Quality of Care of Maternal and Neonatal Health Services: A Stakeholder Participatory Assessment

Prepared for

THE WHITE RIBBON ALLIANCE FOR SAFE MOTHERHOOD

White Ribbon Alliance, Bangladesh

Prepared by

Abul Barkat
Avijit Poddar, Murtaza Majid, Golam Mahiyuddin
M Abdullah, Shahnaz Munni

HDRC
Human Development Research Centre
www.hdrc-bd.com

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Abbreviations

ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
CRHCC	Comprehensive Reproductive Health Care Centre
CSD	Cesarean Section Delivery
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
IUD	Intrauterine Device
KII	Key Informant Interview
MCH-FP	Maternal Child Health and Family Planning
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goal
MNH	Maternal Neonatal Health
MOH&FW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
NVD	Normal Vaginal Delivery
PH	Private Hospital
PNC	Postnatal Care
UHC	Upazila Health Complex
UN	United Nations
UPHCSDP	Urban Primary Health Centre Service Delivery Point
WRAB	White Ribbon Alliance Bangladesh

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Introduction and Methodology

1.1. Background of the Study

Pregnancy, birth and motherhood pose a considerable risk to the death of women in Bangladesh. The current maternal mortality ratio in Bangladesh is 194 per 100,000 live births[1]; the ratio was 320 per 100,000 live births in 2007[2]. Reportedly, 95 percent of total maternal deaths and 90 percent of total neonatal deaths occur in the two continents of Asia and Africa. Recent researches reveal that despite global efforts there is no remarkable improvement in the reduction of maternal mortality and morbidity as compared to other human development in the developing countries. According to Target 5 of Millennium Development Goal (MDG), the maternal mortality ratio has to be reduced by 75 percent between 1995 and 2015. However, the maternal mortality rate has decreased from 430 per 100,000 live births in 1995 to 400 per 100,000 live births in 2005, which accounts for only 5 percent of the MDG target[3]. Thus, 70 percent of the targeted maternal mortality ratio has to be reduced between 2005 and 2015.

The truth is that most of the factors related to maternal mortality and morbidities are preventable. It has been reported that 80 percent of the maternal mortality can be averted if women have access to adequate nutrition, proper antenatal care, skilled attendance at birth, emergency obstetric care when necessary, post-natal care, essential newborn cares, knowledge on proper breast feeding practices, and education to improve health and hygiene behavior.

Although the under-5 mortality has (50 per 1000 live births) decreased considerably during recent decades, the neonatal mortality ratio did not decreased much[4]. The current neonatal death ratio in Bangladesh is 32 per 1,000 live births[1], which was 37 per 1,000 live births as reported in BDHS 2007. According to the latest world health organization estimates, 40 percent of the under-5 mortality occurs in the first 28 days of life. Seventy percent of these deaths take place within 7 days of life or in the early neonatal period.

The health of mothers and newborns is closely related. Hence, in most of the cases, preventing death requires the same interventions. Keeping this in mind, White Ribbon Alliance, Bangladesh feels that an assessment of the existing quality of maternal and newborn health care and the underlying facts would be crucial in improving the condition.

1.2. Aims of the study

This study aims to assess the quality of maternal and newborn health care provided at some selected levels of public facilities, facilities run by NGOs and private clinic/hospitals in Bangladesh. It also aims to explore the perceptions of service recipients, service providers/managers, civil societies and other stakeholders to identify barriers and possible solutions for improving the quality of the care.

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[1] *Bangladesh Maternal Mortality and Health Care 2010*
[2] *BDHS 2007*
[3] *State of the World's Children: Maternal and Newborn Health 2009*
[4] *BDHS 2007 Preliminary Report*

1.3. Objective of the Study

To promote an improved quality of care in MNH services in various health facilities (GoB, Private & NGO) in Bangladesh.

1.4. Scope of the Study

The tasks included in the study are as follows:

a. Understanding White Ribbon Alliance's (WRA) requirements
b. Developing a qualitative study methodology, clarifying indicators and study parameters, and implementation plan
c. Preparing a checklist for facility assessments and an exit interview schedule for the service recipients. Formulation of issues for the key informant interviews for the service providers/managers and their finalization with WRAB input.
d. Brainstorming among the team members as regard to data collection
e. Selection of health facilities by types and location in consultation with WRAB
f. Collecting data as per study design
g. Ensuring quality of data
h. Data analysis (with required specialized input)
i. Reviewing secondary data source/literature
j. Dissemination of study finding at 4 divisional level seminars
k. Dissemination of study finding at national level seminar
l. Finalizing report with feedback of divisional and national presentations & WRAB

1.5. Methodology

The current assignment is a rapid and smaller scale attempt of a cross sectional descriptive study being conducted systematically in 5 major divisions (Dhaka, Chittagong, Rajshahi, Khulna and Sylhet) using a number of quantitative methods – check list for facility assessment, clients' exit interviews, key informant interviews with service providers/managers and observation. The methodology of the study was finalized in a consultation meeting with the representatives of MOH&FW, Planning commission, members of White Ribbon Alliance, BD and the study team under the chairmanship of Deputy Chief (Health), MOH&FW. The study was conducted in 3 district hospitals, 1 MCWC, 4 upazilla health complexes, 1 NGO Health centre and 1 private hospital.

