to comment whether the choice is based on 'a well considered decision' that is based on information and understanding. The influence of provider bias in choice of method was difficult to assess.

Recommendations

- The quality of counselling services should be improved by strengthening the skills of providers in counselling in various situations (discussed under the section on 'provider need for information, training and development') and by providing full information on the topic of concern.
  - FP counselling should include information on all methods available, advantages and disadvantages, side effects, action to be taken in case of missing dose and provision of condoms for back up protection and for dual protection if at risk. In case of IUDs and surgical contraception, counselling after the procedure is equally important.
  - As identified earlier in case of STI clients, focus should be on prevention of future infections, increased risk of HIV, importance of taking full course of treatment, follow up, partner counselling and treatment.
  - Clients of post-abortion care should be counselled for FP. The information shared should focus on the risk of immediate conception if no FP is used and the methods that are most suitable for immediate use and for use after a prescribed duration of time.

Counselling helps duty bearers (health service providers) to enable rights-holders (clients) to realise their rights.

- In case of non-emergency situations, a system of counselling clients before obtaining consent for procedures should be initiated. However, in case of emergencies, stabilisation of clients should be done first.
- Information on importance of voluntary donation, screening of blood and obtaining safe blood should be provided to key decision makers of the families of clients needing blood transfusion. This is critical since the most common practice in UHCs and MCWCs and private sector is obtaining blood from private blood banks for women who need transfusion.

WHO's Decision making tool for FP clients and providers is a very useful tool for promoting informed choice.

7. Clients' right to access to services

The continuing disparities in access to maternal health services by income status, with women belonging to the lower economic quintiles having poor access to reproductive health care especially EmOC is a concern. Although the access to antenatal care is good, the utilisation is poor as evident from the data presented earlier. The major access issues are access to skilled care during home deliveries and in institutions after hours. The other issues are poor linkage with nutrition programmes for improving the nutritional status of the undernourished pregnant women, poor access to laboratory services for STI diagnosis and safe blood transfusion services. Postpartum FP is not actively promoted. Cost is a major barrier to accessing the public sector services. The other social barriers are lack of decision- making power even when women have the knowledge about the importance of accessing care.

Recommendations

❖ <u>Safe motherhood</u>

- Recommendations under 'right to information' should contribute to improving antenatal care and postnatal care as well as deliveries by skilled birth attendants.
- Review of human resources in the health facilities should be done to ensure that skilled care is available round the clock in District Hospitals (DHs) and UHCs.
- The SBA training should be expanded to cover all the Upazilas in the districts where the training has started and then to other districts, giving priority to districts with high maternal mortality. Consideration should be given to starting the training programme in urban areas.
- The linkages with nutrition programmes should be strengthened. A system of referral of poor and malnourished women to the nutrition centres should be developed. The linkage with nutrition programmes is also one of the actions listed under the maternal health strategy.
- EmOC facilities
  - Expand access to EmOC by strengthening facilities for provision of EmOC services as envisaged under the HNPSP beginning with high mortality divisions. All the UHFWCs should be strengthened to provide obstetric first aid.
  - While expanding the access, all efforts should be made to ensure the continuation of the EmOC services being provided by the designated facilities. The EmOC monitoring format used by the DGHS and the reports from MCWCs should be reviewed regularly and action should be taken to fill the gaps. The format should be reviewed to ensure that information on availability of all signal functions of BEmOC is available. The clinical and managerial reasons for the gaps should be rectified (linked to the recommendations under 3.3. quality assurance).
- Human resources for safe motherhood should be reviewed critically. The current needs and projected needs should be estimated and should be part of the HNPSP plans (see under sections 3.1 and 3.4 'policy framework and human resource development'). The availability of skilled attendants round the clock should be one of the factors considered while developing the plan.

- FP

- Postpartum FP services should be strengthened in all the facilities. FP should be actively promoted during domiciliary postnatal visits.
- The quality of counselling services should be strengthened (details under the section "right to informed choice"). Dual protection using condoms should be actively promoted.
- A system of follow up of clients should be instituted to track clients on oral contraceptives and injectables who discontinue the method. This could be easily achieved by modifying the existing FP recording system (linked to section 3.9 'right to continuity of care'.
- A directive should be sent out from the DGFP clarifying the issue on registration of facilities under the City Corporation for receiving free FP supplies. Since these facilities cater to the poor urban slum dwellers, access to free services and supplies will contribute to increasing the use of FP methods.
- Availability of emergency contraception should be expanded to the rural areas after adequate training.

- RTI/STI services

- The syndromic management of RTI/STI services should be further strengthened. The treatment facilities should be extended to all the UHCs. The UHFWCs should be strengthened as per national policy to provide RTI/STI services (see recommendations under section --- 'need for staff information, training and development').
- Counselling and partner notification and treatment should be strengthened.

- Laboratory facilities

- The laboratories in the DHs and UHCs should be strengthened for aetiological diagnosis of selected RTIs/STIs. (also discussed under recommendations in the section on 'right to supplies, equipment and facilities).
- Consider starting laboratory facilities in MCWCS to improve access to RTI/STI services.

- Blood transfusion facilities

- As per national policy on blood safety, blood-banking facilities should be developed in all the DHs with priority given to districts where EmOC services are being strengthened.
- Stringent quality assurance mechanisms for safe blood should be instituted as articulated in the National Strategic Plan for HIV/AIDS.

- Economic barriers

- Based on the findings of the evaluation of the pilot projects on maternal health voucher scheme, the scheme should be expanded to other areas. Close monitoring of the beneficiaries of the scheme is important and women's groups can play a major role in this. While introducing the scheme, it is also important to ensure that the beneficiaries are aware of their entitlements under the scheme.
- Community saving /insurance schemes
  - Through women's groups or through other community mobilisation efforts, women from poor families should be encouraged to save for emergencies – pooling of funds is an option. Community insurance scheme and BRAC's micro-health insurance scheme are other options. In case of community insurance schemes, t is important to ensure that poor families are not excluded and that women with complications do have access to the funds.
- Facilities visited had a functioning ambulance, however the availability of the transport 24 hours is a concern. Mostly the ambulance is available for transporting patients to a higher facility and less likely for transferring patients from home. Efforts should be made to identify community transports that are available 24 hours for transporting emergencies. The form of transport may vary according to the local situation. Mechanisms for paying for the transport should be developed in advance.

❖ Social and gender related barriers

- Active partnership with community-based organisations should be fostered to overcome some of the social and gender related barriers listed under findings. Experiences from the CARE Dinajpur project has shown clearly that social mobilisation efforts facilitate participation and inclusion of women in decision making and utilisation of services.
- Although there were no reports of health service provider attitudes being a deterrent to accessing care, all training of health service providers should include the importance of positive attitude towards women, particularly the poor who utilise the services.
- As recommended under section 3.5, the traditional birth attendants and practitioners should be involved in the birth preparedness plan.

8. Client's right to safe services

Standards are essential for delivery of safe services. Although standards for safe motherhood services especially management of obstetric complications have been developed, they were not available in the facilities. Evidence-based management of normal and complicated labour and delivery such as use of partograph to monitor labour, active management of third stage of labour, use of Mag. Sulf for management of eclampsia, assisted vaginal delivery and removal of retained products of conception using Manual Vacuum Aspiration (MVA) technique were not being followed in most of the facilities, however the case management practices are better in MCWCs and UPHCP facilities. Obstetric first aid is not available in any of the UHFWCs. Infection prevention especially waste disposal is another area of concern. Clinical audits are practised in some of the teaching institutions. Referral guidelines for referring obstetric and neonatal complications are not available.

Recommendations

- Written standards should be available in all the health facilities. The existing guidelines and the MCWC operational manual should be reviewed and updated or modified to set clinical standards for health facilities at various levels. From the SBA'S reference manual, standards for home deliveries should be developed. The standards at various levels of health care should be well linked. The standards should include immediate care of the newborn and readiness of facilities for emergency care. In addition, standards for facility management and for protecting the rights of clients should be developed. The recommendation is also one of the actions under the maternal health strategy.

  WHO's safe motherhood publications, listed below, are useful resource materials.

i. Integrated Management of Pregnancy and Childbirth: Managing complications of Pregnancy and Childbirth: A Guide for Midwives and Doctors. WHO Geneva. *(this is already available in Bangla).*

ii. Integrated Management of Pregnancy and Childbirth: Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care. WHO Geneva.

iii. Managing newborn problems: Guide for doctors, nurses and midwives, WHO Geneva.

- Involvement of professional associations in the development of guidelines should be ensured for promotion of adherence to the guidelines.
- Partographs should be introduced in all UHCs and the process should be reactivated in DHs. The staff should be oriented to the importance of maintaining the partograph in all labour cases and the importance of timely action to prevent maternal deaths and morbidity. The review of partographs should become part of the quality assessment tools.
- All efforts should be made to institutionalise active management of third stage of labour.
- The capacity of the MCWCs, UHCs and UPHC centres and selected DHs should be strengthened to provide immediate newborn care and management of complications of newborns.
- The flow charts for management of obstetric and neonatal complications should be displayed in all the labour rooms.
- Mechanisms should be developed to ensure that EmOC trained staff (Nurses and Doctors) are available round the clock every day of the week.
- Guidelines for referral of obstetric and neonatal emergencies should be developed which should include instructions on critical elements such as stabilising the patients before referral, communicating in advance with the facility where the client is being referred, care during transportation, relevant medical records and referral note.

- Management of emergencies and referrals as per guidelines should be instituted and adhered to in all the facilities.
- All six signal functions of BEmOC should be made available as recommended in the section ' right to access to services'.
- The recommendations on safe blood supply are given under the section ' right to access to services'.
- The UHFWCs should be strengthened to provide obstetric first aid.
- Counselling on FP of post-abortion clients (with emphasis on early return to fertility) should be strengthened.
- The importance of counselling while providing emergency contraception should be emphasised to the staff of the facilities where the method is being introduced. Although standards for FP methods exist, it should be ensured that infection prevention during procedures and dual protection with condoms are emphasised.
- The infection prevention practices in all the facilities should be strengthened and adequate supplies for the same must be ensured.
- Clinical audits should be instituted in as many facilities as possible. These should be undertaken by teaching institution staff[2]. Availability of standards is a pre-requisite for clinical audits. The aspects of care that is deficient as identified from maternal and perinatal death reviews should be audited. The audit should contribute to ensuring that the practice in hospitals are governed by the standards and protocols developed. Complete case records are essential for the process. The private sector should be also audited using the same tools.
- Quality improvement processes such as COPE and facility audits should be instituted within institutions so that problems are identified and action is taken (linked to recommendations on quality assurance circles).
- The quality of menstrual regulation services should be monitored. Counselling of clients prior to and after the procedure especially for FP is critical to prevent immediate conception (due to early return of fertility) and another procedure. Infection prevention during the procedures should be strictly adhered to.

3.9. Clients' right to continuity of care

Vital signs of postpartum clients at prescribed intervals are not checked regularly. Follow up of FP clients and STI clients is not satisfactory. Management of referrals is not satisfactory.

Recommendations

- The training in FP should emphasise the importance of providing information on warning signs, care after IUD insertion, surgical contraception and what action to be taken by the client as well as the health service provider an follow up. The importance of post-abortion clients being followed up for provision of FP should be included in the training (stress the early return of fertility and chances of another pregnancy if no contraception is used).
- Institute mechanisms for follow up of clients.
  - The clients should be provided information on when to return for follow up services/ supplies. The importance of follow up visits /check ups should be emphasised to pregnant women and postpartum women.
  - The current HMIS should be reviewed to assess whether it is possible to track clients. The tracking should help to identify defaulters in case of FP spacing methods, women who are due to deliver (to reinforce birth preparedness plan and to provide postnatal care as early as possible) (linked to the recommendation under section 3.8 right to safe services).

[2] Clinical audit is a quality improvement process that seeks to improve patient care and outcomes by the systematic review of care against explicit criteria and the implementation of change. Source: Beyond the numbers. Reviewing Maternal Deaths and Complications to Make Pregnancy Safer. WHO, Geneva.

  - The discharge slips should be modified to include full information about significant history and examination findings and treatment provided, what treatment / care should be continued at home, what to watch for, when to return for follow up.
- Follow up of STI clients should be strengthened as well as treatment of their partners.
- The referral system should be strengthened.
  - Referral guidelines should be developed as discussed under the section ‘ right to access to safe services’.
  - Referral slips should be developed that includes a section on feedback, preferably detachable, that can be sent through the client or relative to the facility that referred the client.
  - The providers in the referral facilities should be oriented to the importance of feedback to the referring facility on diagnosis and management of the case or on follow up treatment. This should help in follow up of referred clients.
  - Linkages should be established with private /NGO hospitals where specialist services are available. However, it is important to ensure that the facility provides quality care. Mechanisms for reimbursement of costs in case of poor patients should be spelt out while establishing the linkages.
  - The facility that is referring should assist with arrangements for transportation of the patients either through the health facility ambulance or a community transport (see recommendations under section 3.7 ‘access to services’).

10. Clients' right to privacy and confidentiality and Clients' right to dignity, comfort and expression of opinion

Maintenance of privacy in FP clinics and labour rooms is not satisfactory. Patients are not provided opportunities to express their concerns, which is critical for improving services.

Recommendations

- Privacy and confidentiality should be improved by changing the attitude of staff through training. Such training should use well-designed role plays that will help the staff understand the “client’s feelings’ and thus realise the importance of these elements of care. This aspect of care should be regularly monitored.
- A system of feedback from clients should be instituted to improve the quality of services. Such a system would ensure that patients whom the system is supposed to serve understand their entitlements (right to information, informed choice, access to services and safe services) and create an enabling environment to demand them. In such an environment, providers will be obliged to follow standards.
- Client/stakeholder involvement should be encouraged using the lessons learned from the various projects in the country.

11. Staff need for information, training and development

Training of Medical Officers and Staff Nurses, Laboratory Technicians and Blood Bank Technicians (from MCWCs and selected UHCs) to upgrade facilities to provide EmOC services has been done. The training in counselling is not satisfactory. SBAs receive competency-based training. FWVs are being trained in midwifery and Nurses from selected facilities receive training in standards of midwifery care. Follow up training is a major gap.

Recommendations

- Staff at all levels including district hospitals (as needed) should be trained in immediate care of newborn.
- All staff should be trained in diagnosis and management of gender-based violence as part of EmOC training and linked with ongoing UNICEF and NGO efforts.
- Midwifery skills of all nurses posted in district hospitals, UHCs, MCWCs and UPCP facilities should be strengthened through short courses. It may be worth considering permanent posting of nurses interested in midwifery in the labour rooms.
- The training of nurses in midwifery standards should be expanded to all the facilities.

- The DH specialists should be oriented to gain their support in the implementation of the EmOC standards.
- The FWV training should be reviewed in the context of the community-based SBA training.
  - The training should include selected BEmOC skills so that UHFWCs can start providing such services as envisaged under the HNPSP plans as discussed under section 3.1 'policy framework'.
  - The training also should include skills in supportive supervision (see also under section 3.11 ' staff need for facilitative supervision and management'.
- Both the SBA and FWV training should be institutionalised (as discussed under the background section, the training of SBAs is not institutionalised).
- The trainees should be followed at their worksites. Follow up of trainees is essential to assess the retention of skills and the quality of services provided. A sample of trainees should be followed up. The training follow up guidelines given in the training management guidelines should be implemented. Plans for follow up of other trainings also should be developed. A well-defined plan for follow up should be part of any training design. Adequate funds should be included for the same.
  - The community based SBA training programme should have a follow up plan for the batches that have been trained / undergoing training and for the new batches that will be trained. The plan should include when the follow up will take place, who will do the follow up, guidelines for follow up, reporting and what remedial actions to be taken in case of gaps in skills or other problems that affect the quality of care. Funding should be provided for follow up.
- A master plan for training of community-based SBAs that includes their follow up should be developed. This should be linked to the training plans and training management information system being developed under HNPSP.
- The job description of the SBAs should be developed by reviewing and modifying the current job descriptions of the FWAs and FeHAs.
- BNC's capacity and capability (managerial and technical) should be strengthened to monitor the quality of the training of SBAs and FWVs and also follow up of trainees. Seconding of competent staff from training institutions to BNC is an option that should be explored.
- Involvement of professional organisations in providing training support. Such involvement will create a supportive environment for mentoring the staff trained in EmOC and Anaesthesia.
  - OGSB should expand its role to support continuing education of doctors in EmOC. It should continue to play an active role in the training of SBAs, especially in the evaluation and the modification of training materials. It should provide inputs into the review and revision of the FHV training in midwifery and support the BNC in midwifery training of nurses.
  - The professional societies of anaesthesia and neonatology should be actively involved.

12. Staff need for facilitative supervision and management

The system of supervision is weak. The decision on supervisors of SBAs is not available.

Recommendations

- Supportive supervision needs to be strengthened at all levels.
  - Besides training supervisors, it is also important to develop supervisory checklists that can be used by the supervisors for monitoring and the next level of supervisors.
  - The technical skills of supervisors need to be strengthened to enable them to assess the quality of services as well as mentor the staff they supervise.
  - The supervision should include (but not limited to) review of protocols to ensure that workers understand them, review of records to see the coverage of services and discussions on gaps, importance of infection prevention and privacy and confidentiality. Clinical audit is a good tool to teach staff.
- The managers of health facilities need orientation in importance of quality improvement and the need to support staff in various quality assurance activities. The support of managers is critical in infection prevention, ensuring privacy and functioning equipment. The managers also should institute a system of recognising staff who perform well

- The recommendations under 'quality assurance' are also applicable to strengthening supportive supervision and management.
- As more community based SBAs are being trained and posted, it is critical to identify and train the supervisors. This should be done on a priority basis.

13. Staff need for supplies, equipment and infrastructure

Shortage of essential EmOC drugs, supplies and equipment were noticed in all the facilities including in MCWCs that has a well-established system of supply and repair. Shortage of Mag. Sulf, mucus suckers, ambu bags and endotracheal tubes were reported in many of the facilities. Readiness of instruments (sterile instruments packed in sets as per requirements of the procedure) is a concern. No clear directions on replenishment of the contents of SBA kits are available. Maintenance of equipment is another area of concern. The contraceptive logistics management system appears to be working efficiently.

Recommendations

- Drugs and supplies
  - A stock position of EmOC drugs and other emergency drugs should be available in the labour room and theatre. The responsibility for the same should be given to a staff member.
  - Regular laboratory supplies should be ensured in all the facilities that have a functioning laboratory (see also recommendations under section 3.7 'right to access to services'.
- Instruments and equipments
  - Readiness of instruments for use should be ensured.
  - All the staff in the labour room should be trained in the use of neonatal resuscitation equipment and its care.
  - Consideration should be given for providing baby radiant warmers/heaters in labour rooms.
  - The system of maintenance of equipment should be strengthened / introduced in facilities where such a system does not exist
  - Equipment for MVA should be supplied to all EmoC facilities and staff should be trained in the procedure.
- Mechanisms should be developed for replenishing the supplies of the SBA kit.
- Logistics management system
  - The current efforts to strengthen the logistics management system should be extended to include EmOC drugs and supplies.
  - Storekeepers should be trained in the system.

14. NGOs and private sector

The main area of concern is the access of the poor to the services provided by the NGOs and private sector. The linkage between the public sector facilities and NGOs/ private sector is not clearly defined. This is critical for improving access to EmOC services.

