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Newsletter

SAFE MOTHERHOOD PROMOTION PROJECT Phase 2 (SMPP-2)
A Technical Cooperation Project of Ministry of Health & Family Welfare and Japan International Cooperation Agency (JICA)

For the purpose of reduction of maternal and neonatal morbidity/mortality, the Government of Bangladesh (GOB) requested & Japan International Cooperation Agency (JICA) to jointly implement the Safe Motherhood Promotion Project (SMPP) in Narsingdi District for 5 year period (2006 to 2011). After successful completion of the 1st phase, SMPP has been started its 2nd phase (5 years) from July 2011.

Private Community Based Skilled Birth Attendant (P-CSBA)

An innovation to ensure essential MNH services in the hard to reach areas

"We have learnt a lot, we were not smart in the past, we could not go out of our home, now everybody knows us, we help them and we enjoy it."

"It has brought financial solvency in my family. Everybody now shows respect to us. We also can contribute to our own families and feel empowered. The new profession has brought financial solvency, authority and respect for us."

(Quotes of Private CSBAs in Narsingdi)

Currently, around three million deliveries are taking place each year in Bangladesh. Among them approximately 31.7%[1] are being attended by medically skilled hands such as medical doctors, nurses, and community skilled birth attendants (CSBAs). The rest of deliveries are conducted by TBAs or other unskilled personnel including relatives and mothers-in-law. More than two-third deliveries are conducted at home. Delivery by skilled persons at home is only 4.4%[2]. This situation is worse in the hard to reach areas where people can hardly find skilled healthcare providers.

SMPP-2 Outline

Overall Goal: Maternal and neonatal health (MNH) status is improved in Bangladesh

Project purpose: The approaches to improve MNH service quality and utilization in line with Health, Population, and Nutrition Sector Development Program (HPNSDP) are expanded in Bangladesh.

Outputs:

1. Function of the MNH activities coordination among stakeholders is enhanced at national level
2. Process of good practices and lessons learnt for improvement of MNH extracted from the Project are disseminated in the country.
3. Local implementation mechanisms of MNCH minimum package and approaches integrated into UHS are defined

Project sites: The National level with direct intervention in Satkhira, Narsingdi, and Jessore districts

SMPP introduced Private Community Based Skilled Birth Attendants (P-CSBA) in the hard to reach areas of Narsingdi in 2008. It was the first time in Bangladesh to train non-government community women to be the government recognized CSBA. This initiative was started from an idea of Union Parishad Chairman in the Char area of Raipura Upazila who wanted to establish community owned CSBA services.

Ref:-
1. Bangladesh Demographic and Health Survey 2011
2. Bangladesh Maternal Mortality Survey 2010

Background of Community Skilled Birth Attendant (CSBA)

Ministry of Health and Family Welfare (MOHFW) has taken the initiative to produce CSBAs in 2003 with the objectives to ensure a female birth attendant with minimum skills required to conduct a normal delivery and the capacity to identify situations adverse to the mother and the baby, and make early referral of such cases to the nearest comprehensive EmOC centre. The CSBAs are basically selected from Family Welfare Assistants (FWAs) and Female Health Assistants (HAs), the grass root level health and family planning workers under the government employment. Among these cadres, those who are having a minimum education of SSC (Secondary School Certificate or passed grade 10), aged less than 45 years old, willing to reside in the assigned rural areas, and to serve women in the community were selected for training. After a basic course of 6 months, these workers were allowed to conduct Normal Vaginal Delivery (NVD), provide

Antenatal Care (ANC), Postnatal Care (PNC), and immediate New born care (NBC), etc. The curriculum was designed and approved by the Bangladesh Nursing Council (BNC) to have six months basic training followed by 9 months community services under supervision and finally 3 months additional course to complete the requirements of 18 months training on midwifery and few lifesaving skills.

Since 2003 until the end of May 2013, a total of 7,672 CSBAs were trained covering more than 347 upazilas of 62 districts. Under the Health, Population, Nutrition Sector Development program (HPNSDP) increasing the number of CSBAs is regarded one of priority areas. Government has a plan to produce 13,500 CSBAs by the

P-CSBA in Raipura Upazila, Narsingdi

year 2015 which will allow the government to have one CSBA per 6,000 people or one per Community Clinic.

