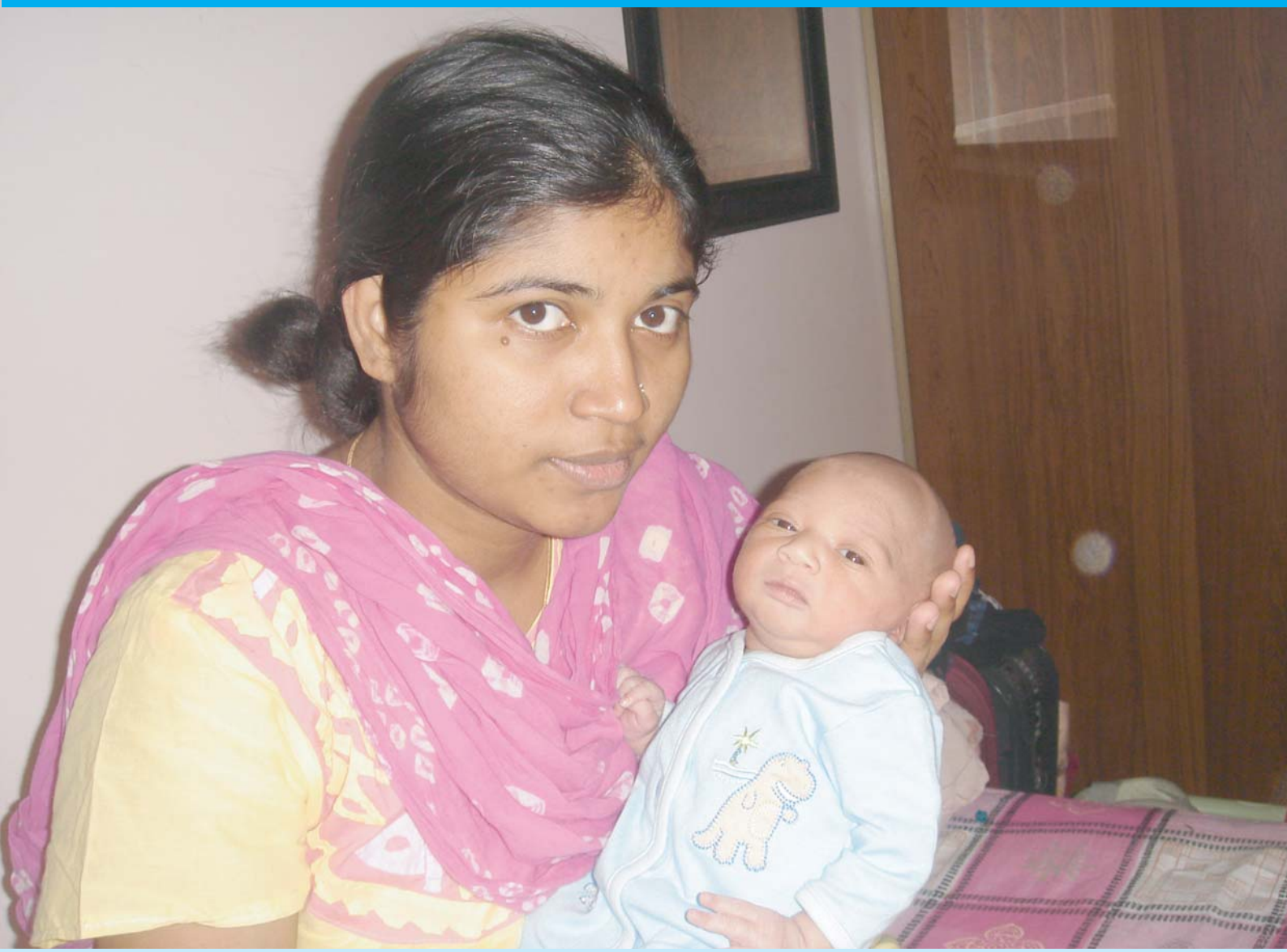
Study on
Maternal & Neonatal Child Health