Recommendations

- NGOs
  - A review of the current linkages between NGO institutions and Government Institutions should be undertaken with a view to identify potential areas of linkages in the delivery of safe motherhood, FP, RTI/STI services. Once the areas are identified, formal referral linkages should be established including mechanisms for reimbursement of cost of hospital care.
  - Monitoring the use of services by the poor under the UPHCP should be introduced.
- Private sector
  - Private sector institutions should be identified for collaboration based on specific selection criteria. Linkages with such institutions should be formalised including mechanisms for reimbursement of cost of hospital care.
  - The private sector institutions should be oriented to national standards and guidelines and mechanisms should be developed to monitor the quality of care provided.

15. Maternal mortality data

The current HMIS or maternal death reviews do not provide complete information for monitoring maternal mortality as planned under the HNPSP.

Recommendations

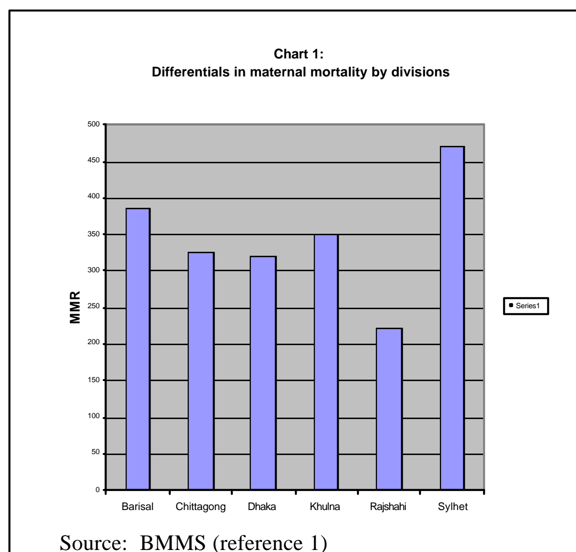
- As recommended under section 3.3, maternal death reviews should be improved and a system of verbal autopsy should be introduced for completeness and accuracy of recording of maternal deaths.
- Perinatal death audits should be introduced.

WHO's publication " Beyond the numbers – Review of Maternal Deaths and Complications to Make Pregnancy Safer" is a very useful publication.

1. Background

1.1. Maternal health status

The health and family planning programme of Bangladesh has made remarkable progress in the last two decades as evident from the decline in fertility rate, infant and child mortality rates. The reduction in maternal mortality in the past 15 years is 22%, right on target towards Millennium Development Goal (MDG) of a 75% reduction between 1990 and 2015[3]. However, the Maternal Mortality Ratio (MMR) is still high (320 per 100,000)[1]. An estimated 600,000 suffer maternal complications every year. Worldwide data indicate that for every maternal death there are a number of women who suffer from chronic complications such as fistula, uterine prolapse, chronic pelvic pain, secondary infertility and urinary incontinence[4]. The prevalence of obstetric fistula in Bangladesh is 1.69 per 1,000 ever-married women[5]. One of the most tragic consequences of maternal deaths is that about three-fourths of the babies born to the women who died also die within the first year of life. The infant mortality is 65 per 1,000 live births with a neonatal mortality rate of 41 per 1,000 live births. There is no significant reduction in infant and neonatal mortality rate. Neonatal mortality rate level is inextricably linked to health of the mother during pregnancy.

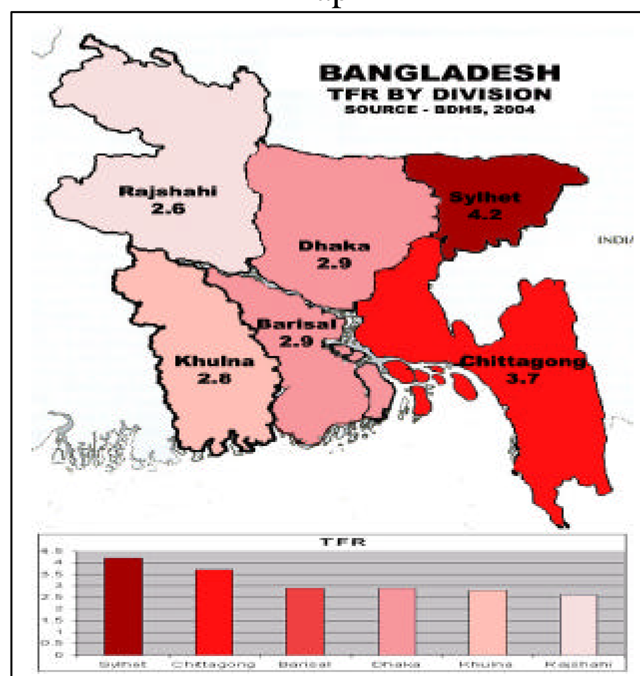


Source: BMMS (reference 1)

An important contributory factor to the high level of maternal mortality, the Total Fertility Rate (TFR), has declined to 3 after a decade of stagnation at 3.3[6]. The Contraceptive Prevalence Rate (CPR) has increased to 58% (modern methods) (an increase by 4%).

There are marked differentials in MMR and TFR rates between the divisions as shown in Chart 1 and Map 1. The rates are highest in Sylhet and Chittagong. The differentials between different economic quintiles are also marked as shown in Charts 2 and 3.

Map 1

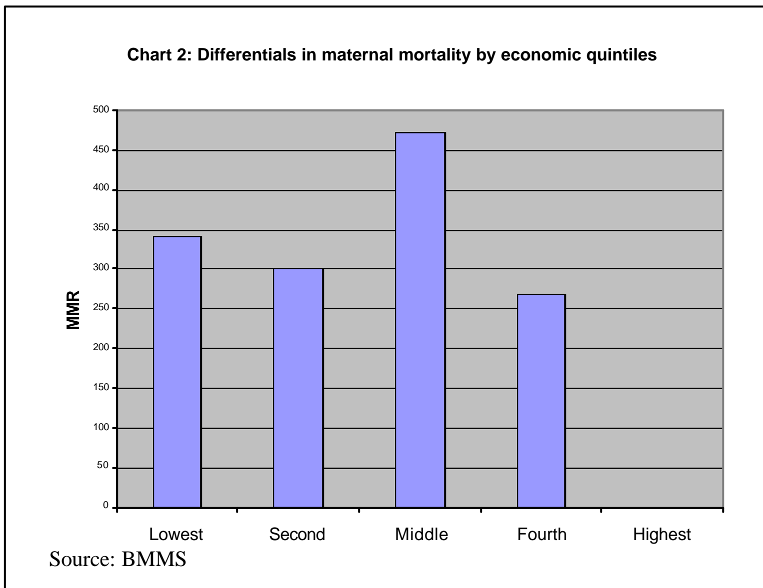


The findings from the Bangladesh Maternal Health Services and Maternal Mortality Survey (BMMS) indicated that maternal deaths accounted for 20% of all causes of death among women of reproductive age[1]. Haemorrhage, eclampsia, prolonged/ obstructed labour, puerperal sepsis and abortion-related deaths are reported as the main causes of death. A significant decrease in abortion-related deaths was reported and has been attributed to the improved accessibility to Menstrual Regulation (MR) services. The

[3] NIPORT, ORC Macro, JHU and ICDDR, B: Bangladesh Maternal Health Services and Maternal Mortality Survey 2001.
[4] Population Reference Bureau: Making Pregnancy and Childbirth safer. 1998
[5] EngenderHealth: Situation Analysis of Obstetric Fistula in Bangladesh. A Report. 2003. (funded by UNFPA, Bangladesh)
[6] NIPORT, Mitra and Associates, Macro International Inc: Bangladesh Demographic and Health Survey 2004. Preliminary Report.

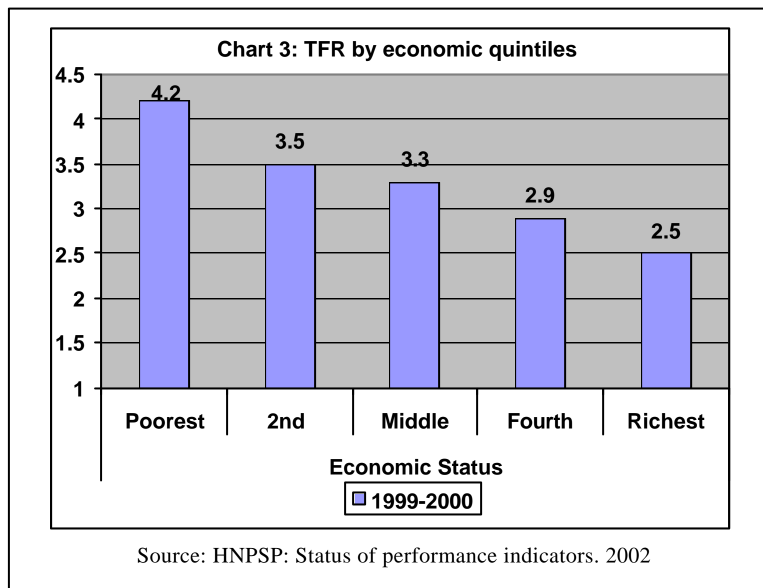
survey reported that the majority of the deaths occurred in the postpartum period.

The BMMS reported that awareness among women about complications was low. The most common complications reported were pre-eclampsia followed by prolonged/obstructed labour and postpartum bleeding. The reason for the low percentage of reported cases of postpartum bleeding could be due to the fact that very few with the complication survived. Retained placenta, excessive vaginal bleeding and signs of eclampsia were considered by the women as potentially life threatening. 60% of those with life threatening complications sought treatment, the most common reasons for seeking treatment were convulsions followed by prolonged labour and retained placenta. Among women with perceived complications, only 32% sought treatment from a qualified practitioner. A high percentage did not seek treatment or sought treatment from an unqualified provider. The most common cause for not seeking care was cost followed by the perception that there was no need. Among the ones who perceived a life threatening complication, 26% recognised the problem immediately and sought treatment and 55% sought treatment within six hours. The travel time to a facility was less than two hours. The patients were attended to within an hour of reaching the facility. The above findings point to the delays in recognition of life threatening problems.



Source: BMMS

Poverty and status of women are the root causes of the problem of high maternal mortality and are linked to underlying and immediate causes of death. 33% of the population lives below poverty line. As discussed in the preceding section, even when women recognized life-threatening complications, they did not utilise a facility because of "too much cost"[1]. Transportation and lack of permission from the family were lesser obstacles to seeking care[1]. Although the services in the government facilities are free, the utilization by the poor is very poor. A recent study by DFID has shown that the public sector services are mostly being utilized by the first two richest quintiles. The utilization of government facilities by the poor is a major concern of the health planners and development agencies. The low level of literacy among women is another contributory factor.



Source: HNPSP: Status of performance indicators. 2002

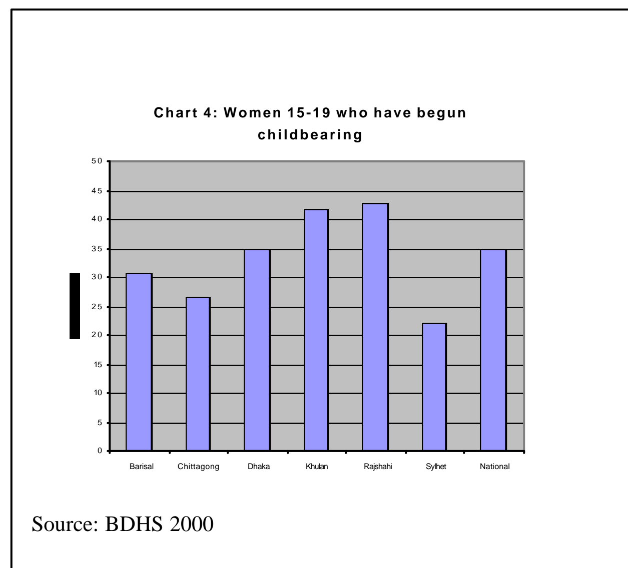
Early childbearing is another important risk factor for maternal death. According to the current fertility rate (Bangladesh Demographic and Health Survey (BDHS) 2004), on an average, women will have 22% of their births before reaching the age of 20[4]. The data from the BDHS 2000 showed that in rural areas 35% of the

adolescents have begun childbearing, the highest percentage being in Khulna followed by Rajshahi[7]. Chart 4 shows the inter-divisional variations.

Abortion is not legal in Bangladesh. However, MR for pregnancies less than 6 weeks of gestation is allowed. The reported rate of abortions is 5% [1]. MR contributes to another 2.4% [1] and the percentage of stillbirths is 2.5%1.

Maternal malnutrition is a major concern. Chart 5 shows the Body Mass Index (BMI) according to division. The percentage of women with BMI less than 18.5kg/m^2 is nearly 45%. 34% of non-pregnant and 51% of pregnant women are reported to be anaemic [8]. These have major implications for pregnancy outcome.

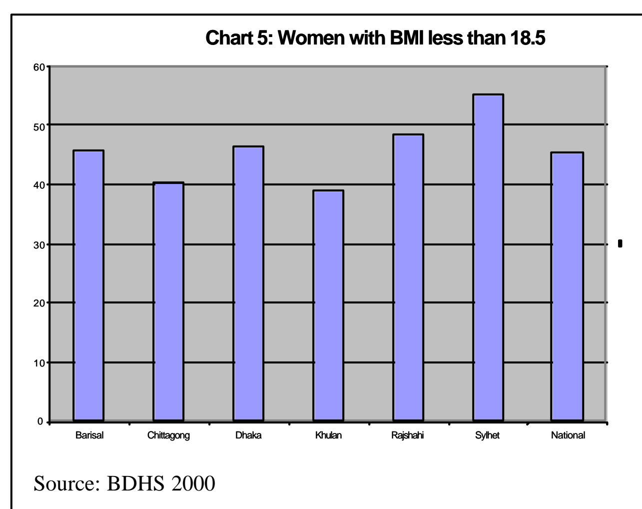
363 cases of HIV have been diagnosed since 1989 when the first case was detected[9]. So far 57 cases of AIDS have been reported. The figures are considered underestimates of actual figures as no comprehensive reporting system exists. The HIV prevalence rate is less than 1% in all high-risk groups except Intravenous Drug Users (IDUs) (4%). Although the HIV prevalence rates are low, the various risk factors that facilitate transmission are present in the country. Among Sexually Transmitted Infections (STIs), syphilis tops the list (9.7%)[7].The prevalence rate of Hepatitis C is 83% among IDUs. Women and girls are considered highly vulnerable to HIV/AIDS and STIs due to the high incidence of violence against women and girls[7].



Source: BDHS 2000

1.2. Policy framework

The Bangladesh National Strategy for Maternal Health was developed in 2001. The goal of the strategy is to reduce maternal mortality and morbidity[10]. The aims and objectives to be achieved by 2010 are given in Annex 1. The Strategy focuses on the rights of women to safe motherhood and the programme of action is built around the 'three delays' framework of factors that hinder the women from receiving the services they require. The strategy is the basis for the safe motherhood sub-area activities under the Health, Nutrition and Population Sector Programme (HNPSP)[6]. The National Strategy for Economic Growth and Poverty Reduction and Social



Source: BDHS 2000

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[7] NIPORT, Mitra and Associates, Macro International Inc: Bangladesh Demographic and Health Survey 2000.
[8] MOHFW: Health, Nutrition and Population Sector Programme July 2003-June 2006. Programme Implementation Plan. March 2004.
[9] GoB: National Strategic Plan for HIV/AIDS 2004-2010. National AIDS/STD Programme, DGHS, MOHFW. 2004.
[10] MOHFW: Bangladesh National Strategy for Maternal Health. October 2001.

Development, 2003 includes reduction in maternal mortality as one of the targets, thus recognising maternal mortality reduction as an essential element of the poverty reduction strategy[11]. Maternal mortality reduction is a priority objective for the HNPSP. Table 1 shows the targets set under various national development frameworks. The efforts are to ensure that poor women have equitable access to quality safe motherhood services.

Table 1: Targets for Maternal mortality and fertility reduction under National Development Frameworks

HNPSP				
Indicator	**Unit of Measurement**	**Benchmark (with Reference Period and Source)**	**Projected***	
			Mid-2003	**End HNPSP Mid-2006**
Maternal Mortality Ratio (MMR)	Annual number of maternal deaths per 1000 live births	3.2 (Bangladesh Maternal Health Services & Maternal Mortality Survey, 2001)	2.95	2.75
Met Need for EOC	Percentage of deliveries with an obstetric complication managed at GOB EOC facilities	12.6% (2002; UMIS estimate based on EOC reports from 218 GOB facilities)	13%*	25%*
Total Fertility Rate (TFR)	Life time number of birth per woman at current period	3.3 (BDHS 1999-2000)	3.2	2.8
A National Strategy for Economic Growth, Poverty Reduction and Social Development				
Indicator	**Unit of Measurement**	**Benchmark (with Reference Period and Source)**	**Projected**	
			Mid-2000	**2015**
Maternal Mortality Ratio (MMR)	Annual number of maternal deaths per 1000 live births	3.2 (Statistical Year Book of Bangladesh Bureau of Statistics (BBS)	3.2	1.47

*Unified Management of Information System (UMIS) projection

1.3. Decentralization and local level planning

The HNPSP has initiated decentralisation and local level planning process. A pilot programme in six districts has been implemented where the local-level planning with stakeholder participation has taken place. The local level planning enables 'pulling down' of resources and improves ownership (due to involvement of local staff). The ultimate aim is to move towards decentralisation and devolution of powers. The need for strengthening skill in strategic planning, professional management, budget and financial management and personnel management for achieving the aim is well recognised[12]. The plan is to expand the project to all Districts and Upazilas. With decentralisation, the centre will be taking on new roles in policy formulation, regulation, resource allocation and performance management[10].

1.4. Human Resource Development

The National Maternal Health Strategy defines five core areas under human resource development, which are: ensuring adequate supply of staff to achieve the maternal health objectives, education and training to produce appropriately skilled staff, performance management to optimise the quality of work and technical efficiency, providing working conditions conducive to meeting the needs of maternal health services and institutionalisation of training with a focus on standardised training programme[8]. The Strategy also has defined the human resources needed for meeting service delivery targets for Comprehensive Emergency Obstetric Care (CEmOC), Basic Emergency Obstetric Care (BEmOC) and Midwifery care. Under the Strategy, the midwifery care is expected to be provided by community-based Skilled Birth Attendants (SBAs) (from the cadre of Family Welfare Assistants

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[11] GoB: A National Strategy for Economic Growth, Poverty Reduction and Social Development. 2003. Economic Relations Division. Ministry of Finance.
[12] MoHFW: HNP Strategic Investment Plan. July 2003 – June 2004.

(FWAs) and Female Health Assistants (FeHAs) and Family Welfare Visitors (FWVs). The SBA training programme has started. The FWVs are being trained in midwifery, Nurses and Medical Officers from DHs, UHCs and MCWCs are being trained in EmOC and Anaesthesia and Blood Bank and Laboratory Technicians are being trained to support EmOC. The HNPSP includes human resource management plans under the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The plan includes workforce planning, deployment and capacity building through training. A detailed plan for training, monitoring, follow-up and supportive supervision are included and a Training Management Information System is planned.

1.5. Reproductive health (RH) service delivery

1.5.a. Organisational structure and service delivery

All countries, with the support of all sections of international community, must expand the provision of maternal health services in the context of primary health care. These services are based on the concept of informed choice, should include education on safe motherhood, prenatal care that is effective and focused, maternal nutrition programmes, adequate delivery assistance that avoids recourse to caesarean sections and provides for obstetric emergencies, referral services for pregnancy, childbirth and abortion complications, postnatal care and family planning. ICPD PoA 8.22.

