

Chapter: 1

Maternal Health Scenario in Bangladesh: The Policy Context

1. Introduction

1.1 Situation Analysis

As we know the reduction of maternal mortality has been selected as an indicator of development of a country in the Millennium Development Goals which set the target to reduce the maternal mortality ratio by three-quarters, between 1990 and 2015. To achieve this Bangladesh must reduce the MMR from 5.74 in 1990 to 1.43 in 2015. The MMR and rate of childbirth by skilled attendants have been selected as the principle indicators of the maternal health situation.

From the human rights point of view maternal mortality seriously hampers a women's right to life and health. The impact of morbidity resulting from childbirth related complication has further devastating effect on a woman's marital, social and personal life. In Bangladesh the maternal health scenario is quite alarming.

According to the 2001 data, only 48% of all pregnant women receive ante-natal care, and only 24% received post natal care among which only 9% is from a qualified provider. Among births which take place at home (90.8% births) 74.4% births are attended by untrained birth attendants, relatives and friends¹.

According to the data, 71.75%² of all admitted patients in the EmOC (Emergency Obstetric Care) facilities are reported of having obstetric complications, but the EOCs meet only 13 % need of these complicated cases. Moreover, the results of a multi-country collaborative study showed that the ratio of maternal morbidity to maternal mortality to be 186:1 in Bangladesh due to different mistreated/untreated obstetric complications during childbirth. In Bangladesh, there are about 9 million women who have survived the rigors of pregnancy and childbirth to suffer from lasting complications such as fistulae, uterine prolapse, inability to control urination and painful intercourse.

1.1.1 Eclampsia

Eclampsia as a major problem causing maternal mortality and morbidity has been selected as the starting point for the analysis of the situation and the relevant policies. In Bangladesh 40 %³ of maternal death in facilities occurs in patients admitting with eclampsia and 6% with pre-eclampsia. Among all childbirth related complications in facilities pre-eclampsia accounts for 12% percent and eclampsia accounts for 16%. Eclampsia is the second major cause (11%) of all maternal deaths due to obstetric complications in the country, following ante-partum and post-partum haemorrhage (19%)⁴.

The term 'eclampsia' is applied to toxic complications that can occur late in pregnancy. **Toxaemia** of pregnancy occurs in 10% to 20% of pregnant women; symptoms include headache, vertigo, visual disturbances, vomiting, hypertension, and oedema. The four categories of hypertension during pregnancy are pre-eclampsia, eclampsia, chronic hypertension, and transient hypertension. Pre-eclampsia, which occurs late in pregnancy, is characterized by decreased cardiac output and increased blood vessel resistance. It may be prevented with calcium supplements and low-dose aspirin, and a caesarean section is often safer than natural childbirth. Only 5% of women with pre-eclampsia progress to eclampsia which is accompanied by convulsions and coma.

To avoid renal and cardiovascular damage of the mother and to prevent fetal damage, the condition is treated by termination of pregnancy or caesarean section. Eclampsia is the second leading cause of maternal mortality, constituting 12-18% of pregnancy-related maternal deaths. Younger women have as much as 3 times the relative risk of developing eclampsia.

¹ Bangladesh Maternal Health Services and Maternal Mortality Survey 2001

² Voice of UMIS, issue 3, October 2003, UMIS, DGHS, DHAKA, BANGLADESH

³ Voice of UMIS, issue 3, October 2003, UMIS, DGHS, DHAKA, BANGLADESH

⁴ Bangladesh Maternal Health Services and Maternal Mortality Survey 2001.

The Causes of Eclampsia:

The exact cause of pre-eclampsia has not been elucidated. Current research utilizes the known risk factors to help shape theory about the exact aetiology of pre-eclampsia.

- Four times relative risk - Daughter or sister of a woman who has had pre-eclampsia
- Three times the relative risk - **Young maternal age**
- Null parity (85% of pre-eclampsia cases occur in prim gravid women)
- Twin pregnancies
- Additional risk factors:
 - Diabetes: Women with gestational diabetes have a 15% increased risk; women with pre-gestational diabetes have a 30% risk of pre-eclampsia.
 - Hypertension
 - Renal disease
 - Women who smoke have a decreased incidence of pre-eclampsia

1.2 The Policy

This study focused on the “Bangladesh National Strategy for Maternal Health” (October 2001) of the Ministry of Health and Family Welfare (MoHFW). Focusing on eclampsia, the importance of proper antenatal care and full-fledged EOC service becomes apparent from which perspective this policy seems the most relevant one. It is currently in the implementation stage. This strategy paper provides:

1. The outline of the essential services that will be established to meet the needs of women during pregnancy, childbirth and puerperum.
2. The human resources development and management plan for establishing services.
3. A guideline for quality assurance, management, communication, and social mobilization.
4. An idea of financial investment needed to put the plan in place,
5. Direction and basis for the preparation of annual operation plans.

In the “Maternal Health Strategy” the *Safe Motherhood* component is discussed in details which focus on creating the conditions necessary for preventing maternal death and disability with emphasis on provision and utilization of quality ANC, safe birth practices, PNC, and EOC services together. But in reality the Maternal Mortality Ratio in Bangladesh is still 3.2 per thousand live births and trained personnel attend only 12% of the births. By analyzing this policy with HerWAI we expect to find out whether it specifically prioritizes the detection of pre-eclampsia during ANC and treatment of eclampsia and other obstetric emergencies in the facilities.

Other policies relevant to this issue are the National Health Policy (2000) and the Health Nutrition and Population Sector Program (2004). We have selected the Maternal Health Strategy as it is directly related to the issue of safe motherhood.

