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Promising Results

Empowering individuals, families and communities to improve maternal and newborn health in rural Bangladesh: A qualitative review

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As in many developing countries, women and newborns in Bangladesh face significant risks related to pregnancy and childbirth. This is especially true in rural regions where a myriad of obstacles at the community and health services level contribute to high maternal and newborn mortality and morbidity. In response to these challenges, PARI Development Trust, a local NGO, supported by the Swiss NGO Enfants du Monde, has implemented a maternal and newborn health (MNH) programme in Netrokona district to empower individuals, families and communities to improve MNH and increase access to health services for women and newborns.

A recent review of this programme at its midpoint indicates that important changes are occurring in response to programme interventions, including community mobilisation in favour of MNH, an increase family level planning for birth and potential obstetrical and neonatal emergencies, a shift in preference toward skilled attendance at birth and a transformation in the role of traditional birth attendants. Moreover, the percentage of women receiving the recommended four antenatal care visits has increased from 4% to 12% and skilled attendance at birth has increased from 12% to 20%. These results are very promising and highlight the importance of working with the community as a critical component of improving MNH.

Background

Bangladesh is among the many countries that have struggled to reduce risks faced by mothers and newborns. With an official maternal mortality rate of 240/100,000, a Bangladeshi woman faces a 1 in 170 risk of death due to causes related to pregnancy and childbirth (1). Moreover, 36 infants per 1,000 die before they reach the end of the first month of life, with neonatal

mortality now accounting for 57% of all deaths of children under the age of five (2). The risks faced by women and newborns are magnified and especially difficult to address in remote, rural regions of the country.

Netrokona district, located in northern Bangladesh near the Himalayan border is characterized by low socioeconomic status, a paucity of local health services and poor infrastructure to reach health facilities. As a result, delivery with the support of a skilled birth attendant is much lower than the national rate of approximately 26% (3), with only 12% of women in the intervention area giving birth with a skilled attendant at baseline. In light of these challenges, PARI Development Trust (PARI), a locally based NGO, supported by the Swiss NGO Enfants du Monde, has implemented a programme based on the World Health Organisation's framework for working with Individuals, Families and Communities (IFC) to improve maternal and newborn health (MNH).

The overarching objectives of the IFC framework are to empower women, men, families and communities to improve MNH and increase access to quality MNH services. This is achieved through a combination of community level and health services level interventions. The following four priority areas form the basis of interventions within the IFC framework: 1) developing capacities to stay healthy, make healthy decisions, and respond to obstetric and neonatal emergencies; 2) increasing awareness of the rights, needs and potential problems related to MNH; 3) strengthening the linkages for social support between women, men, families and communities and with the health delivery system; and 4) improving quality of care, health services and interactions with women and community (4).

Based on this guiding framework and in consultation with local authorities and community members, the programme in Netrokona district has emphasized preparation for birth and potential emergencies, community mobilization in favour of MNH and promotion of skilled attendance at birth. Data was recently collected and analyzed in collaboration with the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) at this programme midpoint to explore the progress that the IFC programme in Netrokona district have accomplished. The primary objectives of the review were to assess the level of community mobilisation that has taken place in favour of MNH, the changes in planning for birth and emergencies and the changing role of traditional birth attendants (TBAs).

Programme Implementation

The IFC programme was initiated in 2008 by PARI with the financial and technical support of Enfants du Monde. Four of the eight unions of Kalmakanda Upazila (sub-district) of Netrokona district were selected for implementation of programme activities, namely Barkhapon, Rangchati, Nazirpur and Kharnoi, comprising a total of 167 villages.

Consistent with the IFC framework emphasis on inter-sectoral and inter-agency collaboration, various partners have joined forces through participation in IFC committees formed at the union and upazila levels. Participating actors include the Health and Family Welfare

Department of Netrokona district and the following local NGOs: Jatio Tarun Sangha, Garo Baptist Convention/Primary Health Care Project and World Vision Bangladesh in addition to PARI. Such collaboration between governmental and non-governmental actors is uncommon in Bangladesh and a hallmark of the programme. All actors work to ensure that interventions are in line with and complimentary to the national MNH strategy and other local MNH efforts. While collaboration at the national level is still a weakness of the programme, discussions have been initiated with national governmental and non-governmental organizations to promote IFC action on a broader scale.