The Ministry of Health and Family Welfare (MoHFW) is headed by the Secretary. The DGHS and DGFP implement and supervise, health and FP activities. In addition, a Directorate of Drug Administration and a Directorate of Nursing exist. The six divisions have Divisional Directors under the DGHS and the DGFP, with no service provision role. The 64 Districts have separate management structures under the DGHS and the DGFP, responsible for service provision. The Civil Surgeon is responsible for services under the DGHS and the Deputy Director FP is responsible for services under the DGFP. The 397 rural Upazilas have Upazila Health Complexes (UHCs) the administrative centres for Upazila health and FP services.

The structured, hierarchical pyramid of the public health system has five layers. At the ward level, the FeHAs (under the DGHS) and FWAs (under the DGFP) provide services in the community through home visits or through community clinics. After the prescribed training, these categories become community-based SBAs. Union Health and Family Welfare Complexes (UHFWC) function at the Union level. The UHCs are the first referral facilities. Staff appointed by the DGHS and the DGFP function in this facility. Medical Officers, staff nurses and FWVs (from the DGFP) are posted here in addition to FP service staff and laboratory staff. Junior specialists in Obstetrics and Gynaecology (O&G) have been posted in some of the UHCs. Each district has a District Hospital (DH) under the DGHS. The DHs have posts of O&G, Anaesthesia and Paediatrics and are considered as CEmOC facilities. The DHs have a laboratory capable of carrying out the common diagnostic tests and a blood transfusion facility. The Maternal and Child Welfare Centres (MCWCs) under the DGFP function at the district level and are expected to provide CEmOC. The Medical Colleges and specialist Hospitals are the tertiary-level referral facilities.

In an attempt to strengthen safe motherhood and FP services at the Union level, the DGHS and DGFP have posted few Medical Officers at the Union level.

Table 2. Expected reproductive health services at different levels of health care facilities

Health care facility	Level and number	Provider (only those related to RH)	Expected services
Medical College Hospital	District (13)	Specialists, Medical Officers, Nursing Staff, Lab Technicians, Blood Bank Technicians	Antenatal, delivery and postnatal services, CEmOC, FP (all methods), full fledged laboratory and blood bank

Health care facility	Level and number	Provider (only those related to RH)	Expected services
District Hospital	District (59)	Specialists, Medical Officers, Nursing Staff, Lab Technicians	Antenatal, delivery and postnatal services, CEmOC, FP (all methods), laboratory with facilities for VDRL testing and other RTI/STI tests and blood transfusion facility
Maternal Child Welfare Centre (MCWC)	District (54)	Medical Officers, FWVs, Dai Nurse	Antenatal, delivery and postnatal services, CEmOC, FP (all methods)
	Upazila (23)	Medical Officers, FWVs	Antenatal, delivery and postnatal services, CEmOC, FP (all methods),
	Union (12)	Medical Officers, FWVs	Antenatal, delivery and postnatal services, CEmOC, FP (no surgical contraception)
Upazila Health Complex (UHC)	Upazila (402)	Junior specialists in O&G (in few facilities), Medical Officer, Nursing staff, FWVs (3), Upazila FPO, Assistant FPO, medical technologists, radiology technicians	Antenatal, delivery and postnatal services, BEmOC (in selected facilities) and CEmOC (in selected facilities) (all methods except surgical contraception. Few facilities provide surgical contraception and the rest through camps)
Union Health & Family Welfare Centre	Union (3,477)	Medical Officer in some facilities (both from DGHS and DGFP), FWV, SACMO/Medical Assistant	Antenatal, delivery and postnatal services, FP (all methods except surgical contraception. Surgical contraception provided through camps), MR
Community	Village (10,819)	FeHA, FWA, community-based SBA (after training)	Antenatal, postnatal, FP (condoms, oral contraceptive pills and injectables). SBAs provide antenatal and postnatal services and conduct home deliveries in addition to FP

The STI services are provided through specialised clinics at Medical Colleges and DHs (selected). Reproductive Tract Infections (RTIs) other than STIs are generally treated by O&G specialists. The Medical Officers at the MCWCs and the UHCs manage STI cases using the syndromic management approach. Drugs for treating are available in all the MCWCs and selected DHs and UHCs.

1.5.b. HMIS

The current HMIS on RH includes maternal health and FP records. The FWA maintains a register that has details of pregnant mothers and FP clients. She also maintains a contraceptive stocks register. The newly developed cadre of SBAs maintains antenatal registers that records delivery as well as postnatal details. Each pregnant mother registered at the clinic has an antenatal card that includes sections on delivery and postnatal care. Antenatal clinic registers are maintained in the clinics. Delivery registers are maintained in all the facilities that provide the service. The current records do not allow for tracking clients. The reports are compiled at various levels in the health and FP system and it is expected that the feedback will be provided to the peripheral levels.

1.5.c. Logistics management system

The Central Medical Store Department (CMSD) procures all the major medical and supplies including overseas procurement of drugs and also receives the drugs and equipment procured by donor agencies. The CMSD distributes the commodities to the district stores that in turn supplies to the facilities below the district level. The Civil Surgeon receives funds for drugs, supplies and minor equipment and purchases the items according to the demands of the DHs and UHCs. The DGFP purchases the necessary drugs, FP commodities, equipment and supplies and stores them at a central warehouse. The supplies are sent to the Deputy Director FP who distributes them according to demands to the UHCs and MCWCs. The FWAs receive supplies from the Upazila FPO. In addition, UNFPA provides special funds for MCWCs to procure EmOC and RTI/STI drugs and to repair equipment.

The MoHFW has developed a system to forecast contraceptive commodity requirements for the country. The system involves key persons from the MOH&FW, External Resources Division and the DGFP. The forum also includes representatives from USAID, UNFPA, CIDA and DELIVER-Bangladesh. The objective is to review the contraceptive commodity stock position and give direction on the projected number of contraceptives required for Bangladesh (both in the Government and NGO sector). This forum has already given contraceptive needs projection from 2000 to 2015 and the procurement plan is based on this forecast. This committee, coordinated by UNFPA and DELIVER-Bangladesh, reviews and monitors the situation every six months.

1.5.d. Referral linkages

Patients referred from the community level (by the FeHA/FWA) either to the UH&FWC or to the UHC depending of the condition. UHFWC refers cases either to the MCWC (at the Upazila level, if available) or to the UHC. UHCs and Upazila level MCWCs refer complicated cases either to the district level MCWCs or DHs. District level MCWCs refer complicated cases either to the DHs or Medical College Hospitals. Complicated cases from the DHs are referred to the Medical College Hospitals for tertiary care. Referral slips are provided to the cases referred from the MCWCs.

1.5.e. Quality assurance (QA)

To ensure the quality of services at the MCWCs, Family Planning Clinical Services Team and Quality Assurance Teams (FP CST & QAT) have been formed under the leadership of the Senior Assistant Directors in eight regions. The teams are responsible for ensuring readiness of the facilities to provide EmOC by ensuring that the trained staff, drugs and equipment are available (and functioning) and that the facility is maintained well and infection prevention practices are followed. The team also provides support for strengthening sterilization and clinical family planning services. The team submits reports to the Director of Maternal and Child Health (MCH) Services and UNFPA for information and necessary actions. The team regularly visits the facilities once a month and use a checklist for assessing the facilities and take necessary action. Documentation of the actions taken is expected. The MCWC team is expected to do a self- assessment using a checklist that also includes some form of audits of case management. The system contributes greatly to the functioning of the MCWCs.

To ensure quality of services provided under the DGHS, especially at the UHCs, QA teams have been formed at the Medical College Hospitals. The team consists of representatives from the Departments of O&G, Anaesthesia and Blood Bank and the Nursing Institute. Guidelines and tools for assessing quality have been developed. During the visits each team assesses the facilities for readiness and quality of services provided and discusses with the local EmOC team to solve the problems identified. Records are also reviewed by the team. This team finally submits the report to the Line Director In Service Training and Essential Services Programme, Programme Manager of RH programme, Divisional Director and the Civil Surgeon of the specific area for information and necessary action.

In addition, maternal death reviews and clinical audits are done in selected facilities (mostly Medical Colleges). The QA system under the urban projects is discussed under section 1.7.

1.6. National nutrition project

The National Nutrition Project (NNP) interventions are designed to reduce the prevalence of moderate and severe underweight in young children, increase pregnancy weight gains, reduce the incidence of low birth weight and reduce the prevalence of iron-deficiency anaemia among adolescent girls and pregnant women. Community nutrition activities are organized at the Community Nutrition Centres (CNCs), established for a population of 1,250 to 1,500, and are run by female workers called Community Nutrition Promoters (CNPs). Specific activities at the CNC include growth monitoring of children, monitoring of weight gain of pregnant women, targeted food supplementation to undernourished pregnant women and breastfeeding mothers and adolescent girl nutrition services. Pregnant mothers also receive iron-folic acid tables and postpartum Vitamin A supplementation from these centres. The health system is expected to refer pregnant mothers to the nutrition centres.

1.7. Urban RH services

The urban population of Bangladesh comprises the population living in six city corporations and 223 municipalities. Approximately 23% of the total population lives in urban areas and it is expected to increase at 33 percent by 2010. The mandate for providing primary health care in urban areas is with the Ministry of Local Government and Rural Development (MOLGRD), delivered through City Corporation Clinics. Health care services provided directly by the DGHS in the urban areas are confined to the Medical College Hospitals, DHs and Government Dispensaries. MCH services are provided by the DGFP through the MCWCs. Apart from for-profit private providers, RH care is mainly provided by the NGOs contracted by the Asian Development Bank-financed Urban Primary Health Care Project (UPHCP) implemented by six City Corporations. UNFPA is one of the collaborating agencies.

The Comprehensive RH Care Centres provide CEmOC and laboratory services. The centres do not have blood-banking facilities. The services are provided on payment except for the poor (based on a selection criteria). RH education in the homes is carried out by community workers supported by UNFPA.

The QA system set up under the UPHCP is comprehensive. A private agency (Mitra Associates in collaboration with the Johns Hopkins University) has set up a system for monitoring the quality of services. The objective is to provide the program managers and donors and UPHCP partners regular feedback and indications of progress and lack of progress, to track actual performance and situation against what was planned and expected according to pre-determined standards and to provide comparative picture of various partner's performance. The assessment is done through household surveys, health facility surveys, participatory evaluation studies and regular project monitoring activities at specified periods. The integrated supervision instruments use a wide range of qualitative and quantitative approaches to monitor the performance at the service delivery points by undertaking a quick and valid assessment of functioning of the health facility within a period of a single day's visit. Scores are given to each of the instruments and a composite score is used for each NGO.

1.8. NGO and private sector

NGOs have played a key role in the delivery of RH and FP services. Some of the NGOs that have introduced innovations for improving the quality of services, cost-effectiveness, equity in coverage and sustainability are listed below. NGOs such as Bangladesh Rural Advancement Society (BRAC) have developed strategies for increasing the access of the poor to maternal health services including EmOC. Many of the NGOs provide subsidised maternal health services so that the poor can easily access them. While the majority focuses on community-based midwifery services, some have developed CEmOC facilities. Some such as Lamb Hospital have developed competency-based

training programmes in midwifery and also a blood bank that caters to the public sector as well. The NGO facilities that do not have EmOC facilities usually refer them to the Government Hospitals. The linkages are formalised in the urban sector as described above. In the rural sector, the Bangladesh Population and Health Consortium has contributed to increasing the frequency of the antenatal visits. The International Centre for Diarrhoeal Diseases Research, Bangladesh (ICDDR, B) in collaboration with the MoHFW has introduced BEmOC services at UHFWC level in selected districts and has also contributed to surveys and research on reproductive health. International NGOs such as CARE have set up models for community mobilisation to impact the delays in seeking care in case of obstetric complications (discussed under section 1. 10 on newer initiatives). Although the client satisfaction is high with NGO services, the actual utilisation is low and thus the population coverage of the services is limited. Most of the facilities are also located in the urban areas, thus limiting the access of the rural population to these facilities.

The private, for-profit providers provide RH care mainly in the urban areas through individual clinics, diagnostic centres, nursing homes or hospitals. Private sector facilities are a major source of EmOC services. Of concern is the fact that although only 25 per cent of women experiencing obstetric complications avail private sector services, half of the caesarean sections are performed in this sector. The situation of record keeping and reporting is inadequate. The current regulatory framework for private sector facilities is fragmented and weak and is not implemented.

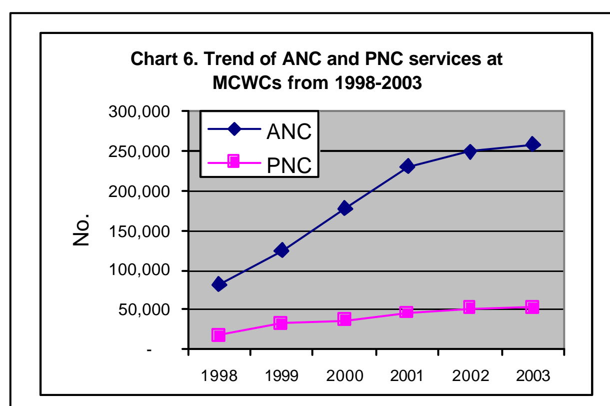
NGOs and private sector are identified as key partners under the HNPSP and re-iterated under the HNPSP Sector Investment Plan. Collaboration with NGOs at all levels of services is envisaged. There are plans to set up a regulatory framework that ensures provision of quality services, financial accountability and transparency. One of the main areas of collaboration proposed is provision of publicly funded pro-poor services.

1.9. Current status of coverage of maternal health and FP services

1.9.a. Safe motherhood

GoB with the assistance of development partners and NGOs has achieved significant progress in coverage and utilisation of maternal health and EmOC services. Data from DHs, UHCs and MCWCs indicate that there is significant improvement in utilisation of facilities for antenatal care, deliveries and postnatal care and FP services as indicated in Charts 6-8. The Charts 7–8 show the increasing number of C-sections in the facilities (approximately 6-10% during the years 2001-2003). The Chart 8 shows an encouraging trend of increase in complications treated in the UHCs. While there is a sharp increase in antenatal clinic (ANC) attendance, the increase in postnatal clinic attendance is not that significant.

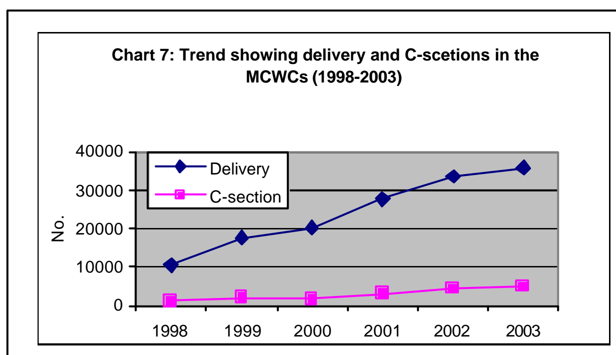
The BDHS 2004 reported an increase in antenatal care by skilled providers (48%) and also an increase in the number of visits to the clinics (increased to 2.9 visits from 1.9)[4]. However, compared to the high level of awareness about the importance of attending ANC among pregnant women, the utilisation is still low. The lack of perceived need on the importance of antenatal care was reported as the common reason for low utilization of ANC. Cost and lack of transport were found to be less important reasons and on the positive side, health system related factors were not reported as barriers (cost was a major concern when accessing services for complications). However, there is a significant difference in the ANC utilisation rates among various economic quintiles[13]. Evidence from

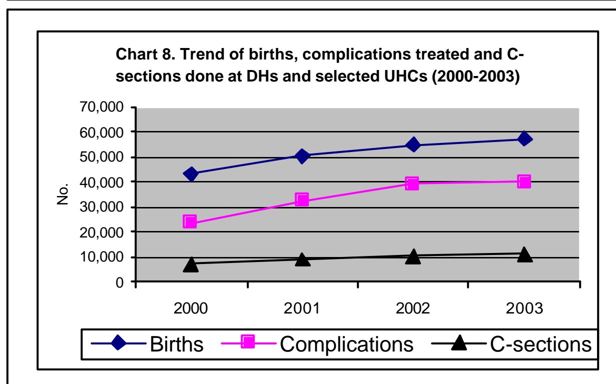


[13] MoHFW: Monitoring the status of progress of indicators. HPSP 2002.

surveys indicates that the full complement of examination and laboratory tests are usually done in the ANCs. As mentioned under section 1.1, the survey also pointed out the low level of knowledge about life threatening complications especially among pregnant women below 20 years and also lack of birth planning by majority of the pregnant women. The birth preparedness plan, that identifies the SBA, preparation for home delivery, transport, emergency funds and location of EmOC facility, is critical to avoid delays in accessing care and thus prevent mortality. The BMMS also reported that only 50% of the women were told about the possible complications in ANC visits and where to go if they experienced complications.

Although the percentage of deliveries in selected institutions has increased as shown in Charts 6-8, the BDHS 2004 does not report any improvement in the proportion of deliveries by skilled providers (14%). This is a cause of concern as majority of the maternal deaths take place at the time of the delivery and immediately after the delivery. Experiences from the countries in the region that have reduced maternal mortality show that maternal mortality reduction cannot be achieved unless access to skilled care at birth is ensured. There are significant differentials between various economic quintiles in the utilisation of skilled care[11]. There are also significant variations among the divisions, Sylhet, Chittagong and Barisal report the lowest percentage of deliveries by skilled attendants as shown in Map 2.





The percentage of mothers who received postnatal care from a skilled provider has increased marginally (increased to 18% from 14%), but is still very low. Low perceived need is reported as the main reason. Besides missing the opportunity of caring for the mother and the baby, the opportunity to provide FP is lost when no postnatal contact is established.

Access to EmOC is a major concern. Table 3 shows the current availability of EmOC services in the public sector (based on the reports of 2004).

The number of facilities currently available is far from adequate to meet the optimum level of EmOC process indicators given in Table 4[14]. Even the current facilities identified as providing EmOC services are not performing the full complement of signal functions listed in Box 1. A facility is designated as an EmOC facility only when it is performing the full complement of signal functions during the three months prior to the assessment. The implication is that the actual availability of EmOC facilities is even lower than the reported figures. The proportion of deliveries in EmOC facilities is low (the proportion of births in institutions is only 10% (BDHS 2004)[4]. The met need is

Box 1: Basic emergency obstetric care functions

The six Basic EmOC functions are:

- IV/IM antibiotics
- IV/IM oxytocics
- IV/IM anticonvulsants
- Manual removal of placenta
- Assisted vaginal delivery
- Removal of retained products of conception

Comprehensive emergency obstetric care functions

All the six Basic EmOC functions plus the following:

- Caesarean section

[14] UNFPA: Tool Number 6: Programme Indicators. Part II: Indicators for Reducing Maternal Mortality. March 2004

reported to be 27% (the BMMS reported 13% which is also the baseline indicator for HNPSP targets as shown in Table 1)[1]. The proportion of C-sections varies with the facility; indications are that there are more C-sections in the private sector.