1.2.1 Main actors involved

The main institutions to implement the ‘National Strategy for Maternal Health’ are all government and non-government (NGO) service delivery points in the urban and rural area. To implement the maternal nutrition programs the main actors are Community Nutrition Centers, Community Nutrition Providers and Community Nutrition organizers. The strategy stresses antenatal and postnatal care at all levels at urban and rural areas by Family Welfare Visitors, Nurses and Doctors. The institutions involved in implementing safe motherhood are all Government facilities where essential obstetric care (EOC) and/or emergency obstetric (EmOC) care are available and the actors are doctors, nurses and anaesthesiologists. The trained birth attendants (TBA), trained in the district level hospitals, are also important actors to ensure safe childbirth.

1.2.2 The vision

The stated vision of this policy is “*All Bangladeshi women with their heads held high, smiling in the fulfilment of their right to safe motherhood.*” The mission is “*To nurture a socio-cultural movement that reduces maternal mortality and morbidity as a woman’s right, and also enhances her self-esteem and status.*”

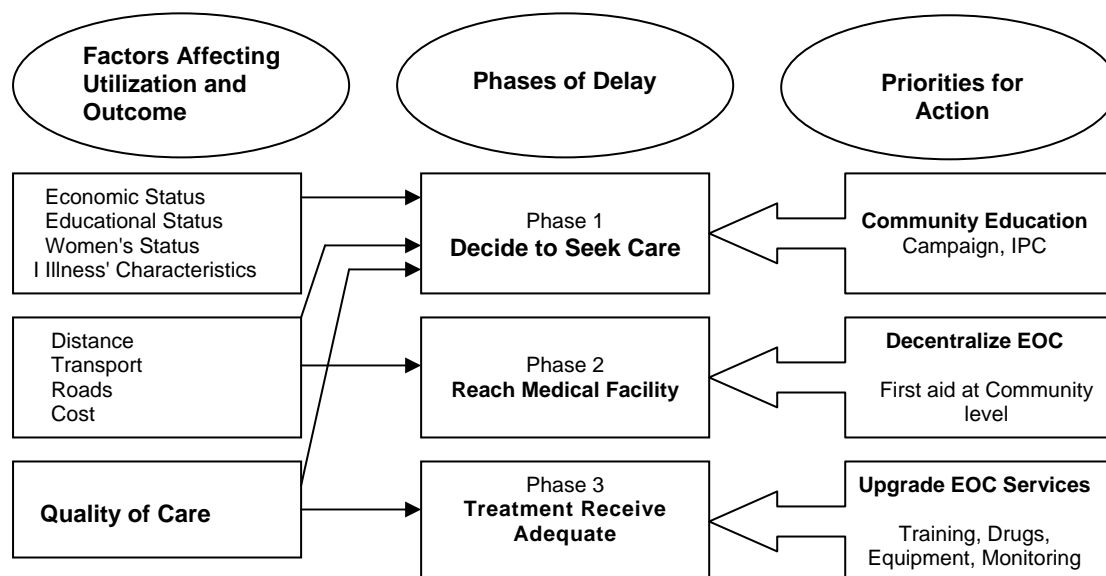
1.2.3 The priorities of this policy are:

Focus on emergency obstetric care for reducing maternal mortality.

The basic assumptions in this regard are:

- All pregnant women are at risk of developing life-threatening complications.
- ⊕ Proper antenatal care predicted and Emoc can prevented most complications.
- ⊕ Once a woman develops complications she needs prompt access to emergency obstetric care services (EmOC) if death is to be prevented.

The "Three Delays" framework of factors, (as stated below) which hinder a woman receiving the service required, provides a basis for strategic interventions. The "three delays model" will be used to design, implement and monitor strategic activities. The elements of the model will not be used in isolation. Rather it will be addressed as a system.



Provision of essential obstetric care/basic maternity care services for promotion of “good practices”, early detection and appropriate referral of complications.

The appropriate provision of these services serves to:

- Provide women with a skilled birth attendants including community midwives
- ⊕ Provide opportunity for communication with woman and her family, among other reasons to promote the appropriate use of hospital care as over 90% births take place at home.
- ⊕ Prevent complications such as septic abortion (by meeting unmet needs of contraception)
- Detect complications such as toxæmia of pregnancy and prevent the development of eclampsia in such cases
- Facilitate a referral system for complications such as obstructed labour or haemorrhage.
- Reduce socio-economic differentials in access and use of essential obstetric care services.
- ⊕ Improve access to EmOC and sexual and reproductive health care including MR by adolescents, as the MMR for girls aged 15-19 is twice as high as those of 20-34.

Promoting women’s access to resources

The strategy:

- Builds on established initiatives and
- Promotes stakeholders participation and specially focuses on the role of men
- Emphasizes communication for behaviour change and development.

Quality of service

The strategy includes:

- Development of a common understanding of quality of care.
- Involvement of professional, local and central political bodies.

1.2.4 The stated aims of this strategy are:

1. To strengthen the provision of essential (including emergency) obstetric care and improve referral and utilization of services.
2. To improve the nutritional status of women and adolescent girls.

3. Ensure that the right people with the right skills are trained to provide quality maternal health services (MHS) at all levels of health system.
4. To promote women friendly health services.
5. To bring about positive changes in the perception and behaviour of individuals, family, service providers and the community to support women in the realization of their right to safe motherhood and a life free of violence and discrimination.

Though the above mentioned propositions of the “Bangladesh National Strategy for Maternal Health” are important and appropriate to improve the situation, the picture of maternal health situation is still precarious as we discussed above. At present all the Government facilities meet only 13% need for safe childbirth. 14% of maternal deaths occur due to violence. Among the most recent reference complication, treatment was sought for 62% of those complications perceived as life threatening among which only 32% women sought care from a qualified provider.