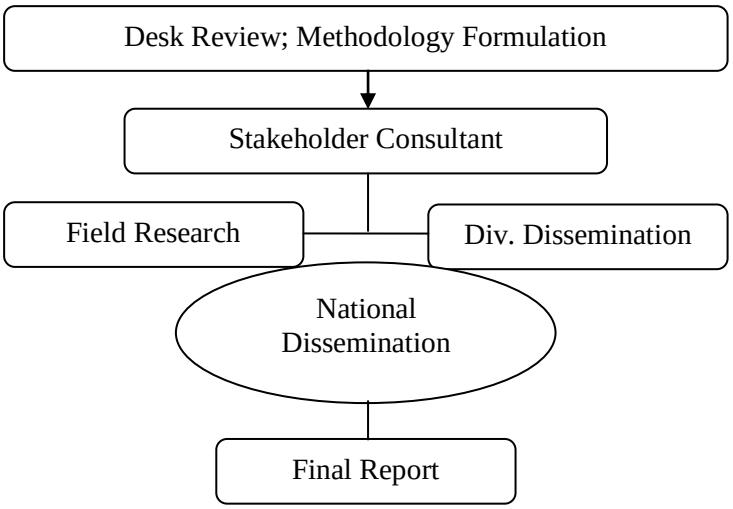
The quality of care at the facility level was assessed by a participatory approach involving researchers (team of 3 members led by a research physician), GOB, Civil Society (NGO, Journalist) and service providers using a pre-tested checklist with special focus on the availability of infrastructure, its capacity to provide services, capacity utilization, quality of services, drugs, equipment and supplies and steps needed for improvement. Among the service recipients, married women who came for maternal health care and/or newborn health care were randomly selected for exit interview using a pre-tested questionnaire. Key informant interviews were conducted with providers and managers, beneficiaries etc. at various levels by a trained research team. Additionally, the study team has observed the overall cleanliness of the surveyed facilities as well as the general performance of the service providers.

Table 1: Distribution of sample locations, type of facilities and sample size

Type of facilities (Purposive)	Size	Facility Assessed	Exit Interviews	Key Informant Interviews
District Hospitals (*Pabna, Habigonj and Magura)*	3	3	15	3
MCWC (*Brahmanbaria)*	1	1	5	2
Upazila Health Complex *(Sarail, Chunarughat, Iswardi, Mohammadpur)*	4	4	20	3
NGO Clinic (*Hazaribag CRHCC, UPHCSDP: PA 3)*	1	1	5	4
Private Hospital *(Health & Hope Hospital, Dhaka)*	1	1	5	3
Altogether	10	10	50	15

All the information collected were edited at HDRC HQ and the data was entered and analyzed using Excel spreadsheet software. Qualitative data from the exit interviews and KII were transcribed from notes or audio recording into text and processed as indicators to quality of care.

Figure 1: Snap short view of methodological approach



1.6. Data/Information Collection

In each of the five study districts under five divisions, a team comprising of one research physician, two enumerators, representative from WRAB, Civil society member (NGO and journalist), GOB representative, service provider/manager of the respective facility collected the field data/information. Additionally, a consultant from a core study team accompanied the field team in two districts. During the study, with the permission of the respective health manager, a short video-graphy was taken in several surveyed health facilities to capture the quality of care provided by the facilities as well as to frame the opinion of the service recipients regarding maternal and neonatal care.

The Team Leader kept close contact with the field teams and provided required input to ensure high quality output during the field activities.

1.7. Limitations of the Study

Due to constraints in time and money, the study has been conducted with small number of health facilities within a very short period of time. Therefore, interpretation of the study findings with national figures of similar nature is to be done cautiously. Nevertheless, the study findings will be useful in planning and formulating forthcoming policies to improve the quality of MNH care in health facilities.

Chapter 2
Study Findings

2.1. Basic Information of the Surveyed Facilities:

2.1.1. District Hospital (DH)

All the surveyed health facilities are providing maternal health services, including comprehensive obstetric care both to the outdoor and indoor patients. However, there are no separate obstetric wards in any of the surveyed hospitals and pre-delivery room in two hospitals surveyed. The service delivery space is insufficient both for outdoor and indoor patients. Patients were found sharing beds as well as lying on the floor in the inpatient wards. Together with maternal care, each of these facilities is also capable of providing neonatal health care to a large extent. Out of the three, a separate neonatal unit was found in one hospital. Except one hospital, the overall cleanliness of the hospital is poor: beds and beddings are unclean, and toilets are dirty. None of the hospitals have any dedicated space for waiting patients. However, all of facilities have electric connection and piped water supply. A separate space for breastfeeding was not available in 2 DHs.