Prepared by:

Abul Barkat
Murtaza Majid
Azizul Karim
Golam Mahiyuddin
Avijit Poddar
Asmar Osman

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

Prepared for:

JICA

JICA Bangladesh Office
Uday Tower (7th Floor),
57 & 57A, Gulshan Avenue (South)
Circle 1, Dhaka 1212

Dhaka: March 2010

Executive Summary

In Bangladesh, Maternal Neonatal child Health is now a programme of national importance, although MNCH status continues to be a matter of serious concern. Maternal mortality rate is estimated at a range of 320-400 per 100,000 live birth and less than 50% women avail of even a single ANC visit[1]. Only 35% of pregnant women suffering from complications are receiving EmOC during delivery. Neonatal mortality now accounts for over 70% of overall infant death taking places during the first four weeks of life. Nearly 85% of the births take place at home. Pre-maturity, low birth weight, birth asphyxia, birth trauma and infections are the major causes of neonatal death[2].

Bangladesh government has been implementing the Health, Nutrition and population Sector Programme (HNPSP) since 2003. JICA supports the Ministry of Health and Family Welfare (MOHFW) in collaboration with UN Agencies and other development partners (DPs) in the implementation of HNPSP which covers nearly 90% of development projects under the Annual Development Programme of the government.

Prior to closing of the SMPP planned in July 2010, GoB has officially requested Japan for its continuous support in MNCH sector. In this connection, the study was conducted to find out strategic approaches for strengthening a health system in MNCH, which may be applied to a future project by JICA.

The core objective of the present study was to understand the current situation (MNCH) and to get an overview of constraints of MNCH programme in Bangladesh with a view to examine/explore the possibilities of extending JICA cooperation in MNCH-FP sector.

The `Study on Maternal and Neonatal Child Health was designed to collect information from five districts namely – Barguna, Bandarban, Jessore, Satkhira and Kurigram as agreed in a meeting held in Ministry of Health and Family Welfare chaired by the Joint Chief, attended by two Dy. Chiefs, Health and Family Welfare, Director MCH-FP DGFP office, DGHS representative, JICA representative/JICA consultants and two HDRC Consultants, prior to launching of the study in December 2009. There were two upazilas under each study district as follows:

Districts		**Upazilas**
Barguna	:	Patharghata and Betagi;
Bandarban	:	Lama and Ruma;
Jessore	:	Chowgacha and Jhikargacha;
Satkhira	:	Kolaroa and Debhata
Kurigram	:	Rajarhat and Nageswari

The research design was an assimilation of qualitative and quantitative methods. Data and information were collected from primary as well as secondary sources and Key informants interviews were held. The Key officials interviewed were Civil Surgeons-5, Deputy Director FP-5, Upazila Health and Family Planning Officer-10, Consultants Obs/Gynae-5, Medical Officers MCWCs-5, and also NGO Managers, Private Clinic/Hospital Service-providers.

---

[1] Community Support System for EmOC, Mira Mitra et al Health Nutrition section UNICEF, Oct, 2006.
[2] Lawn J E et al. 4 million neonat death: When? Where? Why? Lancet (neonatal survival); March 2005

An overview of the five study districts revealed Jessore had the largest number of union and population with density of 962 per km, whereas Bandarban has the smallest number of unions, populations with density of 67 per Km. All 10 upazilas (UHCs) have electricity, water connections and road communication.

The ***overall national policy framework*** particularly those related to health, social welfare, women development lack sharp focus on MNCH. Higher priority consideration for MNCH may rightly be given in all related national policies of the government.