If service can be provided properly, the best possible outcome of the Maternal Health Strategy would be:

- Substantial reduction of MMR
- Increased met need of EmOC facilities
- Increased uptake of ANC (3 visits)
- Increased Skilled Attendance at birth
- Increase PNC
- Increase maternal nutrition level
- Accreditate facilities as women friendly with provision of services for women subject to violence

The Government also has these objectives stated in the strategy. To achieve these, a serious, national level campaign is necessary that will change the ideologies and cultural stigma related to pregnancy among people and earn faith for the Government health facilities, and will promote women to come to the hospital or at least to the trained attendants for care and childbirth.

The Government facilities also need to have means of transportation to transfer emergency cases quickly to the hospitals, need to have provision for giving at least first aid to the emergency patients. All Government hospitals need to have blood banks and blood transfusion system ready for the emergency patients and necessary arrangements for the child to survive. The Government should have specific guideline provided to prioritize the cases of pregnancy related emergencies and quick arrangement of caesarean section in the hospitals to prevent the delay in getting treatment. The administrative process to admit a patient in the hospital should be simple and quick in the emergency cases.

1.2.5 Special programs to implement policy

The special programs to implement the policy include:

- *National Nutrition Program* - Implemented through Community Nutrition Centers
- *Communication Program for Reduction of Maternal Mortality and Violence Against Women* - Implemented nationally at district and sub-district level.
- *Women friendly Hospital Initiative* - Implemented through Ministry of Health and family Welfare with assistance from UNICEF.
- *Community Clinics* - Implemented through Ministry of Health and Family Welfare
- *Government-NGO/Private Cooperation* - Implemented through combined effort of the Ministry of Local Government and Rural Development and NGOs, funded by Asian Development Bank.

1.2.6 Protocols and regulations to guide the implementation of the policy

Obstetric and Gynaecological Society of Bangladesh (OGSB) in partnership with Government of Bangladesh and UNICEF undertook a small project on “Standardization and accreditation of standard protocols and guidelines/sharing experience” in 2004. A committee consisting relevant persons and members of OGSB made the draft protocols which were then sent to the head of the department of all medical colleges for review. The inputs on the protocols were then repeatedly reviewed in different workshops that included consultants of medical colleges and district hospitals and doctors trained on EOC from Upazila health complexes.

Finally fifteen protocols were developed titled “*Clinical Protocols on Emergency Obstetric Care in Bangladesh*”. The protocol prioritized the following cases in the EmOC: Obstetric shock, Vaginal bleeding in early pregnancy, Convulsion in pregnancy, Eclampsia and severe pre eclampsia, Ante partum haemorrhage, Malpresentation and Malposition, Ruptured uterus, Unsatisfactory progress of

labour, Delivery options after CS, Post partum haemorrhage, post abortion care, Immediate newborn care, Newborn resuscitation and “I treat patients and their families in the way I would like to be treated.”

1.2.7 Groups that the government (or the other actors) intend to reach with this policy

The Government intends to reach all the women who are of childbearing age and are pregnant. The aim of this policy is to provide every pregnant woman with proper care and adequate facilities to have safe childbirth to ensure a healthy life onwards for the mother and child.

1.2.8 Actual beneficiaries of the policy

The policy and the improvement in facilities and care in the Government hospitals as a result of its implementation actually benefited the middle and upper-middle class people more. Especially who are aware of these facilities and the importance of utilizing these. Moreover, the urban people living nearer to the hospitals tend to avail these facilities more. This policy does not affect any group of people negatively but it fails to improve the health condition of the poor and hardcore poor and people living in remote villages in the country who are unaware of these facilities.

1.2.9 Results

There are major discrepancies in the use of the EmOC services in different subgroups of women. The analysis of the available statistical information shows that:

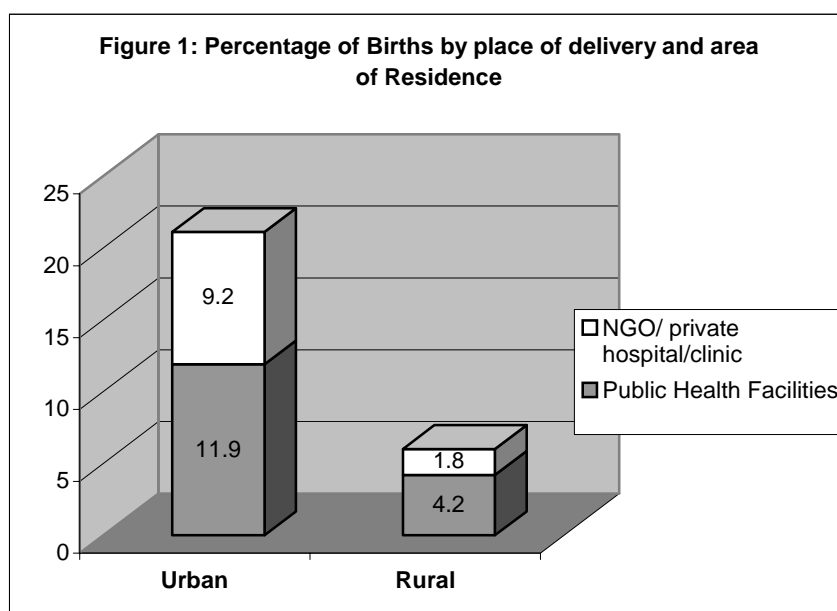
1. Fewer rural women have health facility based deliveries

Table 1: Delivery of children in a health center or hospital by area of residence

Year	National (%)	Urban (%)	Rural (%)
1997	6.2	28.1	3.8
1999	7.4	31.0	4.6
2000	7.8	29.0	5.4

Source: BBS⁵ and UNICEF, 2000; BBS and UNICEF, 1999; and BBS and UNICEF, 1997.