In order to promote birth and emergency preparedness, partner organisations worked with community representatives to elaborate a community awareness strategy, including educational activities and a toolkit. To facilitate implementation, partners developed a health workers training strategy to instruct all community and healthcare personnel working within MNH in the intervention area. Following the training, health workers are prepared to work individually with women and families to assist them in creating a birth and emergency plan and in groups with community representatives to foster community awareness of the importance of birth and emergency preparedness.

A foremost tool for planning is a card called *the Birth and Emergency Preparedness Plan* (BEPP) which was produced by local partners and endorsed by the District Department of Health and Family Welfare. This card illustrates through pictograms the choices and preparations that need to be made for birth including selecting a birth place and transportation to reach the birthplace, indicating a birth attendant, choosing a birth companion, identifying a potential blood donor, developing a strategy for saving money for costs related to pregnancy and identifying where to seek care in the case of complications. The card also contains pictographs of the most common danger signs to help women and families identify complications and seek care in a timely manner. Pregnant women receive the BEPP card and discuss it with community health workers and with health care providers at the time of antenatal visits and at any further encounters with health workers during pregnancy. They share and discuss it with their husbands and other influential family members, particularly mothers and mothers-in-law. These activities encourage women and families to choose skilled attendance during birth and seek care at health facilities in response to danger signs.

Additionally, communities are mobilised through meetings and awareness campaigns in favour of MNH. Communities are encouraged to see MNH as a responsibility of the entire community, and as such, work collectively to identify key barriers to health care seeking for pregnant women and explore solutions. Once solutions are agreed upon, the community takes concrete action to implement these solutions.

Finally, action is taken to assist TBAs in defining and assuming a new role in maternal health. This new role does not recommend attendance at birth and emphasizes on other essential roles such as education of pregnant women and new mothers, referral of women to health services for birth or in response to danger signs and providing social support for women and families. Meetings are conducted with TBAs, village doctors and homeopathic doctors to

address defining new roles and responsibilities for them within MNH and discuss the importance of birth with a skilled birth attendant. Discussions are held also with women and community member to discuss these changes in role.

Methodology

The mid-term review relied primarily on qualitative methods to explore the changes resulting from the IFC programme interventions. Focus group discussions (FGDs) and semi-structured interviews formed the basis of qualitative data collection. Six FGDs were conducted throughout the course of the study with community members, TBAs and health workers. Each FGD consisted of 6-9 participants, invited to participate based on a detailed list prepared by PARI and EdM. Informed consent was collected from each of the participants prior to participation. These FGDs addressed birth and emergency preparedness, routine care seeking behaviour and other issues related to MNH.

In-depth interviews with semi-structured guidelines were conducted with TBAs (4), community health workers (4), pregnant women/women having given birth within past 12 months (4), family members/husbands (4) and clinic-based health providers and health clinic managers (7). These in-depth interviews focused on participants' awareness of the programme and their understanding of its related activities, the benefits that they have noticed resulting from the programme, as well as any suggestions for improving it.

The data analysis followed a standard textual analysis process. All the FGDs and in-depth interviews were transcribed verbatim. Field researchers who collected the data were involved in the process of transcription in order to ensure accuracy. These transcripts were then reviewed to ensure completeness. Two research officers then coded a limited number of transcripts and prepared an initial list of codes. Once inter-coder reliability was established, all transcripts were coded. Finally, a thematic analysis based on the resulting codes was conducted. Results were compared against the situation analysis conducted in the intervention site in 2005 and the baseline study from 2009.

In addition, internal programme reports and data were reviewed to better understand that status of community actions having occurred in favour of MNH.

Results

Community mobilisation

Communities are successfully coming together to address transportation and financial barriers to care seeking. Three out of the four intervention unions have purchased and are effectively managing transportation for pregnant women to reach health facilities. The Kharnoi union purchased and began managing a rickshaw van in 2009. Inspired by their example, Nazirpur union mobilised political will and through community members' contributions also purchased a rickshaw van to transport pregnant women to services. The Rangchati union has also taken

steps to overcome transportation barriers for women reaching health services and repaired an abandoned rickshaw ambulance donated by the government. In each case, the transportation is managed by van committees within local community development groups.