Table 3: Functional EmOC facilities (comprehensive and basic) in the public sector

Medical College Hospital	13		13
Facility	**Comprehensive EmOC**	**Basic EmOC**	**Total**
District Hospital	54	5	59
MCWC	60	4	64
UHC	82	38	120
Urban clinics	21	4	25
Total:	**230**	**51**	**281**

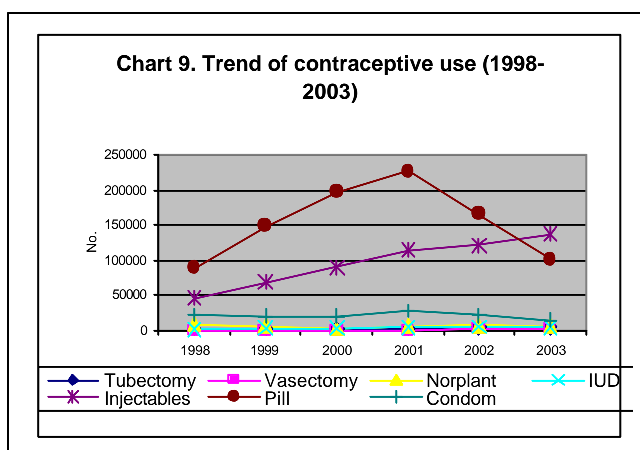
Table 4: Indicators for monitoring EmOC in Maternal Mortality Reduction programmes

Indicator	**Optimal Levels**
1. Proportion of deliveries assisted by skilled attendants [15]	
2. Amount of Basic and Comprehensive EmOC facilities available per population	For every **500,000 population**, there should be: **- At least 4 Basic** EmOC facilities **- At least 1 Comprehensive** EmOC facility
3. Geographical distribution of EmOC facilities (sub-indicators: time to reach EmOC facility and proportion of households within 2 hours of Basic EmOC facility)	Ideally, basic EmOC facilities should be located so they can be accessed within a maximum of 2 hours. Comprehensive EmOC facilities should be accessible within a maximum of 12 hours.
4. Proportion of all births in Basic and Comprehensive EmOC facilities	**At least 15% of all births** in the population should take place in basic or comprehensive EmOC facilities
5. Met need for EmOC: Proportion of women with obstetric complications who are treated in EmOC facilities	**100%** of women with obstetric complications should be treated in EmOC facilities.
6. Caesarean sections as a proportion (%) of all births	Caesarean sections should account for **no less than 5% more than 15%** of all births (C-sections performed for emergency purposes only)
7. Obstetric Case Fatality Rate	The case fatality rate among women with obstetric complications in EmOC facilities should be **less than 1%** (indicator best interpreted at facility level)

Source: Except for the first indicator, the others are adapted from Maine, Deborah et al. Guidelines for Monitoring the Availability and Use of Obstetric Services. UNICEF, WHO, UNFPA. August 1997

1.9.b. Family Planning

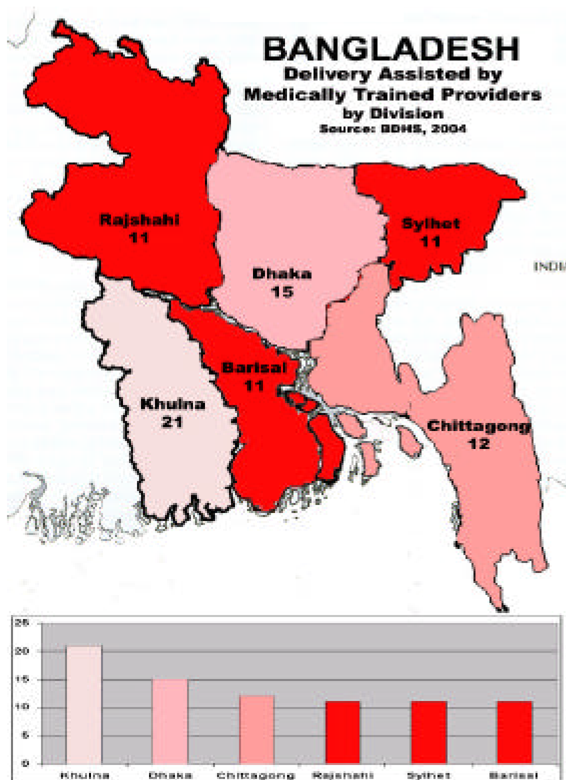
58% of currently married women are using a contraceptive of which 47% are using modern methods[4]. The differentials in the contraceptive prevalence rates between divisions are significant with Sylhet and Chittagong reporting the lowest figures (see Map 3). The differentials in contraceptive use among various economic quintiles are not significant indicating equity in access to contraceptives.



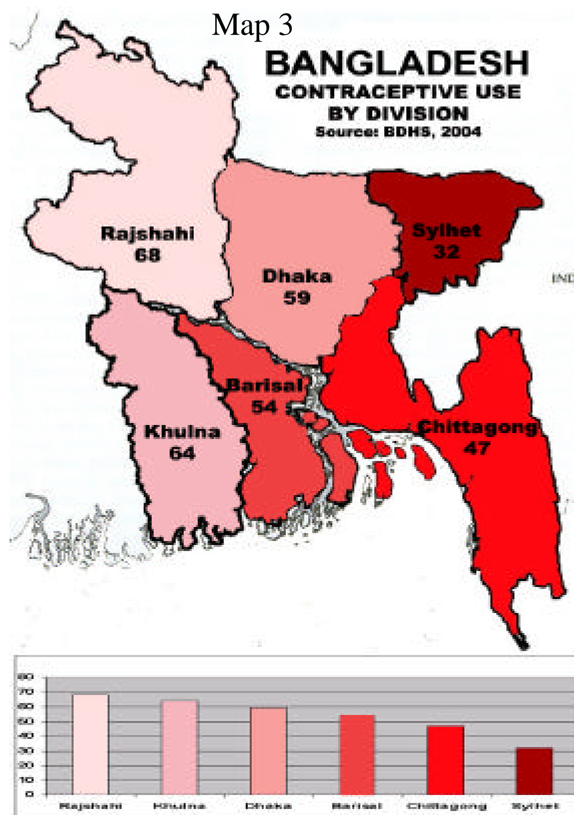
Pills are the most commonly used method followed by injectables. The decline in the use of intrauterine device (IUD), Norplant and surgical contraception is continuing[4]. The Chart 9 based on data from MCWCs confirms the fact. The Chart also shows a steep fall in the use of oral contraceptives after 2001. Nearly half the women using contraceptives stop using the method

within 12 months of starting the method. High discontinuation rates have been reported for oral contraceptives and injectables. These findings indicate poor quality of services especially counselling services.

Map 2



Map 3



1.10. Newer Initiatives

The GoB has been considering several strategies for maternal mortality reduction that includes training of community based midwifery cadres or upgrading the skills of the existing cadres, health system improvements, health financing for the poor and community awareness /mobilisation. Some of the initiatives are listed below.

1.10.a. SBA training

As envisaged in the National Maternal Health Strategy, the MoHFW in collaboration with WHO, UNFPA and the Obstetrical and Gynaecological Society of Bangladesh (OGSB) has developed a training programme to train community-based SBAs to provide domiciliary midwifery services. Based on a needs assessment done by WHO and OGSB and the job analysis of the FeHA and FWA, a competency-based six months training programme was designed. Based on specific selection criteria, FeHAs and FWAs were selected for the training. The training was initially done in 6 districts with support from WHO and UNFPA. From each district 15 trainees were trained. The training emphasised clinical practice and community practice. Trainers, selected using specific selection criteria, were provided training in competency-based training by a group of national level master trainers from the Maternal and Child Health Training Institute (MCHTI) and Institute of Child and Maternal Health (ICMH) and OGSB. The Bangladesh Nursing Council (BNC) conducted the examinations and registered the SBAs. Guidelines for accreditation have been developed. The evaluation at the end of one year showed that the trainees had acquired adequate skills to provide domiciliary midwifery care. The SBAs felt confident of their new role; the communities were satisfied with their work and the referrals to institutions increased. The evaluation also found that the SBAs were contributing to ANC (52%), PNC (44%) and home deliveries (29%). The MoHFW has taken a decision to expand the training and has constituted a high-level task force under the Chairmanship of the Minister of Health

to monitor the progress of the training. UNFPA will be supporting the expansion to potentially 30 districts. A major concern is the lack of decision on the supervisors of the SBAs especially of the SBAs belonging to the DGHS. FWVs have been identified as supervisors for the SBAs from the DGFP. Lack of follow up of trainees at their work site and supportive supervision will have major implications on the quality of the services provided by the SBAs. Besides the competency-based training materials that have been developed under the project, the process used such as selection criteria, training of trainers and accreditation guidelines are useful lessons for other training programmes.

1.10.b. Women's right to life and health project

UNICEF in collaboration with MoHFW and the Averting Maternal Deaths and Disability (AMDD) project of Columbia University supported upgrading of 59 DHs and 120 UHCs for providing comprehensive EmOC services. The aim of the project is to improve the availability and utilization of EmOC services and thus reduce maternal mortality. The selection of the UHCs is based on geographical considerations (2 UHCs per district). The major activities undertaken were human resource development for EmOC through training of Doctors and Nurses and Laboratory Technicians, supply of necessary equipment, facility level micro planning, strengthening HMIS and Behavioural Change Communication (BCC). The current status is that 73 UHCs (out of 120) and 54 DHs (out of 59) are providing CEmOC, while the rest are providing BEmOC services. In addition, 9 UHCs out side the project facilities, are also providing CEmOC services. Data indicates that the coverage and utilization of services have increased compared to baseline data with increased institutional deliveries, met need and proportion of C-sections[16]. UNICEF is continuing its efforts to provide comprehensive services in all selected facilities. Major concerns of the project are retention of trained MOs at the facilities and to ensure 24-hour quality of care. Besides the upgrading of the facilities, the project's main contributions are development of competency-based training materials for EmOC training, introduction of a system of 'appreciative inquiry' (a useful QA tool), quantitative and qualitative survey instruments for assessing the availability and quality of EmOC services and collection of baseline indicators for EmOC services.

1.10.c. Dinajpur safe motherhood initiative (DSI)

The DSI was initiated to address maternal mortality and morbidity by addressing barriers that inhibit women from accessing quality EmOC services[17]. The main objectives of the initiative were to increase the utilisation of the EmOC services in selected UHCs and to ensure that women and girls who are victims of gender-based violence receive appropriate care. The programme strategies were mobilisation of the community for promoting birth planning, creating community support systems and addressing violence against women and girls and enhancing the quality of care of the local UHC by improving the social aspect of the quality of care of the UHC, fostering better relationship with the staff of the facility through creation of stakeholder committees and addressing violence against women and girls. The final evaluation of the project demonstrated an increase in knowledge about danger signs of pregnancy and birth planning, participation of households in the community support system activities, establishment of team norms in the UHC, establishment of stakeholder committee that included women and contributed to improving the facilities at the UHC and seting up a fund for referrals, and the creation of forums to address issues related to gender based violence. The results also indicated increased utilisation of the EmOC facilities (through increased utilisation of the emergency funds and transportation system) and increased institutional deliveries.

1.1O. d. Demand side financing

WHO in collaboration with MoHFW has launched a pilot project on health voucher scheme for the poor pregnant women to increase demand for ANC services and to insure against the cost of EmOC[18]. The purpose is to provide vouchers to the pregnant women to purchase antenatal services and delivery services from an accredited provider. The providers will be reimbursed from a special fund when they

[16] UNICEF: Women's Right to Life and Health Project. Mid-term review. 2003.
[17] CARE, Bangladesh: Dinajpur Safe Motherhood Initiative 1998-2001.
[18] MoHFW: Demand-side Financing Pilot Maternal Health Voucher Scheme. 2004

present the vouchers collected from the clients. The scheme has provision for reimbursing costs in case of referrals. The pilot scheme is being implemented in 21 Upazilas. The lessons learned from this initiative will be useful for improving the access of the poor to EmOC services.

1.10.f. Midwifery training

Midwifery training of FWVs and training of nurses in midwifery standards are the other two initiatives. The training of FWVs should contribute to improving the quality of maternal health services provided at the UHFWCs and UHCs and also of the services provided by the SBAs through supportive supervision. The training of nurses from selected facilities in midwifery standards with WHO support should help in setting standards of care for midwifery services provided in the hospital and in the community.

1.11. UNFPA's current RH sub-programme

UNFPA is currently implementing the Sixth Country Programme (CP). The RH sub-programme has two outputs: 1) Increased accessibility, availability and utilization of clinical contraception, RTI/STI case management, EOC and safe motherhood services, particularly for the high risk and most vulnerable population and youth. 2) Strengthened capacity in service provision, referral and networking to address the three delays in safe motherhood and informed family planning choices. The activities to achieve the outputs are being implemented through three component projects: 1) Strengthening RH services, 2) Capacity development through training and 3) Strengthening RH services for the poor. The main activities are:

- strengthening of MCWCs and UPHCP facilities for provision of CEmOC through training in EmOC and Anaesthesia, provision of equipment, drugs and supplies, updating the national curriculum for EmOC and training of trainers in the revised curriculum, strengthening the MCWCs for provision of safe blood transfusion,
- renovations of selected UHFWCs for conducting deliveries and midwifery training of FWVs
- training of SBAs,
- strengthening facilities for provision of RTI/STI management,
- strengthening MCWCs and UPHCP facilities for clinical contraception and introduction of emergency contraception in selected areas and procurement of contraceptives (with UNFPA funds as well as with funds from the World Bank and Canadian International Development Agency),
- reducing drop-out rates among contraceptive users
- strengthening selected MCWCs and UPHCP facilities to provide Adolescent Sexual and Reproductive Health (ASRH) services, services for men and management of gender-based violence,
- increasing post-natal coverage,
- training of health service providers in counselling, clinical contraception, syndromic management of RTI/STI cases and management of gender-based violence
- pilot project on screening for cervical cancers using Visual Inspection Acetic Acid technique
- pilot project on prevention and management of obstetric fistula
- increasing awareness among women in two districts about danger signs of pregnancy

The activities have linkages with the other sub-programmes on population and development and advocacy and BCC and with the activities to improve reproductive rights of women, men and adolescents.

In addition, UNFPA has raised funding for expanding the SBA training, strengthening the services for prevention and management of obstetric fistula and promoting an integrated multi-sectoral approach for improving safe motherhood with special focus on the poor (through the UN Joint Safe Motherhood Initiative). UNFPA programmes operate in the context of the sector-wide approach implemented through the HNPSP project and collaborate closely with the major donors.

2. Thematic review of the quality of reproductive health services

2.1. Rationale for the review

- Reducing maternal mortality is one of the priorities of the GoB and is reflected in the national poverty reduction strategy and HNPSP. Safe motherhood is recognised as a woman's right.
- Considerable investments have been made in improving access to safe motherhood services, yet the utilization of safe motherhood services has not improved much. Percentage of deliveries by skilled birth attendants, the ICPD and MDG indicators for maternal health, is negligible.
- Lessons learned could be utilized for future advocacy for policy and programme changes.
- The findings of the evaluation could be utilised to mobilise additional resources.

The evaluation will help UNFPA to identify areas of support in the next Country Programme and areas of partnership.

2.2. Objectives of the review

The objectives of the thematic review are to:

- assess the effectiveness of various strategies and approaches for safe motherhood adopted by the Government, donors, NGOs including non-health partners,
- assess the progress towards achieving the national maternal health objectives
- identify lessons learned and
- identify future areas of programme strengthening

The review will specifically assess the strategies adopted by UNFPA in its 6th CP to address Safe Motherhood in the context of the inputs provided by other donors and NGOs and how it contributes to national maternal health objectives.

2.3. Framework for the review

The framework for the review focuses on clients' rights and providers' needs (see Box 2), originally developed by the International Planned Parenthood Federation (IPPF). The framework forms the basis for several of the quality assurance tools (for example, the Client Oriented Provider Efficient (COPE) tools in quality assurance of reproductive health services developed by EngenderHealth is based on the framework). The rights based approach to analysing factors that contribute to high maternal mortality should help to address some of the underlying factors that need to be tackled effectively if significant reductions in maternal mortality is to be achieved. Efforts have been made to link the rights to the 'three delays model' that identifies underlying causes of maternal mortality.

Since maternal death is a violation of a woman's right to survive, the use of the 'rights framework' for analysis of the situation of safe motherhood is very appropriate. Almost all causes of maternal deaths are preventable and are related inequitable access to maternal care. This is an indication of denial of a woman's right to care and the lack of rights based approach of the health system. The framework helps to identify the gaps in realization of the rights of women (right-holders) and also the abdication of responsibilities by the health service providers (duty-bearers) in fulfilling the rights. The framework is also appropriate, as the National Maternal Health Strategy is built on right-based approaches and MoHFW has been promoting client's charter of rights in hospitals and health facilities.

2.4. Key areas addressed

The main area of focus is care at the time of delivery and immediately after delivery including EmOC as maximum complications leading to maternal deaths happen during this period. Although the thematic review is on safe motherhood, the review also included family planning services, as it is one of the key interventions for improving maternal survival and health. The review also included services for RTI/STI, as such services are important elements of safe motherhood services.

The review also looked at key elements such as policy framework, decentralisation and local level planning, quality assurance and human resource development, as these are critical for enabling realisation of rights of clients and staff.

Box 2: The framework for rights of clients and needs of staff

The rights of clients

Information: accurate, appropriate, understandable, unambiguous and unbiased

Access to all services and supplies: location, promptness, reliable, affordable and without barriers that suit their individual needs

Informed choice: Voluntary, well –considered decision based on options, information and understanding

Safe services: Skilled providers, attention to infection prevention and appropriate and effective medical practices, use of service-delivery guidelines, quality assurance mechanisms, counselling and recognition and management of problems

Privacy and confidentiality: During counselling, physical examination and clinical procedures and medical and personal information

Dignity, comfort and expression of opinion: Courtesy, consideration and attentiveness, comfort while receiving services, encouraging clients to express views

Continuity of care: Continuity of care, supplies, referrals and follow up

The needs of health care staff

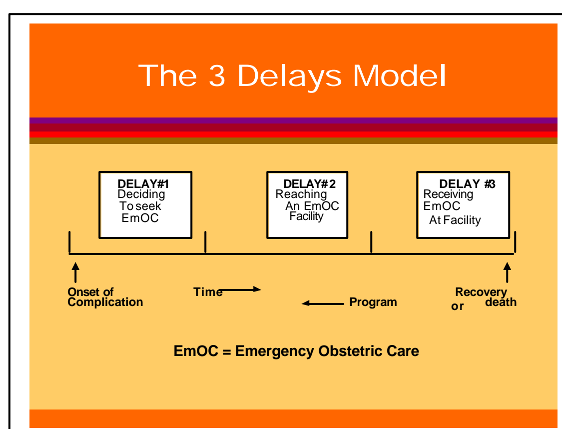
Facilitative supervision and management:

Supportive environment with supervisors and mangers encouraging quality improvements and value staff

Information, training and development: knowledge, skills and ongoing training and professional development to continuously improve the quality of services they deliver

Supplies, equipment and infrastructure: Reliable, sufficient inventory of supplies, equipments and working equipments and infrastructure for uninterrupted delivery of high-quality services

The violation of the rights described above are closely linked to the 'three delays" related to maternal deaths. The denial of rights of clients - right to information and informed choice contributes to Delay 1: Delay in seeking care. The denial of right to access to services and supplies and continuum of care is linked to Delay 2: Delay in accessing care. The denial of the rights of clients to safe services ensuring privacy, confidentiality, dignity and comfort of clients and encouraging expression of opinion and staff needs for supervision, information, training and development and supplies, equipment and infrastructure are linked to Delay 3: Delay in receiving care.