According to Table: 1 around 8% of the deliveries in Bangladesh during the 2000 survey occurred in health centers or hospitals. Deliveries in urban areas were almost 6 times more likely to occur in a facility than those in rural areas. Figure 1 show that the proportion of non-government services used in the urban areas is higher than in the rural areas.



2. Fewer uneducated / poor women deliver in a health facility

Women with higher educational attainment (which to a large extent is related to wealth) are more likely to deliver in a health facility. According to the BBS and UNICEF data, in the year 2000, 40% of the women

⁵ Bangladesh Bureau of Statistics

who read up to secondary or higher secondary levels had their children delivered in the health facility compared to only 2.8% of those that had received no schooling.

Once the urban and rural gap persists; in the rural areas a mere 2.3% of illiterate women delivered in health facilities compared to 10.4% of their urban counterparts. Women from households with the household wealth index 5 were 15 times more likely to have their children delivered in a health facility than those of household wealth index 1 (29.65% vs. 2.1%)⁶.

3. Fewer rural women have trained personnel assist them during delivery

In 2000, 47.7% pregnant women got trained assistance during delivery in the urban area where only 20.9% rural women got that opportunity. Births attended by appropriate health personnel (doctor, nurse, midwife or family welfare visitor) was 4% in case of illiterate mothers compared to a high 50.3% mothers having education at the SSC or HSC⁷ level or above.⁸ According to the 2002 data, 87% of women from households of household wealth index 1 did not have trained assistance during delivery compared to the 46.8% of women in households with household wealth index 5. But still the percentage is quite high in the wealthy households as well.⁹

4. Fewer rural women gets ante natal care

According to the 2002 data only 47.6% women received ante natal care. If ante natal care from health personnel is considered only 40.1% women availed it, while a further 4.7% availed care from skilled personnel such as health assistants, family welfare assistants, and trained traditional births attendants. Other 2.8% got care from untrained persons. 59.1% pregnant women living in urban areas availed ANC while only 36.1% rural women did so.¹⁰

5. Poor women are less likely to avail ante natal care service

In 2002, the percentage of pregnant women to avail antenatal care who had read up to secondary or higher levels was more than twice than of women who had received no education (56.4% vs. 25.8%). It was also more than three times more for at least three antenatal visits (41.8% vs. 10.9%) and making the first visit during the first trimester (28.3% vs. 8.4%).

The percentage of pregnant women to visit for ante natal care of households with household wealth index 5 was 2.75 times more than of women of household wealth index 1 (77.2% vs. 28%). The percentage was also five times more for women from households with wealth index 5 to visit for ante natal for at least three times (52% vs. 9.75%) and to visit during the first trimester (35.7% vs. 7.3%).

Chapter: 2

Government Commitments for Ensuring Health Rights of Women

Bangladesh is responsible towards the commitments it made to the international community as well as to the citizens regarding the conservation of all human rights including health rights.

2.1 Obligations Under International Declarations / Conventions / Treaties Bangladesh Ratified

Through ratifying the following treaties the Government becomes responsible for implementing the cause of each treaty and take proper action against every violation.

- Universal Declaration of Human Rights
- International Convention on the Elimination of All Forms of Racial Discrimination. 1979¹¹
- International Convention on Civil and Political Rights (ICCPR) 2000
- International Covenant on Economic, Social and Cultural Rights (ICESCR) 1998
- Declaration of Alma Ata 1975
- Convention on the Elimination of All Forms of Discriminations Against Women (CEDAW) 1984
- Optional protocol to CEDAW (2000)
- Convention on the rights of the Child (CRC) 1990

⁶ NIPORT and ORC Macro, 2002

⁷ Secondary School Certificate and Higher Secondary School Certificate

⁸ Data from BBS and UNICEF, 2000

⁹ Data from NIPORT and ORC Macro, 2002

¹⁰ NIPORT and ORC Macro, 2002

¹¹ Date of ratification

- ICPD Programme of Action. 1994
- Beijing Platform for Action. 1995
- United Nations Millennium Development Goals (MDG's) 2000
- Patient's Charter of Rights.

2.2 Commitments about Health Rights at the Regional Level

The South Asian Association for Regional Cooperation (SAARC) has a social charter, which the Government of Bangladesh abides by. In the Article IV.1 (on health) of this charter says: State parties re-affirm that they will strive to protect and promote health of the population of this region.

And clause no.4 of this article says:

Realizing that health issues are related to livelihood and tread issues which are influenced by international agreements and conventions, the State Parties agree to hold prior consultations on such issues and to make an effort to arrive at a coordinated stand on issues that relate to the health of their population.

2.3 Commitments about Health Rights at the National Level

The Section XV of the Constitution of the People's Republic of Bangladesh states that:

- a) "Food, Clothing, Shelter, Education and Medicare are the essential elements of life
- b)
- c) A person will have the right to enjoy reasonable amount of rest, recreation and leisure,
- d) A person will have the right to access governmental support to ensure his/her social security (i.e. during his/her unemployment, disability, widowhood, parentless ness, old age, or one or more of such phenomena)"

Section XVIII.1 of the Constitution of the People's Republic of Bangladesh states that:

"The state will consider it to be its prime obligation to ensure enhancement of nutrition level and public health of its citizens..."

There are several laws related to health rights. To ensure that the pregnant women receive proper rest and financial support from their employers there is the "Maternity Benefit Act" (Act IV of 1939). According to this act the women worker in any organization will get maternity leave and maternity benefit for a period of twelve weeks for every child birth.