2.1.2. Maternal and Child Welfare Centre (MCWC)

The surveyed centre is providing maternal and child health services to outdoor patients and conducting normal delivery. Although this facility has 20 beds for indoor patients and is equipped to perform operative procedures like caesarian section (CS), dilatation and curettage etc., no CS operation had been done in the last one month. The utilization of indoor beds is one-fourth of the existing capacity. The location of the centre adjacent to the district hospital may be a possible explanation for such underutilization. MCWC can provide basic essential neonatal care to the normal babies but is not equipped to manage the complicated cases. The cleanliness of the facility is not satisfactory; the beds and beddings are unclean, and the toilets are dirty. The facility has electric as well as piped water supply. There is no separate space for breastfeeding.

2.1.3. Upazila Health Complex (UHC)

All the surveyed UHCs are upgraded 50-bedded facilities. However, staff, drugs, equipment, and supplies remain as before for a 31-bedded facility. Each and every UHCs has an outpatient and inpatient department and a maternal and child health and family planning unit (MCH-FP), which together provide preventive and curative service to the upazila population. None of the UHCs has a separate obstetric ward other than lone female ward. Baby cots for the neonate are available in UHCs. The cleanliness of the facilities is poor: most of the mattresses are without linen, unclean and stained. The cleanliness of the toilets is poor. There is no waiting room for the clients in UHC. Except in one case, other UHCs are overcrowded with patients. A separate space for breastfeeding was not available in any of the surveyed UHCs.

2.1.4. Comprehensive Reproductive Health Care Centre (CRHCC)

This is an UNFPA-supported NGO and a 20-bedded maternity center under the project of UPHCP. Together with normal delivery, the centre is providing comprehensive emergency care to the pregnant mothers. The existing service of delivery space for the outdoor and indoor patients is inadequate. All available clinical contraceptive methods including the facilities for permanent methods are available here. Apart from these, CRHCC is also dealing with other RH cases with possible interventions as required. There is a space with sitting arrangements for patients waiting in the outdoor. In the waiting space, clients were found watching TV. A VCD player was also seen beside the TV, together with a few CDs related to health education. The overall cleanliness of the centre as well as the toilets was up to the mark, though not highly satisfactory.

2.1.5. Private Hospital (PH)

The surveyed facility is a medical consultation centre cum 40-bedded general multipurpose hospital. The specialists of the different disciplines of the medical profession including maternal and neonatal health conduct chamber practice on an out-door basis. During their practice hours, they also care for their own patients who are admitted there. Apart from the chamber practice, in-patient consultation is available on call. Like the others, there are no dedicated outdoor services for routine maternal health care and no dedicated bed(s) for inpatient maternal and neonatal care. However, the hospital provides all the specialist consultation for maternal health services including antennal check-up, conduction of normal/caesarean delivery, and post-natal care whenever any pregnant woman/mother comes seeking these services. There is no special unit for the neonates, but the hospital is equipped to provide essential neonatal care after the birth of the baby. The cleanliness of the hospital as well as the toilets was found to be satisfactory.

2.2. Human Resources and Training

2.2.1. District hospital (DH)

Although all the functionaries are important in providing health care in the medical facilities, the role of the physicians, particularly the key physicians (Obstetrician, Pediatrician and Anesthetist) and the nurses/midwives is crucial for maternal and neonatal care. It has been observed that all the allocated posts for the physician are not filled. Out of the 3 surveyed hospitals, the post of the Obstetrician and Gynaecologist (Obs. & Gynae) is lying vacant in one. However, one female medical officer of an UHC, who has a post graduation degree in Obs. & Gynae (FCPS), is currently working as an Obs. & Gynae specialist in that hospital through the local arrangement from the Civil Surgeon of the respective district. There was no qualified Anaesthesiologist in one hospital. The allocated posts for Anaesthesiologists are reportedly lying vacant in all the hospitals. Where there is no appointed Anaesthesiologist, one graduate doctor trained in Anaesthesiology is doing the job. The post of the paediatrician is also vacant in one hospital. According to the health managers in all the surveyed district hospitals, the posts allocated for the medical officers for 24 hours indoor service is less than what is required. Even if the allocated posts of the nurses and/or midwives are filled up in most of the hospitals, the number is not sufficient to cover 24 hours indoor service. About half of the Medical Officers and Nurses, who are providing MNH services, do not have the

appropriate training in various MNH procedures. Moreover, the number of Aya/Cleaner/ward boys needed to maintain the cleanliness of the hospitals and to help the patients according to their needs is inadequate in all the hospitals. It is to be noted that some of the hospitals were upgraded but the number of posts sanctioned remain as before.