2.5. Methodology of the review

The methodologies used for the evaluation are as follows:

1. Desk review of national maternal health strategy, poverty reduction strategy, HNPSP document, other relevant documents from MoHFW, training documents, surveys on maternal health and mortality, evaluation reports of safe motherhood components of various donor assisted projects and programmes and UNFPA 6th CP document.
2. Review of safe motherhood, FP and RTI/STI services provided at various levels of health care at district level and below in five districts (Sirajganj, Jessore, B.Bharia, Faridpur and Rajshahi), City Corporation Clinic and two partner NGO Comprehensive Reproductive Health Care Centres (CRHCCs) of Dhaka City Corporation and Lamb Hospital run by NGOs. The EmOC assessment tools developed under the AMDD project and quality improvement tools for EmOC by EngenderHealth were modified and used for the review.

   In each of the facilities visited (see Annex 4 for list of facilities visited), the following activities were carried out:

   a. Assessment of facilities using the assessment tools listed above
   b. Client exit interviews and interviews with family members of admitted clients (in 2 facilities)
   c. Review of registers and records
   d. Brief case reviews of clients admitted

3. Interviews with key stake holders (relevant GoB officials, development partners, UN Agencies and NGOs and programme and project staff of UNFPA).
4. Analysis of selected data from facilities (MCWC, DH and UHC)

The major limitation of the review is the few number of facilities visited both in the Government and NGO sectors.

3. Findings, conclusions and recommendations

3.1. Policy framework

Findings and conclusions

As described in the background section, the National Maternal Health Strategy is built on rights framework and is based on the 'three delays' model. Few of the important findings are:

- The reduction of maternal mortality and infant mortality are major goals of the poverty reduction strategy and HNPSP. The slow reduction in maternal mortality and in fertility are recognised as having negative implications for poverty reduction. The commitment of the GoB is reaffirmed through these national development frameworks.
- The operational plans of both the Directorates of Health and FP identify activities for improving access to EmOC facilities, skilled birth attendants and FP services. In addition, the plans include activities for improving adolescent sexual and reproductive health, management of RTI/STI, prevention of HIV/AIDS and provision of safe blood transfusion facilities.
- The allocations for EmOC facilities reflect the commitment of the GoB. However, the budget allocated may not be sufficient to meet the indicator for the amount of EmOC facilities available. The indicator recommended is availability of one functional CEmOC and four functional BEmOC facilities for every 500,000 population[12]. Access to facilities is important for achieving the HNPSP indicator of a maternal mortality ratio of 275 per 10,000 live births. Experiences from countries in the region such as Malaysia and Sri Lanka underscore the importance of access to EmOC facilities for maternal mortality reduction.

Recommendations

- Using the digitised enumeration maps developed by Bangladesh Bureau of Statistics (BBS) (with UNFPA assistance under the Sixth CP), the current and planned availability and distribution of EmOC facilities should be reviewed. The information should be used for planning of facilities.
- Consideration should be given to increasing budget allocations to meet the gaps in number and distribution of EmOC facilities to ensure access within a maximum time of two hours.
- The HNPSP human resource development plan should pay special attention to availability of doctors and nurses trained in EmOC (see more under section 3.4 'human resource development).

3.2. Decentralisation and local level planning

Findings and conclusions

The focus areas of the current efforts at decentralisation of the HNP sector include reduction of maternal and infant mortality and fertility. The budgets are developed based on local level planning.

Recommendations

- Advocacy efforts should be directed at the HNP service development committees to
  - increase budgetary allocations for EmOC facilities
  - improve human resource availability for safe motherhood (including FP and RTI/STI). This should contribute to achieving the targets in reduction of maternal and infant mortality. With increasing number of women especially the poor having access to facilities, equity and gender equality should also improve.
- The management skills of the District and Upazila health managers should be strengthened which should contribute to improving the efficiency of the health system and thereby the efficiency of the EmOC services, as it is inextricably linked to the former.

3. 3. Quality assurance systems

Findings and conclusions

The background describes the various quality assurance mechanisms followed by the DGHS, DGFP and by the UPHCP.

- Reports are sent at prescribed intervals from the peripheral institutions and District Health and FP offices to the respective Directorates and project management units. However, the regular analysis and utilisation of the data for planning actions is not satisfactory.
- The labour room registers and client records are essential tools for monitoring quality of EmOC services. Records in labour room of facilities are incomplete, particularly information related to treatment, procedures and complications. Client records are incomplete, particularly filling of partograph, notes of procedures and discharge notes.
- The FP CST and QAT assessments include both quantitative and qualitative information and are done regularly. The quality of the FP CST and QAT assessments is better. The self-assessments done by the MCWC team are not very satisfactory. Actions taken by the team are not often recorded.
- The quality of monitoring of EmOC services in UHCs by the team from the Medical Colleges varies. Some of the teams do in- depth analysis of cases admitted. The follow up actions are not satisfactory.
- Maternal death reviews are undertaken in few medical colleges and selected district hospitals. It is reported that the activity is not regularly carried out. The other concern is the quality of the review especially the conduct of the review (whether it is for fault finding or for learning lessons).
- 'Near miss audits' of most complicated cases in which pregnant women survive, introduced under the 'Women's right to life and health' project does not take place in most of the hospitals.
- The QA in UPHCP centres is done by an independent agency and the quality and range of services covered is better. Although the checklists predominantly collect quantitative information, there are few checklists for monitoring quality such as observation/review of counselling FP clients, case management and client exit interviews. Feedback on gaps is provided to the individual agencies and to the project manager, however the evidence of follow up action is not available. The composite score that is given to institutions could be misleading as most of the scoring is based on quantitative indicators.

  In conclusion, while the QA systems exist and function, in many instances it has become a routine exercise than an action-oriented system.

Recommendations

The following recommendations are made in the context of the HNP Sector Investment Plan that promotes a health system that is more responsive to clients' needs, efficient and effective in reaching the services to the poor.

- HMIS
  - The proposed strengthening of the HMIS by the DGFP and DGHS under HNPSP should provide an opportunity to institute mechanisms to ensure that the reports are reviewed and appropriate actions are taken. This is also important for performance planning as envisaged under the HNPSP.
  - The labour room and client records should be reviewed to add columns or subtitles to ensure that relevant information is collected. In addition, the maternity ward registers, death records and general statistical records of female patients should be reviewed and modified appropriately. The MCWC reports should include information on complications (linked to recommendations on HMIS under section 3.9 'right to continuity of care').
  - The reporting on EmOC indicators (see Table 4) developed under the 'Women's right to life and health' project should be strengthened. It is important to ensure that the definitions are well understood by the institutions.
- Review of the QA instruments and system should be done to ensure regularity and follow up actions based on the findings of the monitoring visits.

- The quality and coverage of the maternal death reviews should be strengthened with the ultimate objective of reducing maternal deaths and improving the quality of care and not for punitive action. Perinatal death reviews also should be instituted. Training programmes should be instituted to systematically introduce facility-based maternal death and perinatal death reviews[19]. Since substantial number of maternal deaths takes place at home, a system of verbal autopsy should be introduced (ICDDR,B is an excellent resource). The community based SBAs should be trained in the technique. 'Near miss audits' introduced under the 'Women's right to life and health' project should be strengthened. Clinical audits should be instituted in health facilities (see details under section 3.6. 'right to safe services') based on the gaps identified during maternal death reviews.
- Community audits of maternal deaths by women's groups should be encouraged to monitor the quality of care provided at institutions or at home. Such audits also build accountability of the health system.
- The composite score used under the urban project should be reviewed.
- As part of the monitoring process being developed under HNPSP and the decentralisation process, quality assurance circles (building on the existing ones) should be developed. These circles will ensure the quality of various service components of safe motherhood. This will also help to bring accountability as the HNP service development committees include community stakeholders.
- All activities on QA should be linked to the QA system being developed under the HNPSP.

These recommendations reinforce the action plans of maternal health strategy.

3.4. Human resource for safe motherhood

Findings and conclusions

- The National Maternal Health Strategy includes a human resource plan to support safe motherhood services. Although the action plans of DGHS and DGFP under HNPSP recognises reduction in maternal mortality as one of the focus areas, the human resource development planning has no specific focus on human resources for safe motherhood.
- The maternal health strategy and action plans of both the DGHS and DGFP highlight the importance of quality training as well as refresher training. Follow up training is not emphasised.
- The training of various categories described under section 3.11 on 'staff need for information, training and development' is based on the National Maternal Health Strategy.
- Issues related to regulations on scope of practice are not clearly defined, particularly in the case pf community-based SBAs. This has legal implications.
- Practice guides and protocols have been developed under the community-based SBA training and the training of Doctors (under the competency-based EmOC training).
- The EmoC training of doctors currently carried out is of two types: one year training as envisaged under the maternal health strategy and four months competency-based training introduced under the 'Women's right to life and health' project. Reports of the evaluation of the shorter duration course indicate that the duration is adequate for acquiring competencies. The one-year training is recognised. No decision has been taken on the duration of the training.
- Junior specialists in O&G have been posted in selected UHCs (by DGHS).

Recommendations

- Decision should be taken on the duration of the EmOC training of Doctors.
- The excellent training materials developed for the four months course training and the methodologies should be used for training, irrespective of the final decision on the duration of training.

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[19] Facility-based maternal death review is a "qualitative, in-depth investigation of the causes of, and circumstances surrounding, maternal deaths which occur in health care facilities". Source: Beyond the numbers. Reviewing Maternal Deaths and Complications to Make Pregnancy Safer. WHO, Geneva.

- Regulation on scope of practice should be clearly defined. The BNC should take a lead on this issue.
- Quality assurance in training through follow up and clinical audits should be developed (see also under section 3.3 'quality assurance').
- See recommendations for SBA training and FWV training under section 3.11 on 'staff need for information, training and development'.
- An updated human resource plan for safe motherhood should be developed and should be part of the HNPSP plan (as recommended under the 'policy framework'). The plan should include the proposed posting of junior specialists in UHCs.

3.5. Client's right to information

Clients have the right to accurate, appropriate, understandable and clear-cut information related to safe motherhood, FP and RTIs/STIs. Information contributes to empowering women to participate in decision-making and enable them to exercise their right to care.

> Maternal health services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to Caesarean sections and provide for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; postnatal care and family planning …….ICPD PoA 8.22

Findings and conclusions

As described under the section on antenatal care (see background), the ANC utilization rate is increasing with concerted efforts by the Government and partner agencies. However, the awareness about complications and birth planning is still low. The awareness of the woman and more importantly the decision makers in the family about complications is critical for minimizing delay one related to seeking care.

- The MoHFW has initiated public information campaigns on danger signs during pregnancy through television and radio. However, the reach of these messages is not known.
- Facilities such as MCWCs, selected UHCs and UPHCP centres had displayed information on the list of services available and that the services are free of charge.
- The facilities visited had few posters on antenatal care, danger signs, skilled care and FP. Information on likely problems during post-natal period, partner treatment in case of STIs and dual protection with condoms was limited. The reported reason for high level of drop out rates among clients using contraceptives (see background) is the side effects. This points to the gaps in the information provided to FP clients.
- Educational videotapes were being played during the antenatal clinics in MCWCs that were visited. However, no process of feedback from the audience (to assess what was understood) was being followed.
- Awareness about ANC is high, but few attend clinics due to cultural and other factors as discussed in the background section.
- The exit interviews of women attending ANC and focus group discussions held in 1-2 locations during the field visits further corroborates the finding of BMMS (see section on safe motherhood under background) about lack of information provided to women about danger signs during pregnancy.
- Several NGOs, notably CARE and BRAC and ICDDR,B, have been able to create awareness about danger signs during pregnancy and birth planning. UNICEF has played a key role in this activity. USAID has provided funding support to several NGOs to create awareness about danger signs and birth planning. UNFPA supports two pilot initiatives in two districts for creating awareness on danger signs during pregnancy and delivery.

In conclusion, despite the efforts by the MoHFW and partner agencies to increase awareness among women about danger signs during pregnancy, the knowledge gaps are big.

Recommendations

Stimulating demand for services is one of the seven challenges/ strategies identified under the HNP Sector Investment Plan.

- The information campaigns should be complemented with evidence based strategies for BCC for key decision makers in the family and community (using ongoing effective strategies or developing new ones). The aim is to make " every pregnancy special" and ensure that a woman's right to safe pregnancy and delivery is ensured. These efforts should be linked with the various BCC activities being undertaken by various agencies and the proposed BCC strategy with UNFPA assistance. The focus of these should be on complications of pregnancy, birth preparedness planning (see details below), skilled birth attendants at delivery and gender-based violence particularly during pregnancy.
- The capacity of the BCC workers under the UPHCP in interpersonal communication should be strengthened. A system should be developed through which the BCC workers discuss with families the information provided under the public information campaign.
- Regular health education in ANC, maternity wards and postnatal clinics on care of mother and newborn, birth planning, FP and STI/HIV and gender based violence should be provided (as appropriate).
- The health education sessions should ensure "two way communication' to enable clients to clarify doubts. Such an approach will also help health educators to assess whether the clients understood the messages. Consider including the topic during training.
- Posters and leaflets on topics identified above especially on danger signs during pregnancy, skilled birth attendants at delivery, side effects of contraceptives and dual protection, presented in a manner that is easily understood by an illiterate person, should be made available in all health facilities. Such health education material should be displayed in community facilities (as appropriate) as well as in groups organised by women's development programmes.
- The knowledge of the FWAs and FeHAs (in wards and villages where no community based SBAs are available) and FWVs and Nurses in UHCs, UHFWCs and UPHCP centres should be improved to promote birth preparedness planning (The training of community based SBAs does include information on birth preparedness planning). The birth preparedness plan should identify the skilled birth attendant, preparation for home delivery, transport, emergency funds and location of EmOC facility.
- During home visits, the field workers should hold sessions on birth preparedness planning that includes the key decision makers in the family. The planning should ideally include the birth attendant the family traditionally uses and the practitioner (if applicable) to ensure their support in referral of cases during complications (this is important as often the birth attendants/ practitioners delay the referral in case of complications).
- The lessons learned from the CARE Dinajpur Safe Motherhood Initiative and other similar community mobilization initiatives for safe motherhood should be reviewed and replicated elsewhere. Linkages should be established with the existing women's groups to foster partnership with them to help women realize their right to safe pregnancy and delivery. Such a partnership will help women to access information on topics identified above and access services.

3.6. Clients' right to informed choice

Clients have the right to make voluntary, well considered decisions that are based on options, information and understanding. The informed choice is a continuum that begins in the community where people get information even before they come to a facility for services.
Realisation of the right empowers people to make their own decisions rather than being passive recipients of choices made by others.

Findings and conclusions

- As discussed in the earlier section, the quality of FP counselling is poor. With the poor quality of counselling, it is difficult to comment whether the choice is based on 'a well considered decision' that is based on information and understanding. Major gaps identified are incomplete information on all methods available and dual protection. The influence of provider bias was difficult to assess.

- Counselling of STI clients is hardly practiced resulting in gaps in understanding of the importance of prevention, treatment and partner notification.
- Informed consent is taken before procedures such as C- Section and surgical contraception. However the impression gained during field visits and interviews with health care providers is that the "informed consent" is usually not based on ascertaining whether the woman or her family has understood the implications.
- Information and understanding of the client and her family about the importance of safe blood is another area of concern.

Recommendations

- The quality of counselling services should be improved by strengthening the skills of providers in counselling in various situations (discussed under the section on 'provider need for information, training and development') and by providing full information on the topic of concern.
  - FP counselling should include information on all methods available, advantages and disadvantages, side effects, action to be taken in case of missing dose and provision of condoms for back up protection and for dual protection if at risk. In case of IUDs and surgical contraception, counselling after the procedure is equally important.
  - As identified earlier in case of STI clients, focus should be on prevention of future infections, increased risk of HIV, importance of taking full course of treatment, follow up, partner counselling and treatment.
  - Clients of post-abortion care should be counselled for FP. The information shared should focus on the risk of immediate conception if no FP is used and the methods that are most suitable for immediate use and for use after a prescribed duration of time.

Counselling helps duty bearers (health service providers) to enable rights-holders (clients) to realise their rights.

- In case of non-emergency situations, a system of counselling clients before obtaining consent for procedures should be initiated. However, in case of emergencies, stabilisation of clients should be done first.
- Information on importance of voluntary donation, screening of blood and obtaining safe blood should be provided to key decision makers of the families of clients needing blood transfusion. This is critical since the most common practice in UHCs and MCWCs and private sector is obtaining blood from private blood banks for women who need transfusion.

WHO's Decision making tool for FP clients and providers is a very useful tool for promoting informed choice.

3.7. Clients' right to access to services

Clients have a right to services especially 24 hours EmOC that are easily accessible in terms of geographical distance, cost and timing with no medical barriers or social barriers.

Findings and conclusions

The BMMS findings pointed to continuing disparities in access to health services by income status, with women belonging to the lower economic quintiles having poor access. Denial of this right is linked to Delay 2.

❖ Safe motherhood

- Access to ANC and postnatal clinics is good due to the availability of vast infrastructure for MCH services, however the utilisation is poor. On the positive side, it is reported that the women who ad attended the clinics had received the full range of services. As discussed under the background section, in addition to the low percentage of attendance, the number of visits to the antenatal clinics and the timing of visits (in relation to duration of pregnancy) are not satisfactory.

- In health facilities, availability of skilled attendants at birth (Nurses and Doctors) for normal deliveries, especially after working hours, is a concern. Facilities visited, especially the urban facilities, reported shortage of staff nurses. Deliveries are attended by nursing aids who have no training in conducting deliveries. The doctors are informed in case of complications. With no training in conducting deliveries, it is likely that complications are missed or recognised late.
- Access to community based SBAs during home deliveries is limited, as only few from 18 districts have been trained (approximately 390 as of March 2004).
- Advice on nutrition during pregnancy provided, but the adequacy of the advice given was difficult to assess. There is no evidence of link with NNP especially in the case of poor.
- EmOC facilities
    - As per EmOC process indicators, a population of 500,000 should have one CEmOC and 4 BEmOCs. The ratio of facilities to population is much lower than recommended with wide inter-district variations, Sylhet and Chittagong divisions reporting the lowest ratios. The finding conforms with the inter-district variations in maternal mortality.
    - Almost all the medical colleges are located in the urban areas and majority of the private institutions and NGO hospitals providing EmOC services are located in the urban areas mainly in Dhaka, Rajshahi, Chittagong and Khulna, thus decreasing the access of rural populations to services.
    - Even in facilities designated as EmOC facilities such as DHs, UHCs and MCWCs, all signal functions are not performed. The most common missing functions are assisted vaginal delivery and use of vacuum aspiration (for removal of retained products of conception). Designation of a facility as an EmOC facility depends on the signal functions not only being available, but also actually being performed at least once in three months. Reasons for the gaps are both clinical and managerial. Lack of skills in performing a particular procedure and attitudes towards changing clinical management practices and non-availability of equipment are major reasons. Availability of safe blood for transfusion is a major concern (discussed under blood banks).
    - Human resources in EmOC (staff with skills in EmOC as well as Anaesthesia) are a major concern. GoB has been investing substantially in improving access to EmOC facilities by training doctors in EmOC and Anaesthesia so that both speciality services are available in a particular facility (see under section 3.11 on 'staff need for information, training and development'). However, the shortage of anaesthetists is a problem.
    - The BMMS reported that the small percentage of women who accessed EmOC facilities could reach within two hours, however this could be misleading as the women may be living closer to the facilities. The other positive finding is that there was no delay in receiving care once the patients reached the facility.