To regulate the health system and practices of the health care providers there are several laws:

- Medical Practices and Private Clinics and Laboratories (regulation) Ordinance (Act IV of 1982)
- The Bangladesh Nursing Council Ordinance (Act LXI of 1983)
- The Public Health Ordinance (emergency provisions) [Act XXI of 1944]
- The Vaccination Act (Act V of 1880)
- The Dangerous Drug Act (Act II of 1930)

There are some other regulatory documents such as:

- The National Population Policy
- The Health Policy

Though these documents regulate the standard of health services to some extent, there are no specific laws to punish the service providers if a patient dies for their negligence or maltreatment. There are no specific laws to ensure proper and emergency care to pregnant women or to ensure the proper working condition for pregnant women.

2.3.1 Constitutional provisions or other national laws say about other rights relevant to the policy

To ensure equality in quality of life in the urban and rural areas (and therefore equality in healthcare facilities) the Constitution states in Section XVI:

"The State shall adopt effective measures to bring about a radical transformation in the rural areas through the promotion of an agricultural revolution, the provision of rural electrification, the development of cottage and other industries, and the improvement of education communications and

public health, in those areas, so as progressively to remove the disparity in the standards of living between the urban and rural areas.”

About the fundamental human rights the Constitution says in Section XXVIII:

- 1) “The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth.
- 2) Women shall have equal rights with men in all spheres of State and of public life.
- 3)
- 4) Nothing in this article shall prevent the State from making special provision in favour of women or children or for the advancement of any backward section of citizens.”

To eliminate the violence against women and provide social security to vulnerable women the country has such laws:

- The Orphanage and Widows Homes Act (Act III of 1944)
- The Dowry Prohibition Act (Act XXXV of 1980)
- Muslim Family Laws Ordinance, 1961 (as amended in 1982), which provides for increased punishment in cases of polygamy and divorce in violation of the statutory provisions.
- Child Marriage Restraint Act Amendment Ordinance, 1984, which rises the marriageable age for women from 16 to 18 years, and for men from 18 to 21 years. It also provides for punishment for marrying or giving in marriage of a child;
- Nari O Shishu Nirjaton Domon Shongshodhoni Aain* [The Revised Act to Stop Violence Against Women and Children] (Act XXX of 2003)

2.3.2 The Health and Population Sector Programme & National Health Policy

The Government adopted *The Health Policy* in the year 2000.

In this policy there are proposals for interventions aimed at both prevention and treatment of diseases and conditions affecting health. But the gender based perspective has not been used to develop it as it does not address the health related problems faced by women at various stages of life. Though it emphasize on maternal health care and nutrition of women and children, there is no proposal to ensure women’s health rights specifically or to prevent violence against women and offer medical-legal help to the sufferer. It is clear that the policy has not been developed keeping the life cycle approach to women’s health in mind.

In 1998 Bangladesh Government had launched the Health and Population Sector Programme (HPSP) to implement health related goals which ended in 2003. It had the “Safe Motherhood” as a separate and important component. It was the structural blueprint that guided the activities in health sector from 1998 to 2004. HPSP has been criticized for many failures and a new program has been developed to cover the gaps.

Currently the Health Nutrition and Population Sector Programme (HNPS) is being implemented. The goal of the HNPS is sustainable improvement of health, nutrition and family welfare status of the country’s population, especially the vulnerable, e.g., the poor, the women, the children and the elderly. The purpose will be to increase the availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package plus other selected services. Though this has not adopted a life-cycle approach to women’s health, it has particularly focused on women’s health and nutrition issues.

The Fifth Five Year Plan (FFYP) (1997-2002) of the Government was formulated in 1998 which completed a phased program to upgrade a network of 64 Maternal and Child Welfare Centers (MCWCs) with proper equipment and training of staff in EmOC so that these can offer a package of comprehensive maternal health service.

2.4 Government achievements so far

When the Government launched HPSP in 1998 a baseline service delivery survey was conducted by MoH&FW through CIET¹² -Canada in collaboration with NIPORT, NIPSOM and IEDCR¹³. Subsequent two cycles of SDS were conducted in 2000 and 2003 to measure progress. Over 25,000 households were surveyed in each cycle. The findings of the final report of the survey are surprising and frustrating at the same time. The main indicators used were:

1. % households rating service as 'good'
2. % households with unmet need for healthcare in last month
3. % households using service for treatment in last month
4. % treatment service users of Government services/ Private/NGO services/ Unqualified practitioners
5. % preventive service users who used government service
6. % users of government services with all medicines available.
7. Median waiting time (minutes)
8. % treatment service users with 'full explanation of condition'
9. % treatment service users who paid something for visit
10. % government service users who paid provider directly
11. Mean cost (Taka) of all service items (among those who paid)
12. % treatment service users satisfied with provider behaviour
13. % households with home visit in the last month
14. Contraceptive prevalence rate (modern methods) Antenatal care
15. Delivery care
16. % women who had post natal care visit

The proportion of households who rated government health and family planning services as "good" decreased significantly from 38% in 1999 to 10% in 2003. By contrast, the proportion of households who rated private and NGO services as "good" increased significantly from 25% in 2000 to 37% in 2003. In all three surveys, lack of good quality medicines was the problem with government services most commonly identified by the public.

In 1999 only 3% of households reported such unmet need, but this increased to 11% of households in 2000 and 9% of households in 2003. Households in 2003 were three times more likely to report unmet need for health care than households in 1999 and the increase was greater in rural communities.

