

EVALUATION OF SAFE MOTHERHOOD PROJECT: INCREASING ACCESS TO MATERNAL HEALTH SERVICES FOR POOR WOMEN IN RURAL BANGLADESH, 2010

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EXECUTIVE SUMMARY

Introduction

“Working towards Safe Motherhood in South Asia: Increasing Access to Maternal Health Services for Poor Women in Rural Bangladesh” (SMP) of Family Planning Association of Bangladesh (FPAB), is a European Community funded three-year project aimed at creating an enabling environment to promote quality sustainable maternal health services for poor and underserved communities in rural Bangladesh. The project is working in Chittagong and Sylhet divisions in its 6 upazillas where the maternal health scenario appeared most deplorable or alarming, calling for urgent interventions, at least on a pilot basis before undertaking expanded coverage. The current endline study provided data on ten broad variables including suggestions, which have been organized into 12 chapters in this report. The study has been conducted by Human Development Research Centre (HDRC), and the field survey was carried out between March 05 and 17, 2010.

Objectives

The endline evaluation study objectives were as follows: (1) To assess qualitative and quantitative changes owing to increased access at community level to sexual and reproductive health and maternal health information and education; (2) To assess improved access to quality integrated sexual and reproductive health services including safe-delivery and emergency obstetric care; (3) To evaluate the status of recognition of and commitment to women’s rights, reproductive health rights to have access to safe motherhood; (4) To assess the status of Birth and Emergency Planning (BEP); and (5) To identify best practices and learning from the project.

Methodology

Quantitative as well as qualitative methods have been used to evaluate the endline status of “Safe Motherhood Project” spread over 6 underserved upazilas under Chittagong and Sylhet divisions. For quantitative estimation, a three-stage random sampling strategy has been adopted. Using a standard formula as well as deprivation ranking, a total of 644 women of reproductive age group 15-49 years were interviewed. Along others, a total of 110 respondents of women of reproductive age belong to special ethnic minority, 120 pregnant women having pregnancy above 6 months and/or delivered 6 months back, and 100 deprived and equivalent poor women. For every upazilla, sample size had been calculated on the basis of population size with precision level 3% and confidence level of 95% to make the sample upazilla-wise representative. As regard to qualitative assessment, 124 Key informant interviews, 6 FGDs, 7 PRAs, and 6 case studies were conducted. Deprivation ranking was done on the basis of following indicators- income, land ownership, status of homestead land, capability of taking adequate meals, and VGD/VGF card holder; social indicators (capability of sending children to school, and capability of availing health care facilities). The project beneficiaries were classified into four distinct categories namely not-deprived, less deprived, deprived, and most deprived.

Data Collection

The fieldwork (including quantitative survey, inventory of available SRH services, PRA for social mapping and deprivation ranking, conduction of FGDs and KII) was completed in two calendar weeks. A 30 field investigators (including enumerators and facilitators) and 6 field supervisors were deployed for two weeks. They were divided into sub-teams and number of team members was determined by sample size of each locations. A quality control system was

developed to adequately monitor the quality of data collection. For this purpose, four Quality Control Officers (QCOs) were deployed.

Key Findings

The survey respondents have been selected fairly in compliance with the objectives and nature of the study. Respondents in both baseline and endline survey pose almost similar socio-economic and demographic status, particularly with respect to their own age and marital status, religious and ethnic compositions, and educational and occupational patterns.

KAP of WRAs on SRH issues

- Overall knowledge about family planning methods has increased slightly from 98% in baseline to 99% in endline (98% vs. 99%).
- Current use of family planning method has increased (from 42.5% in baseline to 47.2% in endline) with higher increase in case of Tubectomy and Injectables compared to national averages.
- Knowledge on STD (52.4% vs. 65.4%) and on HIV/AIDS increased (48.0% vs. 87.0%).
- Knowledge on MR increased from 37.0% vs. 70.4%, and Abortion 32.2% vs. 55.1%.
- Attitude towards abortion/MR changed to some extent along with increasing its practice.
- Practice of ANC increased (45% vs. 66%) and 3 ANCs (8% vs. 20%).
- Facility delivery increased (6.3% vs. 14.2%), and Safe delivery by trained provider also increased (11.5% vs. 19.7%).
- Practice of PNC has increased (15.4% vs. 28.5%).
- Knowledge on EOC has increased (77% vs. 96%) with knowledge of ‘haemorrhage’ (23.3% vs. 62.5%) and practice of EOC increased among the sufferers (29% vs. 59%).
- Percentage of women suffering from obstetric complications decreased (20% vs. 15%).
- Overall quality of care in clinics has improved (treated fairly 62% vs. 76%).