❖ <u>FP</u>

- All spacing methods are available in all facilities and surgical contraception is available in majority DHs, all MCWCs, majority of UHCs and through camps in UHFWCs.
- The quality of services provided could not be assessed. The quality of counselling of clients is poor (discussed under 'right to informed choice'). Dual protection using condoms is not promoted.
- The impression gained during visits to facilities is that the follow up of clients is not very satisfactory. The current recording system does not appear to provide opportunities to track clients using spacing methods. There are also concerns about the accuracy of the recording by the health workers due to poor understanding of the system.
- The UPHCP centres under the MoLGRD provide all spacing methods and surgical contraception. Stock outs of contraceptives have been reported particularly in the hospitals under the City Corporation. One of the reasons reported is the requirement for registration of the facility with the DGFP for accessing free contraceptives. From the discussions with DGFP officials, it appeared that the issue could be easily resolved.
- Emergency contraception is being introduced in selected urban areas.
- <u>Postpartum contraception is not actively promoted in any of the centres.</u>

- RTI/STI services

- The training of doctors in management of RTIs/STIs and provision of RTI/STI drugs in all the DHs, MCWCs, UPHCP centres and selected UHCs have increased the access to the services. However, the quality of the services provided is a major concern. Major gaps in quality are related to counselling of clients and partner notification and treatment.

- Laboratory facilities

- DHs, UHCs and UPHCP centres have functioning laboratories. In the UHCs, facilities for diagnosing RTIs/STIs are not available, mainly due to lack of or irregular supply of reagents. Most of the laboratory technicians have been trained with UNFPA assistance in laboratory tests for RTIs/STIs. The UPHCP centres charge a fee for the tests.
- The MCWCs have no laboratory facilities. Urine examination and Hb estimation is done for all antenatal mothers. There is no post of laboratory technician.

- Blood transfusion facilities

- Facilities for cross matching, screening and transfusion are available in almost all the DHs, but there are no facilities for storing blood. The UPHCP centres have facilities for blood grouping and cross matching and screening blood, but have no facilities for storing blood. The patients are charged for the tests.
- Almost all the laboratories at the UHCs do not have facilities for blood grouping and cross matching and for screening blood for transfusion.
- The MCWC doctors are trained in blood grouping and cross matching, but there are no facilities for the tests.
- For patients admitted in UHCs and MCWCs needing blood transfusion, the blood is brought from a private blood bank or Red Cross Society. The quality of the blood bought from private blood banks is a major concern.

- Economic barriers

- The BMMS survey showed the differentials in utilisation of services by economic quintiles with the lowest utilisation rates among poorer women. Although the services are free in the Government sector, the cost incurred by the family is substantial, even when no complications are involved. This could be one of the major barriers in utilizing the facilities for care. The survey findings indicate that women had to often borrow from their neighbours, further worsening the spiral of indebtedness and poverty.
- It was encouraging to note that the feedback obtained from women admitted in facilities that were visited did not report any fee being charged. However, they had to buy few medicines and other supplies.
- The UPHCP centres have some provisions for facilitating the access of the poor. The poor families are provided with an identity card, which entitles them to free service. In rural areas, with WHO support MoHFW is introducing demand side financing pilot maternal health voucher schemes (see details under section 1.10). NGOs such as CARE and BRAC also have health financing schemes for poor families in selected areas.

- Social and gender related barriers

- The BMMS and BDHS have shown that the decision to seek care is made by the husband even in situations where the women have the knowledge about danger signs and the need to seek care. The focus group discussions with few women have corroborated the above finding. The unequal power relations constrain the women's decision making ability, physical mobility and access to material resources even in situations where geographical access is not an issue as was found from studies in Nepal[20].
- Another major reason reported for poor attendance in the antenatal clinics is lack of perception about the importance of attending antenatal clinics.
- The sex of the provider has been reported as one of the barriers[1].

[20] DFID, OPTIONS: Nepal Safer Motherhood Project. Sharing Experiences. 2004.

- As indicated in the background section, the traditional birth attendants are the major providers of care at the time of delivery. The BMMS path analysis of care during complications clearly shows the role of the traditional practitioner in delaying seeking care from a skilled birth attendant. The barrier to care by the influence of local traditional practitioners is well known.

> The 1999 review of ICPD implementation stressed the connection between high levels of maternal mortality and poverty and called on states" to promote the reduction of maternal mortality and morbidity as a public health priority and reproductive rights concern" by ensuring that :women have ready access to essential obstetric care, well equipped and adequately staffed maternal health care services, skilled attendance at birth, emergency obstetric care, effective referral and transport to higher levels of care when necessary."
> Source: State of the World's Population 2004.

Recommendations

❖ Safe motherhood

- Recommendations under 'right to information' should contribute to improving antenatal care and postnatal care as well as deliveries by skilled birth attendants.
- Review of human resources in the health facilities should be done to ensure that skilled care is available round the clock in DHs and UHCs.
- The SBA training should be expanded to cover all the upazilas in the districts where the training has started and then to other districts, giving priority to districts with high maternal mortality. Consideration should be given to starting the training programme in urban areas.
- The linkages with nutrition programmes should be strengthened. A system of referral of poor and malnourished women to the nutrition centres should be developed. The linkage with nutrition programmes is also one of the actions listed under the maternal health strategy.
- EmOC facilities
  - Expand access to EmOC by strengthening facilities for provision of EmOC services as envisaged under the HNPSP beginning with high mortality divisions. All the UHFWCs should be strengthened to provide obstetric first aid.
  - While expanding the access, all efforts should be made to ensure the continuation of the EmOC services being provided by the designated facilities. The EmOC monitoring format used by the DGHS and the reports from MCWCs should be reviewed regularly and action should be taken to fill the gaps. The format should be reviewed to ensure that information on availability of all signal functions of BEmOC is available. The clinical and managerial reasons for the gaps should be rectified (linked to the recommendations under 3.3. quality assurance).
- Human resources for safe motherhood should be reviewed critically. The current needs and projected needs should be estimated and should be part of the HNPSP plans (see under sections 3.1 and 3.4 'policy framework and human resource development'). The availability of skilled attendants round the clock should be one of the factors considered while developing the plan.

❖ FP

- Postpartum FP services should be strengthened in all the facilities. FP should be actively promoted during domiciliary postnatal visits.
- The quality of counselling services should be strengthened (details under the section "right to informed choice"). Dual protection using condoms should be actively promoted.
- A system of follow up of clients should be instituted to track clients on oral contraceptives and injectables who discontinue the method. This could be easily achieved by modifying the existing FP recording system (linked to section 3.9 'right to continuity of care'.
- A directive should be sent out from the DGFP clarifying the issue on registration of facilities under the City Corporation for receiving free FP supplies. Since these facilities cater to the poor urban slum dwellers, access to free services and supplies will contribute to increasing the use of FP methods.
- Availability of emergency contraception should be expanded to the rural areas after adequate training.

- RTI/STI services
- The syndromic management of RTI/STI services should be further strengthened. The treatment facilities should be extended to all the UHCs. The UHFWCs should be strengthened as per national policy to provide RTI/STI services (see recommendations under section 3.11 'staff need for information, training and development').
- Counselling and partner notification and treatment should be strengthened.

- Laboratory facilities
- The laboratories in the DHs and UHCs should be strengthened for aetiological diagnosis of selected RTIs/STIs. (also discussed under recommendations in the section on 'right to supplies, equipment and facilities).
- Consider starting laboratory facilities in MCWCS to improve access to RTI/STI services.

- Blood transfusion facilities
- As per national policy on blood safety, blood-banking facilities should be developed in all the DHs with priority given to districts where EmOC services are being strengthened.
- Stringent quality assurance mechanisms for safe blood should be instituted as articulated in the National Strategic Plan for HIV/AIDS.

- Economic barriers
- Based on the findings of the evaluation of the pilot projects on maternal health voucher scheme, the scheme should be expanded to other areas. Close monitoring of the beneficiaries of the scheme is important and women's groups can play a major role in this. While introducing the scheme, it is also important to ensure that the beneficiaries are aware of their entitlements under the scheme.
- Community saving /insurance schemes
  - Through women's groups or through other community mobilisation efforts, women from poor families should be encouraged to save for emergencies – pooling of funds is an option. Community insurance scheme and BRAC's micro-health insurance scheme are other options. In case of community insurance schemes, t is important to ensure that poor families are not excluded and that women with complications do have access to the funds.
- Facilities visited had a functioning ambulance, however the availability of the transport 24 hours is a concern. Mostly the ambulance is available for transporting patients to a higher facility and less likely for transferring patients from home. Efforts should be made to identify community transports that are available 24 hours for transporting emergencies. The form of transport may vary according to the local situation. Mechanisms for paying for the transport should be developed in advance.

- Social and gender related barriers
- Active partnership with community-based organisations should be fostered to overcome some of the social and gender related barriers listed under findings. Experiences from the CARE Dinajpur project has shown clearly that social mobilisation efforts facilitate participation and inclusion of women in decision making and utilisation of services.
- Although there were no reports of health service provider attitudes being a deterrent to accessing care, all training of health service providers should include the importance of positive attitude towards women, particularly the poor who utilise the services.
- As recommended under section 3.5, the traditional birth attendants and practitioners should be involved in the birth preparedness plan.

3.7. Client's right to safe services

Clients have a right to safe services, which requires skilled providers, attention to infection prevention and appropriate and effective medical practices. Safe services also mean proper use of service

delivery guidelines, quality assurance mechanisms within the facility, counselling and instructions for clients, recognition and management of complications related to medical and surgical procedures.

Findings and conclusions

- Standards are essential for delivery of safe services. Standards include those for clinical functions such as protocols or treatment guidelines and those for facility functions such as infection prevention guidelines, supplies and equipment management, etc.

  - Written standards for safe motherhood services including newborn care were not available in any of the facilities. Guidelines on EmOC have been developed and distributed under the 'Women's right to life and health' project.
  - Treatment flow charts on management of obstetric and newborn complications were not found in any of the labour wards in any of the facilities.
  - Guidelines for referral of obstetric emergencies and newborn emergencies are not available.
  - Operational guidelines are available in the MCWCs. These include references to national standards and include recent evidence-based information.
  - Syndromic management guidelines are available with health service providers who have undergone training in the same.
- Partographs for monitoring labour are found in DHs, MCWCs and UPHC centres, but regularly used only by MCWCs and UPHC centres. However, the quality of recording and action taken are concerns.
- Active management of third stage of labour is not practised in most of the UHCs and DHs. It is routinely practised in MCWCs and UPHC centres.
- The proportion of C-sections in MCWCs and UPHCP centres appears to be high.
- From the observations in facilities, it appears that immediate newborn care especially ensuring warmth is not satisfactory. Lack of knowledge about neonatal problems and skills in the use of available equipment his could be the reason (see also section 3.13 ' staff need for supplies, equipment and infrastructure).
- From the visits to the facilities and information from the BMMS indicate that prompt care is provided in case of emergencies. But the quality of care provided is not known.
- Availability of staff trained in EmOC after hours is a major concern.
- It is reported that patients are stabilised before referrals. No standards for referral of complications are available.
- As discussed under the section on 'right to access to services', three of the BEmOC signal functions such as assisted vaginal delivery using vacuum extractor and evacuation of the uterus using vacuum aspiration are not routinely practised in many of the facilities partly due to non-availability of drugs and equipment. All MCWCs have been provided with a Vacuum extractor. Manual Vacuum Aspiration (MVA) syringes have not been provided; facilities for electrical evacuation are available in almost all the facilities. Management of eclampsia cases using Mag Sulf is followed by majority of MCWCs. Review of records of the MCWCs, UHCs and DHs that were visited showed that a high proportion of cases of eclampsia are referred to Medical Colleges. The records also showed that eclampia was the lead cause of death in DHs. These findings point to gaps in management of obstetric complications.
- Concerns about safety of blood transfusions using blood from private blood banks has already been raised in the previous sections.
- The capacity to manage complications of newborn is limited in the UHCs and MCWCs and also in some of the DHs.
- Obstetric first aid is not available in any of the UHFWCs.
- Infection prevention
  - All the facilities visited had adequate equipment for infection prevention. Shortage of bleach was found in some of the UHCs. Decontamination practices appear to be satisfactory, however sterilization and disposal of waste are concerns. The overall infection prevention in MCWCs is more satisfactory.

- Clinical audits are practised in some of the teaching institutions. It is not routinely practiced routinely. Maternal death reviews are undertaken in selected teaching institutions (details under the section on quality assurance).
- Although the level of complications reported from MR is not high, the quality of services provided is not satisfactory. The discussions with the service providers such as FWVs point to some serious gaps in the quality of services such as lack of counselling and poor infection prevention practices.

Recommendations

- Written standards should be available in all the health facilities. The existing guidelines and the MCWC operational manual should be reviewed and updated or modified to set clinical standards for health facilities at various levels. From the SBA'S reference manual, standards for home deliveries should be developed. The standards at various levels of health care should be well linked. The standards should include immediate care of the newborn and readiness of facilities for emergency care. In addition, standards for facility management and for protecting the rights of clients should be developed. The recommendation is also one of the actions under the maternal health strategy.

  WHO's safe motherhood publications, listed below, are useful resource materials.

  iv. Integrated Management of Pregnancy and Childbirth: Managing complications of Pregnancy and Childbirth: A Guide for Midwives and Doctors. WHO Geneva. *(this is already available in Bangla).*

  v. Integrated Management of Pregnancy and Childbirth: Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care. WHO Geneva.

  vi. Managing newborn problems: Guide for doctors, nurses and midwives, WHO Geneva.
- Involvement of professional associations in the development of guidelines should be ensured for promotion of adherence to the guidelines.
- Partographs should be introduced in all UHCs and the process should be reactivated in DHs. The staff should be oriented to the importance of maintaining the partograph in all labour cases and the importance of timely action to prevent maternal deaths and morbidity. The review of partographs should become part of the quality assessment tools.
- All efforts should be made to institutionalise active management of third stage of labour.
- The capacity of the MCWCs, UHCs and UPHC centres and selected DHs should be strengthened to provide immediate newborn care and management of complications of newborns.
- The flow charts for management of obstetric and neonatal complications should be displayed in all the labour rooms.
- Mechanisms should be developed to ensure that EmOC trained staff (Nurses and Doctors) are available round the clock every day of the week.
- Guidelines for referral of obstetric and neonatal emergencies should be developed which should include instructions on critical elements such as stabilising the patients before referral, communicating in advance with the facility where the client is being referred, care during transportation, relevant medical records and referral note.
- Management of emergencies and referrals as per guidelines should be instituted and adhered to in all the facilities.
- All six signal functions of BEmOC should be made available as recommended in the section ' right to access to services'.
- The recommendations on safe blood supply are given under the section ' right to access to services'.
- The UHFWCs should be strengthened to provide obstetric first aid.
- Counselling on FP of post-abortion clients (with emphasis on early return to fertility) should be strengthened.
- The importance of counselling while providing emergency contraception should be emphasised to the staff of the facilities where the method is being introduced. Although standards for FP methods exist, it should be ensured that infection prevention during procedures and dual protection with condoms are emphasised.

- The infection prevention practices in all the facilities should be strengthened and adequate supplies for the same must be ensured.
- Clinical audits should be instituted in as many facilities as possible. These should be undertaken by teaching institution staff[21]. Availability of standards is a pre-requisite for clinical audits. The aspects of care that is deficient as identified from maternal and perinatal death reviews should be audited. The audit should contribute to ensuring that the practice in hospitals are governed by the standards and protocols developed. Complete case records are essential for the process. The private sector should be also audited using the same tools.
- Quality improvement processes such as COPE and facility audits should be instituted within institutions so that problems are identified and action is taken (linked to recommendations on quality assurance circles).
- The quality of menstrual regulation services should be monitored. Counselling of clients prior to and after the procedure especially for FP is critical to prevent immediate conception (due to early return of fertility) and another procedure. Infection prevention during the procedures should be strictly adhered to.

3.9. Clients' right to continuity of care

All clients have right to continuity of services while admitted in institutions or follow up at home or institutions. All clients also have the right to continuous supply of contraceptives and other medicines and referral to a higher facility if required.

Findings and conclusions

- In health facilities, checking of vital signs of postpartum clients at prescribed intervals is not done satisfactorily.
- Clients, especially FP clients, are provided some instruction on when to return for services. However the information provided on warning signs and what to do in case of complications is not satisfactory.
- Referrals
  - As discussed under the section ' right to safe services', guidelines for referral of emergencies is not available.
  - Printed referral slips are only available in MCWCs, but they were not being used regularly while referring clients.
  - Ambulances are available in most of the health facilities, but the 24-hour availability of the ambulance service is a problem.
  - A system of follow up of referred clients is not in place.
- Lack of emphasis on follow up and partner notification in case of STIs was mentioned under the section on ' right to access to services'.

Recommendations

- The training in FP should emphasise the importance of providing information on warning signs, care after IUD insertion, surgical contraception and what action to be taken by the client as well as the health service provider an follow up. The importance of post-abortion clients being followed up for provision of FP should be included in the training (stress the early return of fertility and chances of another pregnancy if no contraception is used).
- Institute mechanisms for follow up of clients.

[21] Clinical audit is a quality improvement process that seeks to improve patient care and outcomes by the systematic review of care against explicit criteria and the implementation of change. Source: Beyond the numbers. Reviewing Maternal Deaths and Complications to Make Pregnancy Safer. WHO, Geneva.

- The clients should be provided information on when to return for follow up services/ supplies. The importance of follow up visits /check ups should be emphasised to pregnant women and post-partum women.
- The current HMIS should be reviewed to assess whether it is possible to track clients. The tracking should help to identify defaulters in case of FP spacing methods, women who are due to deliver (to reinforce birth preparedness plan and to provide postnatal care as early as possible) (linked to the recommendation under section 3.8 right to safe services).
- The discharge slips should be modified to include full information about significant history and examination findings and treatment provided, what treatment / care should be continued at home, what to watch for, when to return for follow up.

- Follow up of STI clients should be strengthened as well as treatment of their partners.
- The referral system should be strengthened.
  - Referral guidelines should be developed as discussed under the section ‘ right to access to safe services’.
  - Referral slips should be developed that includes a section on feedback, preferably detachable, that can be sent through the client or relative to the facility that referred the client.
  - The providers in the referral facilities should be oriented to the importance of feedback to the referring facility on diagnosis and management of the case or on follow up treatment. This should help in follow up of referred clients.
  - Linkages should be established with private /NGO hospitals where specialist services are available. However, it is important to ensure that the facility provides quality care. Mechanisms for reimbursement of costs in case of poor patients should be spelt out while establishing the linkages.
  - The facility that is referring should assist with arrangements for transportation of the patients either through the health facility ambulance or a community transport (see recommendations under section 3.7 ‘access to services’).

> “Governments, in collaboration with civil society, including non-governmental organizations, donors and the United Nations systems should: Increase investments designed to improve the quality and availability of sexual and reproductive health services, including establishing and monitoring clear standards of care; ensuring the competence, particularly the technical and communication skills, of service, privacy, confidentiality and client comfort; establishing fully functioning logistical systems, including efficient procurement of necessary commodities; and ensuring effective referral mechanisms across services and levels of care, taking care that services are offered in conformity with human rights and with ethical and professional standards”. Point 5.2.1 under Reproductive Rights and Reproductive Health, ICPD PoA.

3.10. Clients' right to privacy and confidentiality and Clients' right to dignity, comfort and expression of opinion

Clients have a right to privacy and confidentiality during counselling, physical examination and clinical procedures as well as while handling medical records. All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely.