The proportion of households who used government health and family planning services for treatment in the last month decreased from 13% in 1999 to 10% in 2003. In the same period, the proportion using private services (including unqualified practitioners) rose from 30% to 49%. In 2003 one in ten households visited a religious leader for health problems in the last month. The proportion of *service users* who visited unqualified practitioners for treatment increased from 52% in 2000 to 60% in 2003.

The average waiting time in government health facilities remained at 30 minutes from 2000 to 2003, longer than for private (20 minutes) or unqualified (5 minutes) services. The proportion of service users who received all the prescribed medicines from government facilities fell from 33% in 1999 to 20% in 2000, and remained 23% in 2003. The proportion of government service users who considered they got a full explanation of their condition fell from 50% in 2000 to 44% in 2003. The proportion of government service users with a full explanation of treatment stayed the same between 2000 and 2003 (54% and 55%).

Most users of government health services (80%) paid something in 2000, and 82% paid something in 2003. Some 20% reported direct payments to service providers in 2000, and 18% in 2003. Over 90% of users of private and unqualified practitioners for treatment were satisfied with the *providers' behaviour* in both 2000 and 2003. Only 66% of government services users were satisfied with providers' behaviour in 2000, and only 56% were satisfied in 2003. Government service users were less satisfied with the *overall service* than users of private or unqualified practitioners and the

¹² Community Information and Epidemiological Technologies (CIET)

¹³ National Institute of Preventive and Social Medicine (NIPSOM), National Institute for Population Research and Training, Institute of Epidemiology, Disease Control and Research (IEDCR)

proportion satisfied among them fell from 62% in 2000 to 54% in 2003 (similar to the level of 52% in 1999).

Excluding immunizations, only 2% of households had used government services for preventive purposes in the last month in 2000, and only 1% of households in 2003. Only a small proportion of users of health and family planning services used the services for preventive purposes (15% in 2003). Service users were generally satisfied with preventive services, both with providers' behaviour and with the overall service. In 2003 over 90% of users were satisfied, for all types of service provider.

Excluding visits related to immunizations, the proportion of households who had a home visit increased from 7% in 2000 to 11% in 2003. In 1999, 59% of women aged 15 to 49 years who gave birth to a child in the year preceding the survey went for antenatal care. The proportion attending for antenatal care was similar in 2003 (56%). Women who went for antenatal care were less likely to use government services in 2003 (63%) than in 1999 (79%).

Women themselves as the sole decision maker about attending antenatal care doubled in proportion from 1999 (19%) to 2003 (38%). Nine out of ten women delivered at home in 2003. Of those who delivered in facilities, the proportion using government facilities fell between 2000 and 2003 by 1%. Only 15-16% of deliveries were assisted by a trained worker (doctor, nurse, family welfare visitor) in 2000 and 2003. Only 4-5% of home births were attended by a trained worker in 2000 and 2003. Some 7% of women reported problems during their delivery in 2000 and 8% in 2003. Three quarters of the women who reported problems during delivery went for help, and half of them (55% in 2003) sought help from government services.

Certainly these findings are not very promising but according to ICET there is a problem about attributing changes in outcomes to the HPSP. There is no "control" group - a population who did not have the HPSP - for comparison. The decline in public perceptions of government health services between 1999 and 2003 might have happened anyway, if there had been no HPSP. Indeed, the decline might have been even steeper had there been no HPSP. On the other hand, the HPSP might have raised public expectations of improved services and when these were not quickly realized then the public became more dissatisfied.

The met need of EOC services is only 13%, moreover, people do not have much faith in Government services due to the maltreatment and negligence of the providers in the Government hospitals. Such a case¹⁴ related to eclampsia came to light during our field visit in Kolapara Upazila.

2.5 Other relevant national policies

The most important Government policy relevant to the policy under consideration is Poverty Reduction Strategy Paper (PRSP) the draft of which has been completed in December, 2004. PRSP expresses a particular goal to reduce maternal mortality rate by 75% by 2015 complying with the MDG and to ensure access to reproductive health services to all. As PRSP will be the key plan for the future development strategy and poverty reduction and will be the premier guideline for donors, it is absolutely necessary for it to have a pro-poor perspective in health sector also.

The HNP sector program is very much related to the National Strategy for Maternal Health, almost the directive force behind its proper implementation. In the HNPSP the key strategies proposed for reducing maternal mortality are:

Public Information Campaigns to raise awareness of problems during pregnancy, labour and the post-natal/neonatal period and obstetric complications. This will also address the need for better maternal and early childhood nutrition.

Jorina, the pregnant woman, had TT vaccines but the providers did not examine her blood or urine during pregnancy. In the date of delivery she developed serious convulsion but her family members gave her *pani pora* (holy water) and *tabiz* (holy pendant to prevent evil spirits) instead of taking her to the hospital. When the condition deteriorated, the relatives of the patient decided to take her to hospital. The mother of the patient said that the patient was brought to the UHC in a very serious convulsive stage of eclampsia and she had a stillbirth. But for the following month the doctors gave her treatment of Tetanus. When she was taken to the Barisal Divisional Medical College and Hospital (which is 6/7 hours journey by bus from Kolapara), the doctors declared that the patient had eclampsia and had been given wrong treatment which caused much damage to her condition.

¹⁴ The names used in the case study are fictive

Skilled Birth Attendants: Community based six month training on basic midwifery for community health workers (FWAs and female HAs) has already begun. The expansion/scaling up from the piloting Skilled Birth Attendant (SBA) Training to a national SBA training and Service Program up to the year 2010 has been agreed by the MoH&FW and will require funding.

Strengthening emergency obstetric services: There is a need to strengthen CEmOC at UHCs and MCWCs already serving as CEmOC centers and the increase the numbers of basic and comprehensive EOC to ensure that properly equipped and stuffed units are easily accessible in all parts of the country.