Service Providers

- Knowledge and practice of ANC and PNC amongst RHPs is much higher than it was with TBAs in baseline.
- Knowledge and practice of RHPs on EOC is also much higher than the TBAs in baseline.
- Awareness regarding recommended least number of ANC visit (4 ANCs) shows more than 3 fold higher amongst RHPs in comparison to the baseline figure with TBAs.
- Knowledge and practice of ‘thermal control’, ‘birth asphyxia’ and ‘special care of pre-term or low birth weight baby’ was reported by 21% of the TBAs during baseline, which amongst the RHPs at present is 91%, 73% and 54% respectively during evaluation.
- Knowledge and practice of TBAs was low on ‘emergency contraceptive (21%)’, ‘post abortion care (21%)’ and ‘side-effect management (7%)’, which with RHPs is above 90%.

- Less than 50% of the TBAs during baseline were aware and provided BCC, counseling and promotion of condom for STIs/HIV prevention, which is above 90% with the RHPs.
- Knowledge and practice of the TBAs on maternal nutrition was 43% with BCC and 36% with iron/folic acid distribution as compared to 91% and 100% with RHPs currently.
- Some 77% TBAs knew ‘exclusive breastfeeding’ in baseline against 91% RHPs now.
- During baseline 68% TBAs knew 3 or 3+ postpartum complications and all RHPs know it currently.
- In baseline, below 27% TBAs were aware about ‘dissemination about right of choosing contraceptive method and knowing its side-effect’, that during endline is 100% in RHPs.
- Around 20% of the TBAs were familiar and involved with provision of MR and prevention of unsafe abortion during baseline, which is above 80% with RHPs currently.
- At the time of baseline, as low as 14% TBAs could name three facilities providing MR service, which during endline are known to all RHPs.
- Three danger signs of pregnancy were known to only 32% TBAs during baseline, and currently more than 82% RHPs know it.
- Regarding ‘practice of referral of complicated pregnancy’, it was 59% with the TBAs during baseline as compared to all with the RHPs currently.
- Merely 29% of the TBAs were involved in ‘promotion of IEC on adolescent care’ during baseline as compared to 91% in RHPs at present.
- ‘Components of obstetric first aid’ were known to 23% TBAs during baseline, while all of the three components are known to more than 90% of the RHPs at present.
- Currently, 54% of RHPs can name ‘Cesarean section and blood transfusion’ together as components of Comprehensive EOC, where none of TBAs could do so during baseline.
- During baseline, 23% of the TBAs did not know any facility providing EOC service, which during endline it is known to all RHPs.
- Knowledge on ‘at least two sexually transmitted diseases’ was known to 77% TBAs during baseline. Reportedly, these are known to all RHPs at this point in time.
- During baseline, hardly 4% of TBAs could mention the name of more than two facilities providing service for STIs. Currently, it is known to all RHPs.
- In baseline, barely 4% TBAs could name at least three facilities providing SRH services. At endline, reportedly, name of at least three such facilities are known to 36% of RHPs.

Gender and Women's Empowerment

- More women of reproductive age now get information about safe motherhood than the baseline situation.
- Right to get information about the reproductive health more or less has been ensured.
- Support from the family and the community for protection of the pregnant mother indicates the changed attitude of the people.
- Eagerness of husbands for expenditure on health of wife has increased.
- Although slow, a positive change has been observed in health seeking behavior of the community. Women themselves are now allowed to visit the health centre those are nearby.
- Awareness of menstrual hygiene has increased.
- Health and EOC service for WRAs has been made available at the upazila level through the FPAB SMP clinics.
- Service quality of the Abortion/MR service has improved.
- Higher proportion of service providers have informed WRAs about induced abortion (10.7% vs. 40.6%).
- More WRAs have been informed about their legal rights of performing abortion (4.9% vs. 29.4%).
- RHPs of SMP are providing safe delivery service and reaching SRH message at the community level.
- Society still blames wife for infertility. Social mobilization is highly needed to get rid of the evil practices.
- In many of the cases males are unwilling to use any family planning method and they think it as the responsibility of women only.
- Husband's involvement/assistance in pregnancy and delivery issues has increased, especially among the poor.
- Gender discrimination in the family is still there and status of women is still low.
- The senior gatekeepers (mother-in-law, father-in-law), still are not sufficiently motivated for providing emergency care to the pregnant or delivering women.