The present ***study was designed to seek responses to 13-15 major issues.*** The ***Findings*** based on field responses recorded carefully are summarized below:

Maternal Neonatal situation, MNCH activities – Services were issues responded to by Civil Surgeons, DDFPs, UHFPOs, UFPOs, Consultants and MOs of MCWCs. Except Jessore, all have similar opinion, they rated MNH as poor/ unsatisfactory. Jessore case is a little better, - rated as somewhat satisfactory. **Two reasons** were identified for poor performance –

- ***One:*** Lack of awareness about MNCH services; the rural poor are unaware of how, where they are to available of the services;
- ***Two:*** Lack of manpower particularly trained doctors (MOs, Consultants), Nurses, FWVs, CSBA and others related to MNH service delivery.

Facilities providing MNCH services are mainly, District Hospitals, UHCs MCWCs, Union level upgraded FWCs/RDs, some community clinics and satellite clinics (limited service). For providing full-range of MNCH/BEmOC/CEmOC services, only a few are well-equipped at upazila level (UHCs 5 are providing CEmOC, remaining 5 BEmOC). Of the 5 MCWCs, Bandarban is providing EmOC and Jessore, Satkhira, Kurigram are providing CEmOC; Barguna at present is not in position to provide any of the two services because of absence of Anesthetist, Consultant/ MO Obs/Gynae and trained supporting staff.

Regarding ***Health-FP Workforce at 10 upazillas*** for MNCH service delivery, the status is that – Consultant OBs/Gynae, MO Obs/gynae, Anesthetist, trained FWV, CSBA/FWA posts both sanctioned and actual are far below the required number. Numerous vacant posts/ absence from place of posting are a major concern for program managers at all levels. None of the Field workforce works singularly in one area of activity as his/her job-responsibility cover a wide range of duties.

Status of Community Clinic (CC) appeared to some what confusing – it neither belongs to FP Department nor to Health Department, for either administrative or for operational purpose. **Dual control/management is going on**. Of the existing community clinics, nearly 75% are fully functional as reported by the Deputy Directors of FP. The Civil Surgeons of 5 districts are of the view that service delivery and monitoring of CCs are not yet upto the mark. Supervision of CCs by DDFPs is also quite weak. **They (CS/DDFP) are not fully aware of how many CCs are going to be built in future.**

About ***sources of income*** for FP-MCH facilities, most of the DDFPs replied in the negative. Scanty information about FP-MCH facilities and even of annual budget allocation for Dist FP programme was matter of great concern. UFPOs betrayed their ignorance. On the other hand, it was gathered from civil surgeon's office the ***budget for each bed*** of a 100-bed hospital is Tk.25,000/- and Tk.18,000/- for each bed of 31-bed and 51-bed hospitals.

Local level planning (LLP) is still at its nascent stage. Civil Surgeons reported that LLP is yet to be implemented in Barguna, Jessor and Satkhira. Two others, Bandarban, Kurigram have received a small amount of fund for LLP. DDFPs affirmed LLP except Jessore as his district is not a pilot for LLP. They (DDFP) said they get support from central authority/level. But for LLPs, UFPOs wanted budget allocation, support from Upazila Administration/ Upazila Parishad, training on LLP and feed back from central level.

Management Information System – is not yet fully equipped – technically or otherwise. DDFPs reported that information collected is partially computerized and partially manually compiled/recorded. Computer programming has not yet been developed; e-mail system and use of internet have to be developed. **Skilled manpower and shortage of equipment is blocking the digital way forward.** Monthly review meeting, staff meeting, discussion, exchanging written reports, monthly report/return, and sharing of information are done regularly.

Referral system prevailing in the Districts and at Upazilas vary from facility to facility and there is hardly any rigidity in the mechanism of referral. Usually, slip-system and then issuance of discharge paper, emergency slips, written chits, accompaning the client (by FWV/FWA) are in practice. Verbal referral to higher authority/facility is also on practice. It was revealed that consultants refer five types of patients to Government Medical College Hospitals which are – obstructed labour, Eclampsia, APH, PPH, retained placenta, hand prolapse and complications of abortion. Normally, complicated cases are referred to District Hospital from union FWCs, RD, UHCS by Medical Officers, FWVs, FWAs and private doctors, NGO doctors and others.