Health voucher programs: The idea is that pregnant women would be given vouchers to purchase antenatal, normal delivery and postnatal services from a designated provider of their choice for the first and second pregnancy. The Government with technical support from WHO has started a pilot program and DFID has expressed interest in expanding the scope of it.

2.6 Local, customary or religious laws that influence the health rights of women

The continuing low status of women in Bangladesh society and the low priority given to their health severely affect maternal and child health. Social and cultural changes are needed before the obstacles to seeking healthcare by women start to disappear. The main delay in taking a woman with obstetric complication such as eclampsia occurs at home. The following case study¹⁵ illustrates this fact.

According to UNICEF (UNICEF 1999) as many as 27 different types of superstitions have been identified in Bangladesh, which is harmful in achieving healthy and safe motherhood. These practices mostly involve restriction of mobility, consumption of adequate food and growth of the fetus. There are many more social practices, which take place during the actual time of child delivery. Some of these delivery-period practices are potentially harmful and are likely to contribute to post partum morbidity.

The common harmful practices during pregnancy and child delivery include:

- Internal manipulations and massage;
- Introduction of oils into vagina;
- Use of fundal pressure or tight abdominal bands during labour;
- Pulling on the umbilical cord;
- Choking or inducing vomiting in the mother to expedite placental delivery;
- Not using uterine massage to prevent and treat postpartum haemorrhage.
- The social taboo in some places on feeding the newborn with breast milk deprives the infant of much needed colostrums.

Mrufa, a pregnant woman of Kolapara Upazila developed edema at the third trimester of pregnancy. She did not take vaccine against Tetanus Toxoid as she was afraid of injection. She started to have waist-pain in the last month, to treat which the family members gave her holy water, "*pani pora*" from a religious healer. At the night of the second day of developing pain, convulsion started and the woman fainted. The family members then went to the village doctor (quack) who gave some medicine and suggested that the patient should be left alone in a dark room (certainly he suspected eclampsia). Though the patient regained sense after having the medicine, she again had convulsion within a few hours and fainted again. This was the third day of her developing pain. Her condition was same throughout that day. On the fourth day, the family member realized that her condition was serious and then they transferred her to the Kolapara Upazila Health Complex. The doctors operated the patient and her life along with her baby's life was saved. But due to the delay, the patient has developed several gynaecological complications and hernia.

In rural areas, the convulsion in pregnancy due to eclampsia or any other reason is seen as a result of attack by evil spirits and the patient is given holy water prepared by religious persons. This increases the delay in seeking emergency health care. Culturally, hospitalization of women is not considered important and pregnancy is not looked upon as a risky event. These perceptions lead to increased maternal mortality and morbidity rates.

There is a religious law in Bangladeshi society, which prevents people from birth control by establishing it as a sin. Abortion is also seen as a moral and religious sin. The religious perspective does not accept any right of women on her procreation and makes it mandatory for women to comply with the wishes regarding the reproductive process of the husband even if she doesn't feel up to it. The religious practice of *purdha* among Muslim women also discourages them and the family

¹⁵ The names used in the case study are fictive

members to go to the hospital where a male doctor may attend her delivery. It's seen as a violation of privacy and dignity.

Early marriage is another serious problem in Bangladesh, which some girls, as opposed to boys, must face. Child marriage robs a girl of her childhood-time necessary to develop physically, emotionally and psychologically. She is forced to enter into the procreation process, although physically she might not be fully developed. Health complications that result from early marriage include the risk of operative delivery, low weight and malnutrition resulting from frequent pregnancies and lactation in the period of life when the young mothers are themselves still growing.

In rural areas of Bangladesh, girls are married shortly after puberty and are expected to start having children immediately. Although the situation has improved since the early 1980s, in many areas the majority of girls less than 20 years of age are already married and having children. Early pregnancy can have harmful consequences for both young mothers and their babies. An additional health risk to young mothers is obstructed labour, which occurs when the baby's head is too big for the orifice of the mother. This provokes vesico-vaginal fistulas, especially when an untrained traditional birth attendant forces the baby's head out unduly. The average food intake of pregnant and lactating mothers is far below that of the average male. Cultural practices, including nutritional taboos, ensure that pregnant women are deprived of essential nutrients, and as a result they tend to suffer from iron and protein deficiencies.

Another economic reason, which perpetuates practice harmful to women's health and life, is dowry. In certain parts of Bangladesh the low status of girls has to be compensated for by the payment of a dowry by the parents of the girl to the husband at the time of marriage. This has resulted in a number of dowry crimes, including mental and physical torture, starvation, rape, and even the burning alive of women by their husbands and/or in-laws in cases where dowry payments are not met. This and other reasons are responsible for a high rate of violence against women especially household violence on pregnant women, which accounts for 14% of maternal death.

Chapter: 3
THE GOVERNMENT CAPACITY FOR IMPLEMENTING THE POLICY

FINANCIAL RESOURCES AVAILABLE FOR THE IMPLEMENTATION OF THE POLICY

3.1 The percentage of national budget allocated to health

The percentage of national budget allocated to health in the fiscal year 2003-2004 budget was 6.7% of the total budget (5.02% of revenue budget and 9.43% of development budget). The percentage allocated for health in fiscal year 2004-2005 is 6.5% of the national budget (4.77% of revenue budget and 9.16% of development budget). The data certainly shows a declining trend of allocation for health in the national budget, though the Government is consistently developing health sector development related plans.