2.2.2. Maternal and Child Welfare Centre (MCWC)

There is no sanctioned post for the obstetrician and qualified Anaesthesiologist in MCWC. A Medical Officer trained in EmOC and another in anesthesiology as well as neonatal care together were providing the services of maternal and neonatal care. Of the two Medical Officers in the surveyed MCWC, one Medical Officer was also providing services in 2 other MCWCs in addition to this. Instead of qualified nurses/midwives, the centre is run by Family Welfare Visitors (FWVs) and all the sanctioned 5 posts of FWVs were occupied. The post for the Aya/Cleaner is inadequate in keeping the centre clean.

2.2.3. Upazila Health Complex (UHC)

Out of the 4 surveyed UHCs, the status of manpower in two UHCs is quite good. Reportedly, 88 percent to 94 percent of the allocated posts of doctors are currently engaged. On the other hand, 33 percent to 57 percent of the allocated posts of doctors in two UHCs are lying vacant. Specialist consultation in UHCs is almost non-existent. The posts of the consultants from different disciplines including maternal and child health are usually filled up by medical graduates who are trained in their respective subjects. Additionally, some special training is provided to them so as to manage the cases skillfully. Of the blues, one specialist with FCPS in Obs. & Gynae was seen in one UHC. Similarly, one child specialist with FCPS in Child Health was found to work in another UHC as a Medical Officer. In most of UHCs, there is no qualified Anesthesiologist, and there is also an acute shortage of Anesthesiologist in almost all the UHCs. Due to the vacant post of Obstetrician and Anaesthesiologist, in one of the 4 UHCs, UH&FPO and RMO, who were previously trained in EmOC, are performing in the capacity of the Obstetrician and Paediatrician in addition to their own responsibilities. In one of the 4 surveyed UHCs, a trained Anaesthesiologist was hired from another UHC and deputed there to perform the comprehensive maternal care. The sanctioned posts of staff Nurses/Midwifes are occupied in most of the UHCs but their numbers are not adequate to provide the 24 hours service of the facilities as stated by the health managers in all the surveyed UHCs. The post of Ayas/Cleaners is less than the number required to keep the facilities clean. On top of this, some allocated posts of the aya/cleaner and Ward-boys were found to be vacant.

2.2.4. Comprehensive Reproductive Health Care Centre (CRHCC)

The specialized facility for the MNH services of this centre is within the mandate of UPHCPSDP. All the posts of Doctors and Nurses/Midwives are found to be occupied. One full-time specialist (FCPS) in Obs. & Gynae is currently providing the comprehensive maternal services. The only Obstetrician is providing the comprehensive maternal services as well as meeting the emergency calls outside the official hours. However, full-time Doctors serving in the posts of Child Specialist and Anaesthesiologist were not available. A Pediatrician is working there on a part-time basis, and an on-call medical graduate trained in anaesthesiology is attending the obstetrical surgeries. Beside the specialists, 4 other medical graduates trained in maternal services provide maternal and neonatal care through assigned duty shifts. The number of Nurses/Midwives appears to be adequate; however, the Ayas/ Cleaners/Ward-boys are far from the number required to keep the facility clean and tidy.

2.2.5. Private Hospital (PH)

There is no full-time specialist in Obs. & Gynae, Anaesthesiology and child/neonatal health. Specialists are available during the hours of chamber practice in this hospital. Specialist consultation is available on call. Round the clock, inpatient services are usually provided by the medical graduates through 8-hour long shifts. The on-duty Doctor calls the specialist whenever necessary for surgeries or for obstetrical/neonatal complication which could not be managed by him/her. According to the Executive Director, they do not experience any drawback in keeping sufficient staff Nurse to maintain the quality of patient care as all the services in the hospital are paid for. He claims that they have appointed a sufficient number of Ayas/Cleaners to keep the facility clean and tidy.

2.3. Provision of MNH Services

2.3.1. District Hospital (DH)

The number of cesarean sections varies between 25 percent and 43 percent of the normal vaginal delivery (Table 2). The number of pregnant women, who have received antenatal care, ranges from 147 to 1622. Table 2 further shows that in two hospitals the number of delivery is higher than the number of ANC. On the other hand, in one hospital, the number of hospital delivery is less than the number of pregnant women who have received antenatal care. This indicates that a proportion of them have delivered their babies at places other than the district hospital which accounts for 72 percent of the deliveries. Moreover, all the mothers who have received antenatal care have not sought postnatal care. Out of 3 district hospitals, one has managed 66 post-abortion cases, where 22 of them were septic abortions. Family planning services are provided only in DHs which have model family planning clinics.