Findings and conclusions

- During visits to facilities, it was found that privacy and confidentiality were not maintained satisfactorily in FP clinics despite the availability of separate cubicles for examination. The privacy in labour rooms was not satisfactory.
- There was no adverse feedback on attitudes of staff (from client interviews during facility visits), but interestingly has been quoted as a reason for not utilising services in other studies.
- The patient welfare committees have been set up in some of the NGO hospitals and higher-level institutions to address the concerns of the patients. Under the CARE Dinajpur Safe Motherhood Initiative, community support systems helped to improve the facilities at the UHCs.

Recommendations

- Privacy and confidentiality should be improved by changing the attitude of staff through training. Such training should use well-designed role plays that will help the staff understand the "client's feelings' and thus realise the importance of these elements of care. This aspect of care should be regularly monitored.
- A system of feedback from clients should be instituted to improve the quality of services. Such a system would ensure that patients whom the system is supposed to serve understand their entitlements (right to information, informed choice, access to services and safe services) and create an enabling environment to demand them. In such an environment, providers will be obliged to follow standards.
- Client/stakeholder involvement should be encouraged using the lessons learned from the various projects in the country.

3.11. Staff need for information, training and development

Knowledge and skills and ongoing training and professional development are critical for staff to continuously improve the quality of care they provide.

Findings and conclusions

- Training
  - 4 months competency-based training in EmOC and Anaesthesia of Medical Officers and Staff Nurses of selected UHC facilities were provided under the "Women's right to life and health" project (Medical Officers – 14 trained in EmOC, 12 in Anaesthesia; Nurses – 21 in EmOC).
  - One year training in EmOC and Anaesthesia of Medical Officers (124 trained in EmOC and 112 in Anaesthesia).
  - Medical Officers of MCWCs and UPHCP facilities have been trained in EmOC and in Anaesthesia to ensure that each of the facilities has specialists in both the subjects. This is followed by clinical updates (MCWC: Medical Officers -128 in EmOC and 122 in Anaesthesia) and UPHCP Medical Officers - 33 in EmOC and in Anaesthesia).
  - Majority of the Medical Officers have been trained in clinical contraception and RTI/STI management (Basic 188 and refresher 202).
  - Doctors of selected MCWCs and UPHCP facilities have been trained in diagnosis and management of gender-based violence (from 9 MCWCs and 20 UPHCP facilities), in ASRH services (from 16 MCWCs and 20 UPHCP facilities) and male participation (from 12 MCWCs and 20 UPHCP facilities).
  - Medical Officers, Staff Nurses and FWVs of UHCs trained in diagnosis and management of gender-based violence (543 trained).
  - Training of laboratory technicians has been done in blood grouping, cross matching, screening of blood for transfusion and RTI/STI diagnoses (Basic 457 and refresher 188).
- The above list of trainings in FP and RTIs/STIs is funded by UNFPA, designed by EndgenderHealth, and managed by partner NGOs and the training is conducted by staff of Model FP clinics located in Medical Colleges. A guideline for training management has been developed, which is very comprehensive.
- Training in counselling is not satisfactory and the lack of proper counselling skills affects the quality of services (linked to sections 3.7, 3.9 'right to access to services and right to continuity of care').
- Community-based SBAs receive competency-based training in management of normal pregnancy, labour, delivery and care of newborn and postnatal care and obstetric first aid (550 trained till the time of the review).
- FWVs (352) are being trained in midwifery by the FHV schools. The current training is not linked to the training of SBAs, who the FWVs are expected to supervise.

- As mentioned under section 1.11, nurses from selected institutions are being trained in midwifery standards with support from WHO.
- Follow up of trainees is a weak area. The training guidelines details out follow up procedures. However, it is not followed.
  - In case of FP training, it is reported that the trainers do observe the trainees while performing minilap and NSV.
  - The current SBA training programme does not have a well-designed plan for training follow up.

Recommendations

- Staff at all levels including district hospitals (as needed) should be trained in immediate care of newborn.
- All staff should be trained in diagnosis and management of gender-based violence as part of EmOC training and linked with ongoing UNICEF and NGO efforts.
- Midwifery skills of all nurses posted in district hospitals, UHCs, MCWCs and UPCP facilities should be strengthened through short courses. It may be worth considering permanent posting of nurses interested in midwifery in the labour rooms.
- The training of nurses in midwifery standards should be expanded to all the facilities.
- The DH specialists should be oriented to gain their support in the implementation of the EmOC standards.
- The FWV training should be reviewed in the context of the community-based SBA training.
  - The training should include selected BEmOC skills so that UHFWCs can start providing such services as envisaged under the HNPSP plans as discussed under section 3.1 'policy framework'.
  - The training also should include skills in supportive supervision (see also under section 3.11 ' staff need for facilitative supervision and management'.
- Both the SBA and FWV training should be institutionalised (as discussed under the background section, the training of SBAs is not institutionalised).
- The trainees should be followed at their worksites. Follow up of trainees is essential to assess the retention of skills and the quality of services provided. A sample of trainees should be followed up. The training follow up guidelines given in the training management guidelines should be implemented. Plans for follow up of other trainings also should be developed. A well-defined plan for follow up should be part of any training design. Adequate funds should be included for the same.
  - The community based SBA training programme should have a follow up plan for the batches that have been trained / undergoing training and for the new batches that will be trained. The plan should include when the follow up will take place, who will do the follow up, guidelines for follow up, reporting and what remedial actions to be taken in case of gaps in skills or other problems that affect the quality of care. Funding should be provided for follow up.
- A master plan for training of community-based SBAs that includes their follow up should be developed. This should be linked to the training plans and training management information system being developed under HNPSP.
- The job description of the SBAs should be developed by reviewing and modifying the current job descriptions of the FWAs and FeHAs.
- BNC's capacity and capability (managerial and technical) should be strengthened to monitor the quality of the training of SBAs and FWVs and also follow up of trainees. Seconding of competent staff from training institutions to BNC is an option that should be explored.
- Involvement of professional organisations in providing training support. Such involvement will create a supportive environment for mentoring the staff trained in EmOC and Anaesthesia.
  - OGSB should expand its role to support continuing education of doctors in EmOC. It should continue to play an active role in the training of SBAs, especially in the evaluation and the modification of training materials. It should provide inputs into the review and revision of the FHV training in midwifery and support the BNC in midwifery training of nurses.
  - The professional societies of anaesthesia and neonatology should be actively involved.

3.12. Staff need for facilitative supervision and management

Supportive supervision and a supportive management are critical for supporting and encouraging the staff to improve the quality of care especially EmOC. The HNPSP lays great emphasis on this aspect of management.

Findings and conclusions

- Clear directives of line of supervision exist. But the system of supervision is weak.
- The line of supervision of the community based SBAs is not clear as some belong to the DGHS and DGFP.

Recommendations

- Supportive supervision needs to be strengthened at all levels.
  - Besides training supervisors, it is also important to develop supervisory checklists that can be used by the supervisors for monitoring and the next level of supervisors.
  - The technical skills of supervisors need to be strengthened to enable them to assess the quality of services as well as mentor the staff they supervise.
  - The supervision should include (but not limited to) review of protocols to ensure that workers understand them, review of records to see the coverage of services and discussions on gaps, importance of infection prevention and privacy and confidentiality. Clinical audit is a good tool to teach staff.
- The managers of health facilities need orientation in importance of quality improvement and the need to support staff in various quality assurance activities. The support of managers is critical in infection prevention, ensuring privacy and functioning equipment. The managers also should institute a system of recognising staff who perform well
- The recommendations under 'quality assurance' are also applicable to strengthening supportive supervision and management.
- As more community based SBAs are being trained and posted, it is critical to identify and train the supervisors. This should be done on a priority basis.

3.13. Staff need for supplies, equipment and infrastructure

Reliable and sufficient supplies, functioning equipment and adequate infrastructure as per prescribed standards are essential for providing quality services.

Findings and conclusions

- Drugs and supplies
  - List of drugs and stock positions are not available in many EmOC facilities. Shortage of Mag. Sulph was observed in some of the facilities particularly UHCs. The situation is better in MCWCs, which could be attributed to availability of funds for local procurement. However, even in MCWCs, the stock position of EmOC drugs was not displayed.
  - The shortage or non-availability of reagents for blood grouping, screening blood for transfusion and for diagnosing RTI/STI and shortage of contraceptives have already been listed under section 3.7 ' right to services'.
- Instruments and equipments
  - The number of delivery sets is adequate in almost all the facilities, however the readiness for use is questionable as autoclaved instruments were not readily available and the instruments were not packed in sets (with all the essential equipment for normal delivery).
  - Similarly, the readiness for use of sets of instruments for C-sections was questionable.
  - As discussed under section 3.7 'right to safe services', while the vacuum extractor for assisted delivery was available in all the MCWCs, the numbers that were functioning were few. This is of concern as a special mechanism for repair of equipment has been set up for the

MCWCs. Most of the DHs and UHCs did not have the vacuum extractor. The UPHCP facilities had vacuum extractor. None of the facilities had equipment for MVA. Non-functioning equipment/ non-availability of equipment is one of the reasons for many of the EmOC facilities not providing all the six signal functions of BEmOC.
  - Incubators and neonatal resuscitation kits were available in most of the facilities that are designated to provide CEmOC. However, they were hardly used and the knowledge of the staff on the use of these equipments was limited.
  - Some of the facilities visited reported shortage of critical supplies such as endotracheal tubes, mucus suckers and ambu bags; the shortages were more in UHCs.
  - Maintenance of equipment is a major concern.
- The mechanism for replacement of contents of the kits provided to community-based SBAs is not clear. Feedback from trainers who have been in contact with the SBAs is that the supplies are bought by the families of the pregnant women.
- HMIS: shortage of antenatal cards was reported.
- Logistics management system
  - USAID assisted DELIVER project has helped the DGFP to develop a contraceptive logistics management information system. A committee has been set up by the Government to develop a system of contraceptive logistics management to forecast requirements and ensure no stock outs.
- The infrastructure of most of the DHs and MCWCs meets the standards set by the MoHFW, but the infrastructure of the UHCs are not satisfactory. There are concerns related to provision of privacy as listed under section 3.10 ' right to privacy and confidentiality'.

Recommendations

- Drugs and supplies
  - A stock position of EmOC drugs and other emergency drugs should be available in the labour room and theatre. The responsibility for the same should be given to a staff member.
  - Regular laboratory supplies should be ensured in all the facilities that have a functioning laboratory (see also recommendations under section 3.7 'right to access to services'.
- Instruments and equipments
  - Readiness of instruments for use should be ensured.
  - All the staff in the labour room should be trained in the use of neonatal resuscitation equipment and its care.
  - Consideration should be given for providing baby radiant warmers/heaters in labour rooms.
  - The system of maintenance of equipment should be strengthened / introduced in facilities where such a system does not exist
  - Equipment for MVA should be supplied to all EmoC facilities and staff should be trained in the procedure.
- Mechanisms should be developed for replenishing the supplies of the SBA kit.
- Logistics management system
  - The current efforts to strengthen the logistics management system should be extended to include EmOC drugs and supplies.
  - Storekeepers should be trained in the system.

3.14. NGOs and private sector

The HNP Sector Investment Plan recognises the collaboration with the NGOs and the private sector as one of the strategies for improving the access to services. The maternal health strategy emphasises the role of NGOs (national and international) and private sector in delivery of safe motherhood services.

Findings and conclusions

- NGOs and private sector provide safe motherhood, FP and RTI/STI services as described in the background section. Some of the NGOs provide training to primary care workers in basic midwifery. In the area of FP, there is a lot of collaboration especially in training.
- The collaboration with NGO sector is formalised in the urban sector. USAID is supporting networking of NGOs in the rural areas.
- The findings and recommendations are covered under specific sections discussed earlier.
- The UPHCP project is built on a pro-poor focus and there is evidence of efforts to provide free care to the poor. However, access to the poor is of concern.
- UPHCP facilities charge for laboratory tests and hospitalisation. The charges are subsidised.
- The contraceptives are supplied free of charge by DGFP. The organisation's headquarters collects the supplies and distributes to the various units. No stock outs have been reported except in situations where the headquarters did not receive the supplies.
- There is no evidence of linkages between UPHCP NGOs and City Corporation institutions.
- The linkages between the big hospitals run by various NGOs and the government institutions for referral of cases, laboratory testing and blood transfusion are not well established (see also under section 3.9 ' right to continuity of care').
- The private sector is a major player in the provision of safe motherhood services especially EmOC services. High rate of C-sections is reported in some of the hospital. The quality of care and cost are major concerns and access to the poor is limited. The national guidelines are not followed by many of the institutions. There are no established linkages for referrals between the Government institutions and private sector institutions.

Recommendations

- NGOs
  - A review of the current linkages between NGO institutions and Government Institutions should be undertaken with a view to identify potential areas of linkages in the delivery of safe motherhood, FP, RTI/STI services. Once the areas are identified, formal referral linkages should be established including mechanisms for reimbursement of cost of hospital care.
  - Monitoring the use of services by the poor under the UPHCP should be introduced.
- Private sector
  - Private sector institutions should be identified for collaboration based on specific selection criteria. Linkages with such institutions should be formalised including mechanisms for reimbursement of cost of hospital care.
  - The private sector institutions should be oriented to national standards and guidelines and mechanisms should be developed to monitor the quality of care provided.

3.15. Maternal mortality data

Findings and conclusions

- The current HMIS or maternal death reviews do not provide complete information for monitoring maternal mortality as planned under the HNPSP.

Recommendations

- As recommended under section 3.3, maternal death reviews should be improved and a system of verbal autopsy should be introduced for completeness and accuracy of recording of maternal deaths.
- Perinatal death audits should be introduced.

WHO's publication " Beyond the numbers – Review of Maternal Deaths and Complications to Make Pregnancy Safer" is a very useful publication for guiding the implementation of the recommendations.

4. Recommendations for UNFPA support to improving the quality of safe motherhood services

The recommendations listed below are relevant for the current CP as well as the next CP. Some of the recommendations are for improving the ongoing activities under the current CP and some are new activities that may not be possible to initiate in the current CP as it is ending in 2005. UNFPA should consider supporting the following:

1. Advocate at the highest level along with other HNPSP partners to increase the budgetary allocations for EmOC activities.
2. Consider expanding the current agreement with the BBS to map poverty zones to include EmOC facilities as recommended under policy framework. The process may not be completed during the current cycle and should be continued in the next CP.
3. Support management training of mangers at District and Upazila level in RH with focus on improving quality of services. Improving leadership in quality improvement of EmOC should be one of the topics under training. This design of the training programme should start during this cycle and the actual training should start during the next CP. The design should be developed in close collaboration with the office responsible for HNPSP implementation under the MoHFW and should be reflected in the training plans of HNPSP.
4. Support QA initiatives.
    - Improve the quality of the existing system practised by the MCWCs and UPHCP.
    - Introduce maternal death audits (facility based) and clinical audits in collaboration with WHO in selected institutions. The background work for the activity should be started during this CP and the activity should be implemented in the next CP.
    - Introduce a pilot project on community-based audits in collaboration with ICDDR, B in wards and villages where the SBAs are functioning.

   and link with the HNPSP QA initiatives.
4. Support the development of a human resource development plan for safe motherhood in collaboration with WHO and link the same with the HNPSP human resource development plan. UNFPA's involvement is critical as it supports several strategies for improving access to safe motherhood activities.
5. Support strategies for improving access to information.
    - Increase focus on remedying information gaps identified in earlier sections by including evidence based communication strategies in the BCC strategy supported by UNFPA.
    - In the MCWCs, implement the recommendations as applicable.
    - In the urban areas, strengthen the skills of the BCC worker to provide information on the areas identified in the earlier sections.
    - Introduce the recommendations on birth planning as applicable in the two pilot districts where activities for increasing awareness about danger signs are being implemented.
    - Collaborate with CARE and other NGOs with community experience to replicate some of their experiences. This should be part of the next CP.
6. Improve the quality of counselling.
    - Support competency-based refresher training and strengthening the training on counselling under the SBA and FWV training under the current CP.
    - Translate and print copies of WHO's Decision Making Tool for FP clients and providers.
7. Support strategies for improving access to services that are safe
    - Besides strengthening the ongoing activities under the current CP based on the recommendations for improving access to services that are safe (sections 3.7 and 3.8), activate postpartum contraception activities in MCWCs under this CP. It should be expanded to all the facilities in the next CP and should be emphasised during the training of various categories of providers.

- Under the next CP, consider supporting activities for BEmOC in UHCs and MCWCs in selected geographical areas and introducing selected BEmOC functions in selected UHFWCs. While introducing services in UHFWCs, experience of ICDDR, B in implementing similar activities should be taken into consideration.
- Review of the current standards and guidelines should be done under the next CP to update them if needed. Development of guidelines for immediate newborn care (in collaboration with other MNH partners) and referral guidelines should be supported.
- In collaboration with WHO, advocate for availability of safe blood transfusion facilities.
- In collaboration with WHO, replicate the demand side financing initiative in other Upazilas under the current CP (if possible) and next CP.
- Under the gender related activities of the current CP, mobilise women's groups to create awareness on safe motherhood issues. Collaboration with NGOs who have successfully implemented similar groups should be considered.

8. Support development of mechanisms for follow up of FP clients as recommended under section 3.9. The training of providers in improving the follow up of clients should be supported.
9. The recommendations for strengthening the performance of health service providers under sections 3.11 and 3.12 should be introduced under the current CP, as most of them are relevant. These should be continued in the next CP.
10. Continue support for logistics management and explore the possibility of adding other RH supplies as recommended under section 3.13. The introduction of equipment and supplies and training for introduction of MVA procedure is covered under the recommendations for strengthening BEmOC (under recommendation 7).
11. Support operation research in public-NGO and public-private collaboration in improving access to EmOC services.