The Quality Management System (QMS) exists in all 5 districts and Upazilas as reported by DDFPs, MOs and UFPOs *but Civil Surgeons of Bandarban and Satkhira reported negatively.* Also UHFPOs of Lama and Ruma declined, again consultants had also negative views about quality assurance system. *The system appeared to be weak and fragile*. The task of quality assurance is maintained by checklist, routine inspection, and by Family Planning Clinical Supervision Team (FPCST). Regarding EmOC team's activity, Civil Surgeons expressed their ignorance, as they were not sure if the team had been formed in the EmOC run facilities. About EmOC team at the UHC, UHPOs of Betagi, Lama, Chougacha and Kalaroa reported in the positive.

In response to the question about sufficiency of ***supplies of emergency drugs*** to manage obstetric emergencies, the response was positive by 4 MCWCs – Borguna, Bandarban, Jessore and Kurigram but Satkhira said no. Satkhira MO explained that local fund is used to buy emergency medicine and *if this is exhausted, patients are asked to buy themselves*.

About **coordination between health and family planning** department's official, both side affirmed good cooperation and hardly there is any problem. They communicate regularly, have meetings attended by both partners. Again, with NGOs they also reported good communication and collaboration except Satkhira having some reservation. Also 50% UHFPOs expressed positive outlook about NGOs.

One of the questions was on ***barriers to MNCH not reaching the rural poor,*** the DDFPs and UFPOs identified the following factors – distance and geographical barrier, transport costs, unfriendly attitudes of the service providers, lack of awareness of the service receivers especially of the poor, acute shortage of trained/skilled doctors/anesthetists/staff for MNCH,

lack of drugs and necessary medical surgical requisites (MSR). The question, *what government can do or should do to improve EmOC service, the District Managers* were not very specific, nor explicit – they think the governments can do many things if the entire bureaucratic machinery is dynamic and efficient.

About the ***activity of development partners and NGOs*** the district and upazila level respondents have though a positive attitude, yet they are largely skeptical about their actual performance as partners in development. The general impression of CS, DDFPs, MOs, UFPOs and UHFPOs and others about NGOs and development partners (DPs)/donor agencies was that for success, or failure of a particular intervention(s) they (NGOs/DPs) are not accountable, can hardly be questioned. They are viewed as fair-weather friend and the fabric of relationship is still growing and confidence-building has to develop further. **As a matter fact, information collected about them was not enough to reach a conclusion.** Nevertheless, our understanding is that at national level the bilateral and multi-bi-relationship is much better and solid.

Good practices are not universally practiced- Barguna DDFP introduced team-work, while Bandarban DDFP – social mapping by Health Assistant, FWA, community support groups; Jessore introduced Award for 3 best (top) performers, stricture for lowest performer, feed-back session, cluster meeting etc.; Satkhira and Kurigram have not done anything as yet. They are pondering over the issue and intend to do something worthwhile.

In brief, about their ***future plan*** DDFPs, MOs and UFPOs have similar views – they are planning to –

- → Launch motivational campaign on greater access of rural poor for availing MNCH services;
- → Improve quality of service;
- → Raise GO-NGO collaboration & cooperation
- → Involve local Government bodies
- → Raise commitment of the service-providers and local community.

Private Clinic/Hospital Service Providers in four out of five study districts who had been providing basic or comprehensive EmOC, were identified and interviewed on - Facility profile, Staff force , Training in neonatal health, who also work at GoB facilities, list of MNH services being provided and Corresponding fees, EmOC Services, Referral of EmOC cases, Supplies and maintenance, Quality Assurance System, Services provided from January to November 2009, MNH services of the GoB, income and sustainability, and Suggestions for improvement.