Violence against Women (VAW)

- During the baseline, 70% reported of knowing about 'battering' some women in their neighbourhood which during endline has come down to 60%.
- It is alarming that 19% reports about 'knowing compel to suicide' during endline, which was 3% during the baseline.
- Service providers are now informing more about various harmful practices- sex selective abortion, female infanticide, child marriage, dowry, and verbal abuse to WRAs.
- During baseline, only 1% of WRAs knew that supportive service is available for women victim of VAW which during endline has increased to 22%.
- The WRAs are now more aware of the harmful practices related to pregnancy period, delivery and postnatal period.

Sustainability

- SMP has received funding from RNG Netherlands to run the project up to December 2010. During 2011-15 three clinics each will be continued with IPPF core fund and the Dutch Alliance.
- Before ending of project SMP organized training for 201 RHPs and 67 CDCOs on Safe Motherhood services to enhance skill of RHPs to continue their work in the community.
- SMP has provided a mini signboard to every RHP and CDCO to hang it in front of their house and have given them identity card to treat their referred clients with priority.
- SMP has provided BP machine, stethoscope, delivery kit box, bag, umbrella and mobile phones to all CDCOs. They are generating some income by providing services locally.

Some Observation and Suggestions

Based on the key findings of endline study, mid-term review and baseline evaluation of SMP, and other documents (project proposal, terms of reference, BEP paper, field Investigators' reports, and our overall observation), following observations and suggestions have been made.

- SMP was a project of innovative nature; some new concepts and tools (BCC) in the selected areas are found effective. Often, home grown strategies and tools are more sustainable than those driven by donor/funding agencies.
- The services provided by SMP clinics and by its field workers (RHPs) are also groundbreaking and need to be extended to other underserved areas.
- Among the SMP locations, Sylhet sadar, Noakhali sadar were not poverty-stricken or hard-to-reach. Moreover, those are equipped with Modernized Sadar Hospital and Medical College Hospital, where SMP services were found less attractive to them.
- In general, reported awareness about family planning (FP) services is low in Noakhali sadar locality. FP is yet to reach the bottom line potential clients.
- Naniarchar has the least facilities from GOB among the SMP intervention upazilas, as Upazila Health Complex (UHC) does not function properly because no doctor is residing there. Conflicts between local indigenous groups and Bangalee settlers also create a tense situation.
- The popularity of the recently introduced BEP is growing slowly. Most of the beneficiaries are using BEP who are having knowledge of it, and BEP has started to make some difference. Reportedly, pregnant women and their families desire to continue BEP practices. However, persistent BCC/IEC, BEP card distribution, and regular field supervision need to be increased.
- Regarding SRH, FP, and maternal health women are better informed and aware than men. BCC must be targeted to male population and motivate them.

- In all interactions, role of women, women's rights and importance of SRH to be highlighted, and BCC ought to be well-designed and should be implemented by the community.
- The sustainability of SMP's community level services should have been considered much before winding, as the RHPs and CDCOs are not getting any salary now.
- Considering the situation of deprived/neglected people of SMP areas of FPAB, government and donors may seriously think of supporting this project or at least provide financial assistance to continue the key activities/interventions for 5 years more.

Suggestions from WRAs

- SMP activities should be continued with new strategy for the hard-to-reach areas.
- More RHPs are to be trained for the project areas.
- Cleanliness of clinics should be given special attention in ensuring quality of care.
- BEP should be introduced in all the project areas, especially for the hard-to-reach areas.
- Some alternative of boat ambulance should be considered in dry season. At Naniarchar it is effective in wet season only.

Suggestions on Gender

- Training and motivational activities on gender issue need to be strengthened for the stakeholder of the society.
- Service provider need to be more gender sensitive.
- Income generating activities need to be arranged to make the women self employed which will improve their health security.

Suggestions from Influential

- Poor women can be provided emergency delivery care through counseling male members of family, meeting, sign board, radio/TV advertisement, and arranging free service.
- Ambulance service needs to be expanded with low payment.
- Health services needs to be increased and modernized.
- Number of trained service providers needs to be increased.
- Full-time doctor in clinic is a necessity.
- Clinics need to be modernized with more equipment.
- Services under SMP need continuity.

Suggestions on Stopping Violence against Women (VAW)

- Social mobilization for elimination of violence against women is needed.
- Awareness raising programme against VAW may be arranged for the service provider, stakeholders and the family members of WRA.
- Publicity of the issues related to VAW and strategy for elimination of VAW should be increased through poster, radio and TV, and workshop.

Change of behavior of male and their participation is critical in bringing change in the RH status of women and to stop the continued deprivation and exploitation on them.