The Barkhapon union has created an emergency monetary fund to support women and newborns in case of emergency. A separate bank account was opened specifically for the emergency fund and a steering committee was organised to oversee its operation. The fund has received a high level of community support, as some community members had no means to access resources in case of emergency. In addition to this emergency monetary fund at the union level, ten additional emergency funds have been created at the village level directed by local community development groups. These funds are accessible for emergency care, to pay for hospital services, medications and transport according to specific criteria varying by the community group. The funds are collected from community members and borrowers return the funds at a 0% interest rate.

Birth and emergency preparedness

According to the FGDs, planning for birth and emergencies is increasing, facilitated by the BEPP card. All participating pregnant and recently delivered women were aware of the BEPP card and had used one to prepare for birth. While some of the husbands admitted that they have not looked inside the card, they have discussed the plan with their wives and have expressed agreement with the prepared plan. Participants stated that prior to the introduction of the BEPP card and the related activities, women did not prepare for birth and emergencies.

Participants had identified transportation to reach a health facility in case of emergency and had developed a strategy for saving money for potential incurred costs related to pregnancy and birth. All participants were aware of the importance of blood group screening, though several women had not completed the screening or had waited until the later stage of pregnancy to be screened. Even in the absence of screening, the women had chosen a potential blood donor.

All participating women had selected a birth attendant and a birth place. In the majority of cases, their choice was to have a birth assisted by a community-based skilled birth attendant (CSBA) at home. All participants expressed a preference for skilled attendance basing this on their awareness that skilled birth attendants were equipped with the appropriate competencies to assist birth than TBAs. They also stated greater confidence that a skilled birth attendant would recognize complications and refer them to a higher level of care more rapidly than TBAs. Women preferred that the skilled birth attendant be a CSBA rather than a facility-based provider as her services were less costly and negated the need to travel the far distance to the health facility. Moreover, women expressed that they were uncomfortable seeking services in the health facility, though agreed that they would do so in response to danger signs.

While the planning for birth and emergencies appears to be gaining traction, barriers still exist for women and families seeking to implement the plan. For instance, women still hesitate to seek services at health facilities due to concern of having a male provider attend the birth, which participants expressed as being culturally unacceptable. In addition, although all participants wished to give birth in the presence of a CSBA at home, this did not always occur due limitations in the CSBA's availability. The default was to give birth with the assistance of a TBA rather than go to a health facility. *Changing role of TBAs*

TBAs continue to be highly regarded within the community. Community members, health workers and the TBAs themselves expressed that as they are locals they are trusted by women and their families. While women and families have expressed a growing preference for skilled birth attendants, they still desire to receive certain services from TBAs and look to them as authorities.

TBAs are enthusiastic to participate in the programme and work with the partner NGOs to educate women on antenatal and postnatal care seeking and self-care during pregnancy. While the TBAs have participated in several training sessions, they could not recall the content of these sessions. They are eager to receive continued training and would like to receive instruction on monitoring patients appropriately and on MNH issues more generally.

The TBA participants view educating mothers and referring mothers to health services in response to danger signs as important aspects of their role. They expressed their desire and willingness to refer women to health services. The TBAs feel they are now well connected to the CSBAs, health clinics and hospitals and general practitioners. They expressed satisfaction with their experiences accompanying women to health facilities and feel that they are treated with respect by health personnel. Some TBAs were provided a card to attest that they had completed training. They perceived that they were accorded increased legitimacy when presenting this card at health facilities.

Conversely, interviewed health providers expressed primarily negative attitudes regarding TBAs. They cited the following reasons for this attitude towards TBAs: TBAs do not encourage women to increase their caloric intake during pregnancy; they counsel women based on traditional knowledge; they will only refer women to health facilities after they have tried to assist a birth; TBAs are overconfident and therefore do not take action in referring women to health facilities in response to danger signs. Health providers were overwhelmingly unsupportive of TBAs accompanying women at the health facility.