At ***present, Bandarban district had no Private clinic/hospital capable of providing BEmOC/CEmOC services.*** EmOC services are available for 24 hours for 7 days a week in all of the clinics, except the 2 in Satkhira. Regarding the year of providing EmOC services all of them, except 1 in Jessore and 1 in Kurigram reported that such services were started in the year 2000 and afterwards. They reported of providing all the services in all the districts, except providing Assisted vaginal delivery in both the clinics of Satkhira. Regarding investigations done in their clinic, they reported of providing almost all except CT Scan, which is done only in Jessore.

Quality Assurance System in these private clinics did not appear to be quite sound and not meticulously pursued. However, *this issue needs further investigation*. About GOB assistance for MNCH services they reported in the negative and none of them are associated with DSF scheme of the government. About income and sustainability, all of them except one in Barguna reported that their clinics are not self-sustainable. They bank upon loans from the Banks.

The NGOs are Surjer Hashi Clinic (SHC) in four upazilas, Marie Stopes Clinic in three upazilas and Addin Hospital in one upazila. The number of clinics operated by the NGOs in each upazila varies between 1 and 5. Although there are some doctors (with out any MNH related training) reportedly provide services in a few upazilas, the number of trained in MNH paramedic nurse is alarmingly low. The health service delivering NGOs are providing a range of MNH services in eight upazilas out of ten. There are no NGO-delivered services in Lama and Ruma upazilas of Bandarban district. The health service-delivering-NGOs are providing: both in clinic and in community MNH services in eight upazilas out of ten. There are no NGO-delivered services in Lama and Ruma upazilas of Bandarban district. SHCs operating in Debhata upazila under Satkhira district and Rajarhat upazila under Kurigram district provide a limited range of in community services. *All Marie Stopes managers and manager of SHC at Rajarhat upazila informed about their intention to expand MNH services for the poor in the future.*

The clinics at Betagi, Jhikargachha, Chougachha *do not receive any financial* and/or in-kind assistance from government sources, except contraceptives. Other clinics receive some assistance. Different NGOs receive different amount of service charges for similar type of services. None of the NGOs/Clinics are financially sustainable, the financial support for SHCs come from USAID, Marie Stopes from UK, Grameen Phone and Marie Stopes Socity. The same for Addin Hospital remained incognito from the managers.

All the NGOs reportedly have their procurement, maintenance policies and MIS.

The ***most important observation is*** – intensive and extensive skill-based professional training of doctors, nurses, FWVs, FWAs/CSBA and all others related to MCH/MNCH service delivery ***must get high priority***. At the same time, awareness-building in the rural community to avail of the EOC services from the nearest centre should be launched seriously. Supportive supervision must continue uninterrupted. ***Lack of commitment to the assigned tasks, and knowledge gap at all levels, had been responsible for poor performance.***

Suggestions made by the field functionaries (both managers and service providers – technical and semi-technical) were numerous on various issues studied in the present exercise undertaken by MOHFW and JICA and accomplished by HDRC. Of the many suggestions for MNCH services reaching the rural poor, there is need for urgent attention on two –

- ***Launch robust advocacy campaign*** for motivation of rural poor to sensitize them of MNCH services and ***enlisting commitment of the community leaders*** for support to the needy mothers.
- ***Ensure posting/staying at the place of posting*** of sanctioned number of trained doctors, nurses, FWVs and Anesthetists working at different locations – Union, upazilla and District.

Limitations and risks – each study has some limitations and risks. The limitations of the present study are that, it could not deal with cross-cutting issues in detail and could hardly address or measure attitudinal issues, commitment level of key actors/stakeholders (Govt. DPs, NGOs, private entrepreneurs, civil society, local leaders and others) that influence implementation of current activities and also future expansion of MNCH program meaningfully. How far could we proceed – a question to be answered, perhaps, by more in-depth study(ies). The present study however, attempted to throw more light than before on answering some key questions. The study team was under the pressure of scarcity of time. Nevertheless, JICA-Consultants support was of great value in the successful completion of the study.