In Raipura upazila of Narsingdi, there are 24 unions and 14 of them are hard to reach as these areas are surrounded be the river and only accessible by boat. In a place like the Char area, the government staffs are often found not available even during their working hours. Reasons may be vacancy in the sanctioned post or workers' not being residential in the assigned areas and a difficulty in commuting from the town, etc. The overall situation obstructs women and children to get minimum healthcare in the community. Considering the seriousness of the problem, SMPP took an action to improve the situation with an innovative idea to train local women as CSBA who can work independently as a birth attendant, are available for providing 24/7 MNCH services at the community, and can earn a substantial living to support her family.

The first candidates of P-CSBA were selected in August 2008 in collaboration with respective Union Parishards, and the CSBA training began in December 2008. There were 11 trainees in the first batch who received basic training of 6 months in the LAMB Hospital, Dinajpur District. The second batch training with 8 participants was organized at Kumudini Hospital, Tangail District in 2010. Those two private hospitals are accredited as CSBA training centers by the BNC. Considering that those P-CSBA candidates are ordinary rural women having no prior experiences of working in the health sector, SMPP provided additional 5 day basic training before official CSBA training started. After successfully completing the six month training and final exam, these P-CSBAs obtained the CSBA certificate from BNC and began to work in their communities. Among them 11 CSBAs received 3 months additional training in Nov. 2011 to complete 18 months full course.

Major Responsibility of P-CSBA

In total 19 P-CSBAs received training under the support of SMPP. One of the P-CSBAs dropped out as her husband did not allow her to do the assigned job after their marriage. Other two P-CSBAs got a job under the MoHFW, one as FWV and the other as FWA. The remaining 16 are currently working in their assigned remote areas in Raipura. They have commitments to provide services to mothers whenever they are in need, and they are allowed to ask for a service charge which does not exceed the limit stated in the agreement with local authorities. Their major responsibilities are as follows:

- Create Awareness on MNH in the community
- Promote birth preparedness
- Provide ANC, PNC, safe home delivery, new born care, and family planning services
- Identify complicated cases and refer to higher level of care
- Work as a depot holder and select clients, counsel and distribute FP methods
- Report their performance to FP managers and local government

Mother gathering during Safe Motherhood Day 2013

Women's Perception and Awareness on eclampsia

"When the pregnant woman comes to us for ANC check-up, if she had high blood pressure and/or oedema, they did not know that she may have pre-eclampsia due to those reasons. They used to think the pregnant women were influenced by the bad spirit. Now they know through ANC and our door to door visit that if mothers have those symptoms they may develop eclampsia (fit) before/after delivery and need to go to the hospital."

(Quotation of a P-CSBA)

As the P-CSBAs are not government staff, they were brought under an agreement with the UP Chairman with some terms and conditions to ensure the accountability. In September 2010, they are enrolled under the national Demand Side Financing (DSF) program, and as a result, they are now eligible to get the benefits from the government for different services they are providing as CSBA. Recently, they have been authorized by the DGFP to work as a depot holder in the community providing FP counselling and supplying the contraceptives to the clients. This has increased their responsibilities and at the same time will also increase their income. The performance of P-CSBAs are compiled and reported under FP monthly MIS.

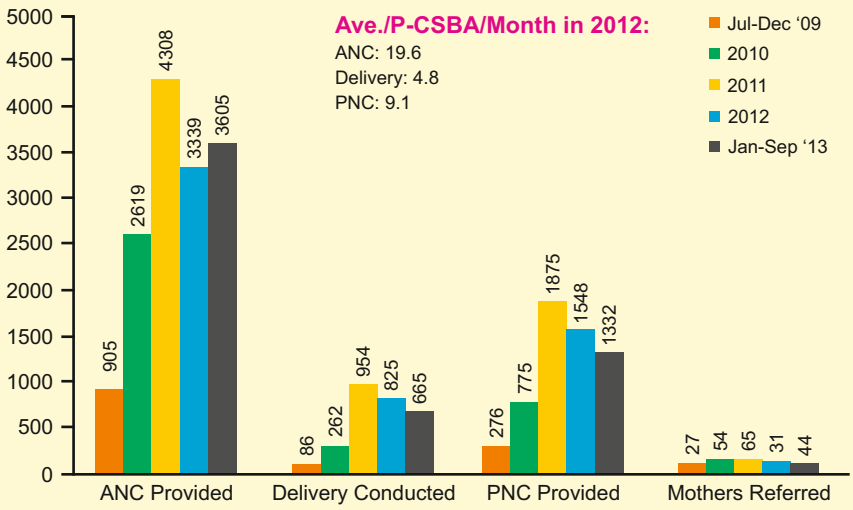
SMPP provided technical support to P-CSBAs through a Technical Officer-midwifery for two years. Since April, 2011, this support has been withdrawn considering that this support is not necessary anymore.