Finally, internal quantitative data suggests that use of MNH services is increasing and is likely influenced by these interventions. For example, the percentage of women receiving the recommended four antenatal care visits has increased from 4% at baseline to 12% at the time of review and births in the presence of a skilled attendant have increased from 12% to 20%.

Discussion

These midterm results are very encouraging in favour of community-based interventions to improve MNH. It is especially promising to note that since the inception of the programme all of the four unions of intervention have taken concrete steps to overcome transportation and financial barriers to health services for pregnant women. These decisions were made at the community level with the input of partner NGOs and governmental organisations and the steps to realise these actions were overwhelmingly taken by the community.

The results suggest that communities have started being empowered to take control of MNH as many members, men as well as women, are beginning to see maternal health problems as a community issue, not one limited to pregnant women. This collective thinking has been exhibited in donations received to purchase rickshaw and to create the emergency monetary funds that are loaned to women specifically for costs incurred in paying for MNH services. This collective action guarantees the community ownership and consequently bodes well for the sustainability of the solution. Women are enthusiastic about using these services once they know that they are available and communities have consistently expressed their support in favour of these services.

In addition, the results suggest that women and families are beginning to take action preparing for birth and potential obstetric and neonatal emergencies. This is particularly promising, as prior to programme interventions this type of planning was virtually unheard of in the intervention site. Women and families previously lacked awareness of the elements of the preparation that should take place but are now aware of the components of a birth and emergency plan and consider seriously and address each component. Moreover, this review demonstrates that the preference of women and families is shifting towards skilled attendance at birth. Women and their family members repeatedly expressed their awareness of the importance of birth with a skilled attendant. While these developments are particularly promising, action must be taken to ensure that women can act on their knowledge. A critical component of creating an environment in which women can act will be to address the unmet need for CSBAs. These birth attendants are capable of assisting uncomplicated births and identifying early on the complications for which women should see care in a health facility. They enjoy wide acceptance by community members and increasing their ranks at the village level is arguably to most feasible method for rapidly increasing the number of skilled attendants. Based on these findings, training and support of CSBAs will be included in the next phase of the programme.

Finally, the early results also provide hope for a new role for TBAs. TBAs continue to be very influential within the community and this influence could prove beneficial for improving MNH. In working with TBAs within this IFC programme, their responses were encouraging towards defining a shift in roles, as they were overwhelmingly positive in committing to persuade women to use skilled care for antenatal and postnatal care visits as well as for birth, and to refer women with complications to an adequately equipped health care facility. These attendants expressed a great desire to make the best decisions to improve their clients' health.

In order to maximize the potential of TBA participation, training for TBAs will be improved and tailored specifically to their needs. Moreover, the results of the review revealed that interventions will need to target health services, as these attendants will not be successful in working in the new role without the support of health facilities. TBAs will be less likely to refer women to health facilities or persuade them to use skilled care if they are not integrated to a certain degree within the health services. The staff at health facilities will serve a critical function in encouraging this new, important role of TBAs. Therefore, activities are planned for the next phase of the programme targeting health care providers. These include meetings with providers to sensitize them on the importance of collaborating with TBAs and address how this collaboration can occur as well as meetings and working groups between TBAs and providers. Also, it will be necessary to discuss with the community and the TBA's to convince them of the importance of the new role and also to find solutions to cover the monetary or in kind loss to the TBA's if they do not attend births.

Conclusion

Though preliminary, the results of the IFC programme implemented in Netrokona district are very promising in favour of community led approaches to improving MNH. Within this programme, the collective community is coming to see MNH as a community issue and has taken concrete action to address priority MNH needs, women and families have begun planning for birth and emergencies and TBAs have started to serve a new function in MNH. Programme adjustments based on the findings, such as CSBA training and targeting health care providers in working with TBAs, will be combined with strategic improvements including fostering partnerships with new inter-sectoral actors and action at the national level with governmental and non-governmental organizations. Planned for implementation in the next phase of the programme, these adjustments are intended to optimize programme impact and results which will be quantified at endline.

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