Table 2: Distribution of selective MNH services in the surveyed DHs during last one month.

MNH Services	Hobigonj	Magura	Pabna
Normal vaginal delivery (NVD)	192	79	375
Cesarean section delivery (CSD)	56	34	78
% of CSD over NVD	29	43	21
Antenatal care (ANC)	147	535	1622
Postnatal care (PNC)	11	137	748
Treatment of Obstetrical complications	37	66	781
Blood transfusion	21	60	271
Female sterilization	00	00	12
Male sterilization	00	00	00
Pills	00	61	122
Condoms	00	00	58
Injectables	00	184	354
Norplant/Implant	00	00	00
IUD	00	9	27
Management of abortion cases	3	66	34

2.3.2. Maternal and Child Welfare Centre (MCWC)

The number of deliveries in the centre is low. A total of 51 normal vaginal deliveries have been conducted, which accounts for less than 2 deliveries per day. No caesarean section delivery was performed in month prior to the month of survey (February 2013). The number of antenatal and post natal cases was 354 and 103 respectively. Apart from this, the centre is also providing family planning services. To this end, the centre has performed 35 cases of female sterilizations and 12 cases of male sterilizations. Additionally, norplants/implants and IUD were inserted in 120 women and 11 women respectively of reproductive age.

Table 3: Distribution of selective MNH services in the surveyed MCWC during the last one month.

MNH Services	Brahmanbaria
Normal vaginal delivery (NVD)	51
Cesarean section delivery (CSD)	00
% of CSD over NVD	
Antenatal care (ANC)	354
Postnatal care (PNC)	103
Treatment of Obstetrical complications	00
Blood transfusion	00
Female sterilization	35
Male sterilization	12
Pills	291
Condoms	45
Injectables	177
Norplant/Implant	120
IUD	11
Management of abortion cases	00

2.3.3. Upazila Health Complex (UHC)

Among the surveyed UHCs, the number of normal vaginal deliveries, conducted in February 2013, varies between 6 and 80. During the same month, the number of caesarean section deliveries ranges between 0 and 36. It was observed that one of the surveyed 4 UHCs did not conducted any caesarean section delivery in February 2013 despite the UHC having specialists in obs. & gynae and anesthesiology as well as two well-equipped operation theaters. The service of antenatal care during the last month varies between 40 and 627 in number where the corresponding figure for postnatal care was 0 and 136. With one exception, all the surveyed UHCs are providing family planning services as well.

Table 4: Distribution of selective MNH services in the surveyed UHCs during the last one month

MNH Services	Chunarughat	Ishurdi	Mohdpur	Sarail
Normal vaginal delivery (NVD)	06	80	54	06
Cesarean section delivery (CSD)	06	36	10	00
% of CSD over NVD	100	45	18	00
Antenatal care (ANC)	40	627	129	479
Postnatal care (PNC)	12	136	64	00
Treatment of Obstetrical complications	03	67	00	00

MNH Services	Chunarughat	Ishurdi	Mohdpur	Sarail
Blood transfusion	00	00	00	00
Female sterilization	00	20	15	14
Male sterilization	00	09	03	00
Pills	00	73	87	7777
Condoms	00	12	00	13563
Injectables	00	137	71	1500
Norplant/Implant	00	114	00	52
IUD	00	24	10	18
Management of abortion cases	9	00	00	00

2.3.4. Comprehensive Reproductive Health Care Centre (CRHCC)

The center has conducted 53 vaginal deliveries and 36 caesarean section deliveries in the month of February, 2013. This indicates that 40 percent of the total deliveries are caesarean section deliveries, which is quite high. According to the Obstetrician of the centre, most of these caesarean section cases were admitted to this centre with very bad maternal condition or with faetal distress and had no alternative other than to perform a caesarean section to save the mother and/or baby. The service of antenatal care during the last month was 54440 in number where the corresponding figure for postnatal care was 151. Besides maternal care, the centre is also providing family planning services and has performed 92 NSV against only 2 tubectomy operations for females. Implants were inserted in 52 females. Reportedly, the centre has distributed 1140 cycles of oral pills, 688 condoms and injectable contraceptives to 1224 women.

Table 5: Distribution of selective MNH services in the surveyed CRHCC during the last one month

MNH Services	CRHCC, PA 3
Normal vaginal delivery (NVD)	53
Cesarean section delivery (CSD)	36
% of CSD over NVD	40
Antenatal care (ANC)	544
Postnatal care (PNC)	151
Treatment of Obstetrical complications	55
Blood transfusion	00
Female sterilization	02
Male sterilization	92
Pills	
Condoms	688
Injectables	1224
Norplant/Implant	52
IUD	
Management of abortion cases	00

2.3.5. Private Hospital (PH)

According to the Executive Director of the hospital, there was no normal vaginal delivery in the month of February, 2013; however, they have conducted 5 caesarean section deliveries during the period.