Are P-CSBAs contributing to ensure MNH services in the remote communities?

The performance of the P-CSBAs is better than CSBAs under the government. In the year 2012, P- CSBAs of Raipura have conducted 3,339 ANC, attended 825 deliveries and provided 1548 postnatal care to the community. On an average, each P-CSBA conducted 19.6 ANC, 4.8 NVD, and 9 PNC per month. In contrast, the CSBA evaluation study of 2011 reported that the average number of NVD assisted by a government CSBA per month was 2. Similarly, the BDHS 2011 found that only 0.3% of deliveries were conducted by CSBA.

A Private CSBA Receiving her Certificate

Performance of P-CSBAs of Raipura July 2009-September 2013



Key Findings of P-CSBA Study

SMPP commissioned P-CSBA study in 2012 to understand the changes occurred after introduction of P-CSBA in the char area of Raipura. The following are key findings of the study:

Differences between P-CSBAs and TBAs described by clients:

- P-CSBAs use hand gloves
- They understand the position of the child.
- They do not put hands frequently into vagina.
- They do deliveries neatly and cleanly.
- They understand critical situations and know when to refer
- They rarely call village doctors
- They have better referral linkage with higher level facilities/providers and sometime accompany referral cases

Challenges identified by P-CSBA:

- TBAs motivate the mothers not to call the P-CSBAs.
- TBAs are afraid of losing their income due to P-CSBAs.
- TBAs have a strong linkage with the community and people rely on them
- TBAs call village doctors who use injections (Most cases injections are requested by clients although there is no need for them)
- Referrals become problematic due to village doctors' interference

ANC provided by a P-CSBA

- Community people are reluctant to take a mother to a facility
- Long distance between the mother's and the P-CSBA's houses
- Commuting in the hard to reach area even at night to attend a call
- Low income of people
- No technical hand to support during emergencies particularly during night
- Referral arrangements (transport, communication with hospitals, costs)
- Community's wrong perception of free of charge MNH services provided by P-CSBAs

Relationship between P-CSBAs and TBAs

"The Dai (TBA) always counsel pregnant women and her mother not to call us. If they call us we will get money and they will lose their earnings. So they always try to create obstacle to call us. But when the Dai failed to do the delivery, they call us to conduct the delivery."

(Quotation of a P-CSBA)

Recommendations:

- Proper monitoring and supervision is essential to improve the performance and utilization of P-CSBAs.
- A minimum financial benefit for P-CSBAs needs to be ensured, may be through the UP chairman
- Increasing awareness on P-CSBA can be beneficial for P-CSBAs to improve P-CSBAs' performance and make community people supportive.
- Number of P-CSBA needs to be increased in the char areas of Raipura and also in many other hard to reach areas of the country.
- A standard reporting format is essential for all the CSBAs for proper reporting. Every CSBA shoud use the same format.

Shilpi apa saved my life and baby

STORY of a client of P-CSBA in Raipura Char

… I got my labour pain on Monday during the time of Magrib prayer. I informed my mother-in-law and she called the dai. The dai called a village doctor (a pharmacy man). The village doctor gave injections (oxytocin, for inducing contractions) and saline, but the baby was not born. He gave six injections to increase my pain but it didn't increase. The dai and the doctor tried to deliver the baby for four long hours. I got tired. Finally, the dai said that she could not deliver the baby. They suggested taking me to the hospital. It was in the middle of the night. We live in the char and no transport was available…. I was crying and praying to God to save our lives.

My husband immediately recalled Shilpi apa (P-CSBA) who had training on delivery. He called her and she agreed to come to my house for the delivery. My husband went to her house and she came to our house at 4:00 am. She checked my baby's position and made me walk in the room. She washed her hands with soap and put gloves on her hands. She said to me, "Don't get nervous, the baby's position is good. It will come out soon." I was crying in severe pain. She calmed me and asked me to have courage. Finally, I delivered my baby at 5:00 am in the morning. The baby cried just after birth and took its first breath. Apa brought out the placenta and cut the umbilical cord. She wrapped the baby and gave him to me to breastfeed.

Conclusion

The impact study concluded that P-CSBAs introduced by SMPP contribute to women and children in the hard to reach areas and can be sustainable. P-CSBA initiative has been taken up by MoHFW and different development partners for nation-wide expansion. At present, there are 238 P-CSBAs already trained and working in the communities. The case of P-CSBA is a good example of public-private partnership involving local government and communities to improve the MNCH status in Bangladesh.

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