Annex 1: Aims and objectives of National Maternal Health Strategy

Aims	Objectives (by 2010)
To strengthen the provision of essential (including emergency) obstetric care and improve referral and utilization of services.	– Increase met need of EmOC to 70% from 17% – Increase uptake of ANC (3 visits) to 60% – Increase skilled attendance at birth to 50% from 13% – Increase PNC to 30% from 2% – Increase CPR to 72% from 53.8% with larger proportion of clinical (particularly long term) methods and discontinuation rates reduced – Reduce unsafe abortion practices and provide post-abortion care – Accreditate facilities as women friendly with provision of services for women subjected to violence
To improve the nutritional status of women and adolescent girls	– To increase weight gain during pregnancy to >9kg in 50% of pregnant women – To reduce the incidence of low birth weight (<2,500g) to <30% – To reduce the prevalence of anaemia among pregnant and lactating mothers by one third – To reduce the prevalence of iodine deficiency (urinary iodine excretion <30 micro g) to 30% – To reduce the proportion of women with BMI<18.5 from 50% to <30%
Ensure the right people with the right skills are trained to provide quality maternal health services (MHS) at all levels of the health system	– Ensure skilled human resources to provide midwifery and comprehensive EmOC services in all district hospitals, district level MCWCs and 40% Upazila Health Complexes (UHC); midwifery and basic EmOC services in remaining 60% UHCs and 50% UHFWCs and Upazila and union level MCWCs – Provide skilled birth attendants (community midwives) – one for every 18,000 community clinics with appropriate back-up services – Ensure appropriate personnel in every static centre able to provide the full package of appropriate MHS – Ensure capacity and quality of training institutes through accreditation
To promote women friendly health services	– To make health service providers more sensitive to women's needs and concerns – To make women more aware of their rights in the health care system – To establish the policy of zero tolerance of violence against women in all facilities providing health services
To bring about positive changes in the perception and behaviour of individuals, family, service providers and the community to support women in the realization of their right to safe motherhood and a life free of violence and discrimination	– To achieve universal knowledge about danger signs of pregnancy/childbirth, and referral to centres, with EOC services – To motivate couples so that women do not have first child before 20 years of age – To ensure that communities/families take responsibility to transport obstetric and neonatal emergencies immediately to nearest EmOC centre, and mobilize blood donation – To motivate men to take responsibility for ensuring health care (including pregnancy care) of their wives – To eliminate all types of misconceptions and wrong practices from families/communities including under-nutrition of pregnant and lactating women – To campaign for zero tolerance of violence – To provide the care needed by women who have been abused – To highlight the role of men in eliminating VAW

Annex 2: Outputs and activities for improving maternal health under HNPSP

A. DGHS

Outputs:

- All 64 district hospitals and 25% of 402 UHCs (100 UHCs) are staffed and equipped for provision of Comprehensive Emergency Obstetric Care (CEOC).
- The remaining 75% of UHCs, i.e., 302 UHCs, are staffed and equipped for provision of Basic Emergency Obstetric Care (BEOC).
- Safe delivery & obstetric first aid service at some selected UHFWCs.
- ANC (3 visits) increased to 60%
- PNC increased to 30% from 20%
- Reduction of unsafe abortion practice and provide post abortion care
- Increased delivery care for all pregnant women from 10% to 25%
- Screening high-risk pregnancy and linkage of referral system development up to 100%.
- Increased clinical contraception services to achieve targeted reduction in TFR to 2.8 by mid 2006

Table: Targets for Emergency Obstetric Care

Facility	HNPSP Baseline (June 2003)	Target		
		2003/04	2004/05	2005/06
Medical College Hospitals - 100% CEOC	13/13	100%	100%	100%
District Hospitals - 100% CEOC	53/59	59=100%	59=100%	59=100%
UHCs – 25% CEOC	45	100=25%	40%	50%
UHCs – 75% BEOC	80	50%	100%	100%

Activities:

- Capacity building for 123 CEOC teams comprised of 1 obstetrician, 1 anaesthesiologist, 3 nurses and 1 Medical Technician (Laboratory) plus 40% to compensate for attrition;
- Capacity building so that each UHC has in place 1 MO and two nurses trained in BEOC; delegation to nurses of responsibility for defined BEOC procedures to ensure round-the-clock preparedness for Basic Emergency Obstetric Care;
- Procurement of drugs and equipment;
- Continued maintenance of equipment;
- Monitoring, through special surveys and EOC reports, increased coverage of EOC services and decreased unmet need for EOC;
- To train health service providers (doctors, nurses & paramedics) on MR programme;
- Awareness creation on adolescent health care through social mobilization and health education among adolescent girls and boys;
- Training of health service providers on infertility;
- Training of health care providers on neonatal care;

- Cervical cancer screening through visual inspection with acetic acid (VIA)
- Strengthened capacity in service provision, referral and networking to address the three delays in safe motherhood and informed family planning choices 75 doctors (11 doctors at MCWCs, 30 doctors at Urban areas and 34 doctors at Sadar Upazila) and 75 FWVs from MCWC/Urban Clinics would be trained to provide CEOC through UNFPA assistance). In addition, a cadre of Skilled Birth Attendants (SBA) from the existing staff would be developed to strengthen safe delivery at home in 45 unions of 6 selected Upazila in two identified districts with UNFPA assistance.

B. DGFP

Outputs:

- Increased coverage of safe delivery care by skilled personnel
- Expanded coverage of EoC and safe delivery including obstetric first aid
- Increased availability and access to ANC, PNC and newborn care
- Improved capacities for service provision and skill-based training for maternal and newborn care
- Collaborative support to child health services

Activities:

- 'User-friendly' UHFWCs for safe motherhood, newborn care, adolescent health care and VSC
- Expansion of coverage of RH;FP-MCH services including comprehensive emergency obstetric care and essential obstetric care services
- Increasing coverage for conducting safe deliveries close-to clients by skilled personnel
- Essential newborn care for reducing neonatal mortality
- Reducing infant and child mortality
- Strengthening of MCHTI
- Implementation of UN Joint Safe Motherhood Initiative

Annex 3: Terms of reference

Terms of reference
Thematic evaluation of safe motherhood programme in Bangladesh

1. Introduction

a. Background:

The Health and Family Welfare programme of Bangladesh has made remarkable progress in the last two decades as evident from the decline in fertility rate, infant mortality and child mortality rates. The reduction in maternal mortality in the past 15 years is 22%, right on target towards MDG goal of a 75% reduction between 1990 and 2015[22]. However, the maternal mortality is still high (320 per 100,000[1]). Haemorrhage is the number one cause followed by eclampsia[1]. An estimated 600,000 suffer maternal complications every year. An important contributory factor to high level of maternal mortality, the Total Fertility Rate (TFR), had declined to 3.3 in 1997, but has not fallen since then. However, the Contraceptive Prevalence Rate (CPR) has continued to increase at 1.5 percentage points per year (1999-2000), reaching 54% in 1999-2000.

Reduction in maternal mortality is a priority for the Government of Bangladesh (GoB) as evident from the various national development frameworks. The following sections describe the investments in maternal health. The National Maternal Health Strategy 2001 has laid out a long-term strategy to address the issue of Safe Motherhood. The strategy focuses mainly on the 3 Delays in Maternal Mortality. The strategy recognizes the linkage between women's status and maternal mortality and addresses Safe Motherhood as a woman's right. The strategy has identified several objectives to be achieved by 2010. The Health, Nutrition and Population Sector Programme (HNPSP), currently being implemented, includes the following targets related to maternal health:

Indicator	Unit of Measurement	Benchmark (with Reference Period and Source)	Projected*	
			Mid-2003	End HNPSP Mid-2006
Maternal Mortality Ratio (MMR)	Annual number of maternal deaths per 1000 live births	3.2 (Bangladesh Maternal Health Services & Maternal Mortality Survey, 2001)	2.95	2.75
Met Need for EOC	Percentage of deliveries with an obstetric complication managed at GOB EOC facilities	12.6% (2002; UMIS estimate based on EOC reports from 218 GOB facilities)	13%*	25%*

* Unified Management of Information System (UMIS) projection

The GoB has invested heavily in health infrastructure development, which is one of the critical investments for reducing maternal mortality. The achievements are evident from Annex 1. The GoB's expenditure for 1998-2003 under Health, Population Sector Programme (HPSP) is reported to be 14% for maternal health and 25% for FP, the latter being one of the critical investments for reducing maternal mortality.

With support from UNFPA, GoB has upgraded 64 Maternal and Child Welfare Centres (MCWCs) and doctors and paramedics have been trained in Emergency Obstetric Care (EmOC). The number of women who visit these clinics has increased and these clinics are declared "women friendly". The above inputs have proved that capacity building together with supportive logistics and administrative arrangements will bring about improved services on Safe Motherhood even at the peripheral level. In addition, UNICEF has provided support for health systems strengthening, specifically for EmOC, in district hospitals.

In addition, to improve access to skilled attendance at birth at home, GoB has adopted two key strategies: 1) Training of a cadre of workers, " skilled birth attendants" (SBA) with WHO and UNFPA support. The trainees are from the existing cadres of FWAs and FeHAs. The GoB is committed to providing at least one SBA per Union level (4500 SBAs required). Only 90 have been trained so far and the challenge is to train adequate numbers to ensure the presence of at least one SBA at every Union level. The SBAs should be able to improve access to quality midwifery and newborn services in the community, motivate couples to consider spacing births and educate the mothers on reproductive rights. Each SBA will be equipped with a SBA kit that has been

[22] NIPORT, ORC Macro, JHU and ICDDR, B: Bangladesh Maternal Health Services and Maternal Mortality Survey 2001- Selected Findings and Policy Recommendations.

designed on the basis of consultations with stakeholders. The Bangladesh Nursing Council is responsible for accreditation of the SBAs and Obstetrics and Gynaecoloical societies of Bangladesh provide technical support. 2) GOB has introduced a six months training of Family Welfare Visitors (FWVs) in midwifery and at present 25 FWVs are undergoing training supported by UNFPA. The vision is to link FWVs to the SBAs for referral of cases as well as to provide supportive supervision to improve the quality of services provided by the SBAs.

The NGOs such as Bangladesh Association for Voluntary Sterilization (BAVS), Bangladesh Red Crescent Society (BDRS), Bangladesh Rural Advancement Committee (BRAC) and International Centre for Diarrhoeal Diseases Research, Bangladesh (ICDDR,B), through various human resource development strategies, are playing a role in improving maternal health services in the country.

UNFPA, WHO, UNICEF, USAID, DFID and World Bank have played major role in contributing to improving maternal health and continue to play a stronger role in turning the wheel of fortune of the women of Bangladesh. The other important donors are ADB, CIDA and SIDA.

The investments in the recent past and continuing investments as described in the preceding sections should contribute to further reductions in maternal mortality. However, the evidence from the recent study on Maternal Health Services and Mortality and other studies shows that the utilization of services is poor due to number of factors.

The analysis of causes of maternal mortality using the findings from the survey of 2001 identifies the few interrelated problems at various levels that are listed in the preceding sections[1]. Poverty and status of women are the root causes of the problem that are linked to an underlying and immediate set of causes of death. 33% of the population lives below poverty line. Even when women recognized life-threatening complications, they did not utilize a facility because of "too much cost" [1]. Transportation and lack of permission from the family were of lesser obstacle to seeking care[1]. The services are free, however the utilization by the poor is also very poor. A recent study by DFID has shown that the public sector services are being utilized by the first 2 richest quintiles. Utilization of government facilities by the poor is a major concern of the health planners and development agencies.

The low level of literacy and the lack of awareness about care and complications and early marriage are some of the underlying causes. 36% of the women below 20 years have begun childbearing. The recent survey on maternal health services and mortality showed that MMR is highest among first births[1]. The awareness about the importance of seeking care for complications is low and 50% of those who sought treatment took treatment from unqualified practitioners[1]. Despite the existing health services infrastructure, only 37 per cent of women giving birth had received some antenatal care, the majority of pregnant women do not receive antenatal care (ANC) in Bangladesh. The anomaly is that about 82 per cent of women received a tetanus toxoid injection. Although awareness of the benefits of antenatal care among pregnant women is about 63 per cent, this knowledge has not been translated to care-seeking behaviour. Majority of the deliveries are home deliveries, with a very small proportion delivered by skilled birth attendants. The absence of skilled attendants at birth delays recognition of complications and thus life saving treatment. Lack of birth planning is another underlying cause. Two thirds of the women in the survey did not make any plans for their delivery[1]. Birth planning helps avoid delays in deciding to seek treatment.

Access to EmOC is another immediate cause. The unmet need for EmOC is reported to be 75%. Most Upazila health centres have vacant posts of doctors, particularly specialists, due to preference for urban posting. Even when records show that the staff are posted, in reality, they are not present at the health facilities. This has resulted in inequitable distribution with rural areas being at a disadvantage. Non-availability of services in district hospitals is due to availability of consultant – either obstetrician or anaesthesiologist and blood transfusion facilities. In Upazila Health Complexes, the non-availability of services is due to non-availability of both human resources and equipment/drugs. On the positive side, the survey showed that when a woman with complications reached a facility, she received timely treatment[1]. However, the majority of women who reached facilities reached them late after having been treated by unqualified practitioners. Timely and appropriate treatment is critical in saving lives of women with PPH and eclampsia, the leading causes of death.

Private sector facilities are a major source of EmOC services. Of concern is the fact that although only 25 per cent of women experiencing obstetric complications avail private sector services, half of the caesarean sections are performed in this sector. The situation of record keeping and reporting is inadequate.

It is evident from the analysis in the preceding sections that there is a need to forge partnership between the Government, development partners, professional bodies as well as other non-traditional stakeholders – women activists, lawyers, media, and NGOs – to further strengthen the maternal health services and increase utilization.

b. The rationale for the thematic evaluation

- Reducing maternal mortality is one of the priorities of the GoB and is reflected in the national poverty reduction strategy and HNPSP. Safe motherhood is recognised as a woman's right.
- Considerable investments have been made in improving access to safe motherhood services, yet the utilization of safe motherhood services has not improved much. Deliveries by skilled birth attendants, is negligible. Deliveries by skilled attendants, is one of the ICPD and MDG indicators.
- Lessons learned could be utilized for future advocacy for policy and programme changes.
- The findings of the evaluation could be utilised to mobilise additional resources.
- The evaluation will help UNFPA to identify areas of support in the next CP and areas of partnership.

2. Objectives of the evaluation

The objective of the thematic evaluation are to assess the effectiveness of various strategies and approaches for safe motherhood adopted by the Government, donors, NGOs including non-health partners, identify lessons learned to identify future areas of programme strengthening and assess the progress towards achieving the national maternal health objectives. The evaluation will specifically evaluate the strategies adopted by UNFPA in its 6th CP to address Safe Motherhood in the context of the inputs provided by other donors and NGOs and how it contributes to national maternal health objectives.

3. Scope of the evaluation

The evaluation will cover the whole country with in depth review of geographical areas

i Assess the effectiveness of the various strategies (including quality of care and availability/access) adopted by the Government and its partners in achieving the national maternal health objectives.

ii Identify lessons learned.

iii Assess progress towards achieving the maternal health objectives particularly utilization of skilled birth attendants at delivery and achievement of EmOC process indicators.

iv Assess the role of NGOs and private sector in safe motherhood.

v Assess the access to and utilization of safe motherhood services by the poor quintiles and adolescent mothers.

vi Assess family and community awareness about obstetric emergencies and level of preparedness for referral and transportation of emergencies.

vii Identify the linkages of the health system with nutrition programmes and women's development programmes.

viii Assess the impact of decentralization on the delivery of health services.

ix Identify barriers to access and utilization of safe motherhood services.

x Assess the UNFPA 6th CP:

a. For the relevancy and effectiveness of inputs related to safe motherhood and its potential contribution to national maternal health objectives.

b. The indicators currently used for monitoring and evaluation of the inputs.

xi Review the performance of FP services specifically with regard to adolescent women, post abortion and post-partum women.

xii Recommend strategies for strengthening the safe motherhood programme to achieve the maternal health objectives through better partnerships between the Government (inter-sectoral and intra-sectoral), donors, NGOs including non-health organisations, communities and families. The strategies should focus mainly on improving access to skilled birth attendants at birth and EmOC.

xiii Specifically, identify areas for future UNFPA support.

4. Expected outputs from the evaluation

A detailed report with findings including performance and progress towards achieving maternal health objectives, lessons learned and recommendations.
Specifically the report should include:

- Lessons learned concerning best and worst practices in achieving progress towards objectives of maternal health and strategic partnership
- Progress towards achieving the maternal health objectives
- Strategies for improving utilization of safe motherhood services with special focus on deliveries by skilled birth attendants and increasing met needs of EmOC particularly by the poor and adolescent mothers
- UNFPA: Recommendations for future areas of support

5. Methodology of the evaluation

i) Desk review of the national policies and strategies, HNPSP document, surveys related to maternal health and mortality, evaluation reports of safe motherhood components of various donor assisted projects and programmes and UNFPA 6th CP documents including RH sub-programme document.

ii) Interviews with key stake holders (programme and project staff of UNFPA, relevant GOB officials, development partners, UN Agencies, NGOs, women's groups and activists and other relevant groups)

iii) Field visits to assess the safe motherhood services: their quality, coverage and their contribution towards achieving maternal health objectives

6. Timeframe

July – August 2004

7. Evaluation team

Local consultants
MOHFW representatives
Other developmental partners
UNFPA CST
UNFPA NPPPs

Coordinator from UNFPA
Mrs. Tahera Ahmed, Assistant Representative.

8. Implementation arrangements

a. Management arrangements – define the role of the various partners
b. Time frame for the evaluation process for the following activities: (suggested list)
    - Desk review
    - Stakeholder meetings
    - Development of instruments for assessments
    - Interviews, field visits
    - Preparation of draft report
    - Finalisation of the report

c. *Resources required: Number of consultants and type of expertise and for how long*

10. Plans for utilization of findings

Annex 1: Health Infrastructure

Health care facility	Level and number	Obstetric care provider	Expected services
Medical College Hospital	District (13)	Specialist, MO, Nursing staff	RH, EsOC & CEmOC
District Hospital	District (59)	Specialist, MO, Nursing staff	RH, EsOC & CEmOC
Maternal Child Welfare Centre (**MCWC**)	District (55) Upazila (12) Union (23)	MOs, FWV, Mid Wives MOs, FWV, Mid Wives MOs, FWV, Mid Wives	RH, EsOC & CEmOC RH, EsOC & CEmOC RH, EsOC & BEmOC
Upazila Health Complex (THC)	Upazila (402)	Medical Officer, Nursing staff, FWV	RH, EsOC, BEmOC & CEmOC
Health & Family Welfare Centre	Union (4,770)	FWV, MA	ANC, delivery
Community	Village (18,000)	FEHA, FWA	ANC, delivery

EsOC= essential obstetric care
CEmOC= Comprehensive emergency obstetric care
BEmOC= Basic Emergency Obstetric Care
RH= reproductive health services

Annex 4: List of people met and institutions visited

List of people met

MOHFW

1. Prof. Md. Mizanur Rahman, Director General, DGHS
2. Md. Fazlur Rahman, Director Gerneral, DGFP
3. Dr. Zafar Ahmed Hakim, Director MCH, DGFP
4. Dr. Ashraf Ali, PM, MCH, Directorate of Family Planning
5. Dr. Md. Bariul Islam, Deputy Programme Manager, RHP, DGHS

BNC

6. Registrar, Bangladesh Nursing Council
7. Deputy Registrar, BNC
8. Principal, Nursing College, Dhaka
9. Principal, Nursing Institute, DMCH
10. Director, Directorate of Nursing Services

OTHERS

11. Prof. AB Bhuiyan, President OGSB
12. Dr. Dinesh Nair, Health Advisor, DFID
13. Dr. SM Asib Nasim, UNICEF
14. Dr. Monira Parveen, UNICEF
15. Dr. Jahangir, CARE-Bangladesh
16. Dr. S Hanna, WHO
17. Dr. A Halim, WHO
18. Ms. Farida Begum, WHO
19. Ms. Rose Jhonsen, WHO

UNFPA

20. Dr. Suneeta Mukherjee, Representative
21. Ms. Tahera Ahmed, Assistant Representative (RH)
22. Dr. Mizanur Rahman, NPPP, UNFPA
23. Dr. Roushon Ara Begum, NPPP, UNFPA
24. Dr. Jebunnessa Rahman, NPPP, UNFPA
25. Dr. Rafiqus Sultan, NPPP, UNFPA
26. Dr. Wali Ahmed Fateh, NPPP, UNFPA

Skilled Birth Attendant (SBA):

Two SBS at each of the following upazilas

- Sarail
- Monirampur
- Bhanga

Staff of institutions visited

List of institutions visited

Health & Family Welfare Centre (H&FWC):

- Chandra, Bhanga Upazila, Faridpur
- Suhilpur, Sadar Upazila, Bbaria
- Japa, Monirampur upazila, Jessore.

Upazila Health Complex (UHC):

- Tarash, Sirajganj
- Sarail, Bbaria
- Bhanga, Faridpur
- Monirampur, Jessore

Maternal and Child Welfare Centre (MCWC):

- Sirajganj
- Faridpur
- B Baria
- Jessore

District Hospital (DH):

- Sirajganj
- Faridpur
- B Baria
- Jessore

Urban Clinic:

- BWHC Clinic (Kamalapur)
- Dhaka City Corporation Clinic (Nazirabazar)
- PSKP Clinic (Khulna)