Table 6: Distribution of selective MNH services in the surveyed private hospital during the last one month

MNH Services	Private Hospital, Dhaka
Normal vaginal delivery (NVD)	00
Cesarean section delivery (CSD)	05
% of CSD over NVD	

2.4. Equipments

2.4.1. District Hospital (DH)

No functional Refrigerator was found in some of the female wards of the surveyed hospitals. Out of 3 surveyed hospitals, laryngoscope (neonate) was not there in 2 DHs. Baby stethoscopes were not found in 2 DHs. There was no functioning incubator in 2 DHs. Similarly, Radiant warmers, room heaters and ARI timers were not found in 2 DHs.

2.4.2. Maternal and Child Welfare Centre (MCWC)

Doppler, oxygen inhalation unit, ARI timer and diathermy machine are not available. Nasal aspiration set, Laryngoscope (neonate), Baby stethoscope are not found. Incubator, Radiant warmer, and room heater are not available.

2.4.3. Upazila Health Complex (UHC)

Ultra-sonography machine, Doppler, Oxygen inhalation unit, and Diathermy machine are not available in any of the surveyed hospitals. Nasal aspiration set, Laryngoscope (neonate), Baby stethoscope are not found. Additionally, incubators, radiant warmer, room heater, ARI timer are not available as well.

2.4.4. Comprehensive Reproductive Health Care Centre (CRHCC)

All the necessary equipments for maternal and neonatal care except neonatal laryngoscope are in place and functional.

2.4.5. Private Hospital (PH)

All the necessary equipments for maternal and neonatal care except the incubator are in place and functional.

2.5. Drugs and Supplies

2.5.1. District Hospital (DH)

With the exception of Ceftriaxone, other Injectable antibiotic like Cephradine was not available in two DHs. Inj. Cefuroxime is not available in any of the three DHs. The emergency drugs, especially, Adrenaline, Atropine sulphate, and Ephidrine are not uniformly available in all the 3 DHs assessed. The availability of I/V fluid, Anticonvulsants/Sedatives, Oxytocics, and Tocolytics was also same on the day of observation. Nevertheless, antihypertensive drugs, which are usually prescribed for the pregnant women, namely Methyldopa and Nifedipine, were not seen in any of the three DHs. Vitamin K, Solbutamol

and Endotracheal tube (2.5 mm to 8.5 mm) with connector were not available in 1 out of 3 DHs assessed. Stomach tubes, Infusion sets and Nasal prongs for the newborn were not available in 2 DHs. Furthermore, Neomycin ointment, Gentian violet, Multivitamin drops, Microdropper/Microburet, Umbilical vein catheter, and Nasogastric (NG) tube for the newborn are not available in any of the 3 DHs surveyed.

2.5.2. Maternal and Child Welfare Centre (MCWC)

Injectable antibiotics of any kind are not available. Not all emergency drugs are available. The availability of Anticonvulsants/Sedatives, Oxytocics, and Tocolytics were also same on the day of observation. The common antihypertensive drugs for the pregnant women, namely Methyldopa and Nifedipine, were not seen in any of the three DHs. Apart from this, drugs and supplies for the neonates like Vitamin K, Gentian violet, Stomach tubes for newborn, Infusion sets for babies, Micro-dropper/Micro-burette, Umbilical vein catheter are not available there.

2.5.3. Upazila Health Complex (UHC)

Unlike others public facilities, Injectable higher antibiotics like Ceftraixone and Cephradine were found to be available in all the 4 UHCs assessed. Most of emergency drugs, especially, Adrenaline, Atropine sulphate, and Ephidrine are not uniformly available in all the surveyed UHCs. I/V fluid and anticonvulsants/sedatives supply are inadequate. Antihypertensives (especially Methyldopa, Nefidipine), Oxytocics, and Tocolytics were not available on the day of observation. Moreover, Vitamin K, Gentian violet, stomach tube for babies, infusion set for babies, Microdropper/Microburet, umbilical vein catheter were not available.

2.5.4. Comprehensive Reproductive Health Care Centre (CRHCC)

Most of the drugs required for maternal and neonatal care are available. All emergency drugs, especially Adrenaline, Atropine sulphate, and Ephidrine were also found to be there. Additionally, I/V fluid, anticonvulsants/sedatives, antihypertensive (Methyldopa and Nefidipine), Oxytocics, and Tocolytics were available on the day of observation. For the neonates, most the drugs and supplies as recommended by UPHCSDP were available. It can be mentioned that in comparison to public facilities, the drugs available in the CRHCC are not free of cost. According to the Project Director, the price of the available drugs in the CRHCC is less than the market price. Red card holders (who account for 30 percent of the total beneficiaries), on the other hand, get medicine and supplies free of cost.

2.5.5. Private Hospital (PH)

As the facility does not have any provision to supply drugs to the patients, this criterion was not assessed when it came to private hospitals. Service recipients collect the prescribed medicines from the market. If any drug is supplied to the patient, the cost is borne by the recipient at per market price.

2.6. Infection Prevention

2.6.1. District Hospital (DH)

All basic procedures are followed in all the DHs surveyed. However, the Standard Protocol (Written guideline) is not there in 1 out of 3 DHs assessed. The most commonly used method for decontamination/sterilization is autoclaving.

2.6.2. Maternal and Child Welfare Centre (MCWC)

All basic procedures are reportedly followed in MCWC. However, the Standard Protocol (Written guideline), elbow basin, sharp instrument disposal appropriate practice and solid waste container are not available. The most commonly used method for decontamination/sterilization is autoclaving.

2.6.3. Upazila Health Complex (UHC)

Basic procedures were reportedly followed; however, the Standard Protocol (Written guideline) was found in only one of the four UHCs surveyed. Additionally, the elbow basin, incinerator, external arrangement for medical waste management, bleaching powder/chlorine solution, povidone iodine, sharp instrument disposal appropriate practice, solid waste container were not available in most of the UHCs. The most commonly used method for decontamination/sterilization is autoclaving.

2.6.4. Comprehensive Reproductive Health Care Centre (CRHCC)

All procedures are followed as per Standard Protocol (Written guideline) with the staff having relevant training in infection control. Medical waste management is done with the help of an external medical waste management organization. The most commonly used method for decontamination/ sterilization is autoclaving.

2.6.5. Private Hospital (PH)

All basic procedures are followed and the Standard Protocol (Written guideline) was found in place. Medical wastes are disposed with the help of an external medical waste management organization. The most commonly used method for decontamination/sterilization is autoclaving.

2.7. Laboratory Services

2.7.1. District Hospital (DH)

Most of the laboratory services are available for the MNH patients in all DHs. However, Albuminometer is not available in all 3 DHs assessed. Haemocytometer, blood collection bags, Refrigerator for the lab, Ultrasonogram machine and Voluntary blood donor list are not available in 1 out of 3 DHs assessed. Moreover, Serum electrolyte, Sputum for AFB and Tuberculin test (MT) were not available in all 3 DHs assessed. Rapid test for malaria was not available in 1 out of 3 DHs assessed.

2.7.2. Maternal and Child Welfare Centre (MCWC)

Laboratory service was not available in MCWC. No sanctioned position for Lab technician. A list of voluntary blood donors was not available.

2.7.3. Upazila Health Complex (UHC)

Limited laboratory services exist for MNH patients. In some places, the position of the Lab Tech. was found to be vacant. Ultrasonography was not available in any of the surveyed UHCs. Blood for cross matching and screening, random blood sugar, BT & CT, HBsAg, Test for Syphilis, serum electrolyte, Tuberculin test (MT), Rapid test for malaria are mostly not available.

2.7.4. Comprehensive Reproductive Health Care Centre (CRHCC)

Most of the laboratory services including ultrasonography are there for the MNH patients in exchange for economic prices. Red card holders (30% of the total beneficiaries) get the services free of cost. However, blood for grouping and cross matching, rapid test for malaria as well as radiological (X-ray) services are not available in CRHCC.

2.7.5. Private Hospital

All the laboratory and imaging services can be accessed by the MNH patients through payment.

Chapter 3
Divisional and National Dissemination Seminars

3.1. Introduction

This section contains the summary of 4 divisional and one national seminar where key findings of the study were presented and general discussions carried out by the participants. Ideas on possible further activities on improving MNH services were suggested by the participants and can be considered as valuable inputs to policy level actors.

Expected outcomes of the seminars:

- To share the present scenario of MNH services in some selected public, NGO and private health facilities in Bangladesh with the seminars' participants representing health and family sectors of the Government, Non-government Organizations (NGOs) providing MNH services, Journalists and Teachers
- To identify specific needs, and practical ways and means to address the major constraints in providing quality care in MNH services
- To develop a uniform check list/tool to assess to quality of MNH care of the health facility at various level.

3.1.1. Divisional Dissemination Seminars

The divisional seminars were held in 4 old administrative divisions, namely Chittagong,

Dissemination Seminar at Chittagong

Dissemination Seminar at Khulna

Dissemination Seminar at Rajshahi

Dissemination Seminar at Sylhet

Rajshahi, Khulna and Sylhet simultaneously on 28th May 2013. It may be mentioned that even though there was a countrywide general strike (*Hartal*) on the day of seminar as well as the day before, more than 90 percent of the invitees attended the seminars. (The list of participants in each of 4 divisional seminars has been provided in Annexes.) The seminars were organized jointly by Human Development Research Centre and White Ribbon Alliance, Bangladesh. In Chittagong and Rajshahi, seminars were held in the conference room of the respective Divisional Director of Health. In Sylhet, it was held in the conference room of an NGO, namely Simantic, and in Khulna, the seminar was held in the conference room of School Health Clinic. Except in Khulna, all three divisional seminars started at 10 a.m. with tea and snacks and ended with lunch at 1 p.m. In Khulna, the seminar started with lunch at 1 p.m. and ended with snacks at 4 p.m. All the divisional seminars were chaired by their respective Divisional Director of Health and key findings were presented by one of the core study team member. Presentations were followed by a short video presentation on the existing quality of MNH care and the floor was opened thereafter for questions/answers and discussion. Almost all the study findings were acknowledged by the participants. One of the associate members of the study team facilitated the interactions between the participants as well as with the team members to draw out the diversity of views and suggestions.

3.1.2. National Dissemination Seminar

The national dissemination seminar was held in the MIS auditorium of DGHS, Mohakhali, Dhaka on 31 May 2013. Like the divisional seminars, the national seminar was organized by Human Development Research Centre and White Ribbon Alliance, Bangladesh. The seminar was chaired by the Joint Chief, Planning, MOH&FW, and the Additional Director General, DGHS, was the chief guest. Representatives for MOH&FW, DGHS, DGFP, representative from UN bodies, members of White Ribbon Alliance, and journalists attended the seminar. (A list of the participants has been provided in Annexes.) The key findings of the study were presented by Team Leader of the core study team. The presentation was followed by a documentary film on the quality of MNH care in the study areas. Immediately after the documentary show, the floor was opened for questions/answers and discussion. Excepting one or two findings, all other study findings were acknowledged by the audiences. Various recommendations were suggested to overcome the barriers to the quality of care in providing MNH services.

National Dissemination Seminar at Dhaka

Chapter-4
Conclusion & Recommendations

4.1. Conclusion

In the last decade, Bangladesh has achieved commendable success in maternal and neonatal health. At present, the maternal mortality rate has dropped to the level of 194 per 100,000 live births, and neo-natal mortality has declined to 32 per 1,000 live births. Bangladesh is on track in achieving MDG goals 4 and 5. The progress can be accelerated if the quality of care could be made certain at the health service facilities. The current study included a multi-stakeholder participatory approach for the rapid assessment of the level of quality in care being provided by selective types of public, NGO and private facilities that revealed a clear indication for improvement. The survey aimed to explore the existing barriers to the quality of maternal and newborn health care like accessibility, time for consultation, the technical competencies, privacies, access to information, and management issues including supplies and logistics. The identified major barriers against the quality of maternal and neonatal health care are as follows: lacking cleanliness, longer waiting time and less consultation time with doctors, none or irregular availability of drugs, inadequate key and support staff together with frequent transfer of key human resources. Apart from these, absenteeism of providers, non-availability of specialist consultation (i.e., non-availability of obstetricians or anesthetists or both) and lack of safe blood transfusion are the major obstacle for proper emergency obstetric services as well as other causes of dissatisfaction to the clients and evidence of poor services. Although, most of the laboratory services are available at district hospitals, NGO health centres and private hospitals, the service is the least offered at the UHCs surveyed.

Alongside increasing the awareness of the community people regarding MNH, a watch dog mechanism can be established involving the government, civil society, elected representatives. As a complementary and supplementary to routine supervision and monitoring of quality and quantity of services by the line hierarchy, it will help the MoHFW, along with other respective bodies/agencies like the DGHS and DGFP, to provide high quality MNH services and achieve an improved scenario in terms of the indicators.

4.2. Recommendations

- Infrastructure should be need based. Medical architect needs to be appointed for structural design.
- Related manpower to be posted according to need of the facility in all categories.
- Consistency of essential supplies of MSR to be ensured.
- Misuse/drainage of MSR should be protected.
- Skillness to be improved of all related manpower (Doctor, Nurse/Midwife, FWV, Aya. Cleaner, Ward-boy)
- Authority is to be given to local level managers for undertaking minor repair and local purchase from revive generated locally.
- Systemic activities should be undertaken to motivate the service providers and support staff to become more empathetic to the patients.
- At the place of working, safety/security of service providers and support staff must be ensured against different types of harassments and maltreatment.

- Junior level support staff like Aya, Ward-boy and Cleaner should be appointed by local authority as "no work no pay" basis to keep the working place clean and tidy or these services could be outsourced.
- More nursing institute/college to be set up.
- Number of bed in the district hospitals is to be increased. Regular budget for patient food/meal should be according to number of patients admitted instead number of allocated beds.
- Recommendations should be reached to appropriate authority through a policy letter.