From the Second National Health Accounts Survey (1999-2001) [Bangladesh National Health Accounts-2] we find that the Government expenditure on health per capita per annum is \$2.53, whereas the Development partner expenditure on health per capita per annum is \$1.46 and private expenditure on health per capita per annum is \$7.99. Total expenditure on health per capita per annum is \$12.16.

3.1.1 Part of the national budget and health budget coming from international cooperation

As per the budget for fiscal year 2004-'05, 3.29% of the expenditure is covered by foreign aid and 12.16% from foreign loan. The consolidated fund receipt by MoH&FW in the fiscal year 2004-'05 amounts for Taka 8,54,185 thousands. The percentage of development budget in MoH&FW budget for fiscal year 2004-'05 is 56.59% which was 64.99% in the revised budget of 2003-2004.

Source of Financing in Healthcare Sector in Bangladesh

Source	Percentage
Private households	63
MOHFW Budget	31
Non profit, NGOs, Donors	3
Other public revenue	3
Firms and private insurance	0.04

Source: Bangladesh National Health Accounts, 1996-97.

3.1.2 Government priorities within health budget

MoH&FW spending under HPSP has emphasized spending on the Essential Service Package delivered at the Upazila level and below. The total budget of HPSP amounted for \$3,373.20 million among which ESP (delivery including overhead) accounted for an estimated 70% of MoH&FW expenditures from both revenue and development budgets. In the year 1998-'99, 60% of the yearly budget was implemented on ESP services of which maternal health accounted for 14%, family planning 25%, other reproductive health services 2% (total 41% on maternal and reproductive health and family planning), child health 31%, communicable disease control 9% and behaviour change and communication 3%.

In 2000-'01 ESP expenditures (revenue and development combined), 41% went to reproductive health including family planning, 40% to child health, 14% to limited curative care, and only 1% and 4% respectively to communicable disease control and behaviour change communication (BCC).

The emergency obstetric care is a sub sector of reproductive health care so it gets only a fragment of the mentioned 41%. Analyzing the budgetary distribution of the year 1998-'99 we find that the same percentage has been spent for reproductive health and family planning from which a probable conclusion can be drawn that the percentage spent in maternal health would be almost same in 2001-'02. Moreover, BCC is most necessary to ensure good ante natal care at home, to generate women friendly atmosphere among family members and to make them understand the importance of proper and timely use of health care services in this regard. But it got only 4% share in the budget.

In MoH&FW spending 6.9% of the budget is allocated to reproductive health and safe motherhood related projects in 2004-'05 budget which was 10.49% in 2003-'04 revised budget. Only 1.37% of the budget allocated to reproductive and maternal health is provided by the Government in 2004-'05 (0.42 crore in 30.52 crore) and only 1.04% of it was provided by the Government in 2003-'04 according to the revised budget.

3.1.3 Health budget trend

During the five-year period up to 2001/02, Total Health Expenditure (THE) has kept pace with GDP growth. However, growth in the volume of Health, Nutrition and Population (HNP) services and in the resources provided by the public sector has fallen consistently behind the Total Health Expenditure and GDP growth rates. According to the Bangladesh National Health Accounts 1999-2000 the share of state services and resources provided by the public sector declined from 32.6 percent of THE in 1996-97 to 26.2% in 2001-2002. Provisions by the MoH&FW as such similarly declined from 27.6% to 24.3% of the Total Health Expenditure in 2001-'02.

3.2 Health and health care facilities, goods and services and programs for the implementation of the policy

Most of the country's health infrastructure and health service system are under the government's management and control. At the local level, 3275 Union Health and Family Welfare Centers (UHFWCs) exist to serve the 4,470 unions. Additionally there are Upazila Health Complexes with 31 beds in 402 Upazilas, 59 district hospitals, 13 government Medical College (MC) hospitals, 6 postgraduate hospitals and 25 specialized hospitals. There are also a further 64 Maternal and Child Welfare Centers (MCWCs) established to provide maternal services at the district level and some upazilas (MOH&FW 2000). Under HPSP the government took an initiative to construct a Community Clinic (CC, 11500) at the village level for every six thousand population.

The health service delivery system in the public sector is divided into primary, secondary and tertiary levels. The following table provides the summary of the level of care and type of facilities available at every level of public administration in the country.

Table: Level of care and type of health facility

Level of care	Administrative unit	Health facility
Tertiary level	Division or national/capital	Teaching hospital/ institute (16), 250-1050 beds each
Secondary level	District	District Hospital (59), 50-150 beds each
Primary level	Upazila	Upazila Health Complex (402), 31 beds each Maternal and Child Welfare Centers (55) 10 beds each
	Union	Union Health and Family Welfare Centers (3275)

Source: DGHS, 2005.

According to UNICEF data of 2002, Comprehensive EOC is available in all teaching hospitals, 60% of the district hospitals, 27% of the MCWCs and in 131 THCs (also known as upazila health complex). There is certainly need of expansion of the EOC services as the GOB EOC facilities satisfy only 27% of the minimum need of Comprehensive and about 15.5% of the minimum requirement of Basic EOC facilities. But even the established structures and facilities are not properly utilized.

Under the "Women's Right to Health and Life", UNICEF established Comprehensive EmOC functions in 190 facilities through facility based micro planning, training and placement of medical officers trained in obstetric and anaesthesiology and EmOC training for nurses; and procurement and installation of critical instruments. But the current overview of the project shows that only 215 of the total 190 facilities are performing at the expected level of CEmOC. Of the remaining, 55 (4 DH and 51 UHC) are providing Basic EmOC. In this context it is more necessary to make the existing facilities functional and make EmOC services available at all potential public facilities.

3.2.1 Staff involved in implementing the policy or related programs

The existing ratio of medical and paramedical service providers and population is as follows:

▪ Total number of MBBS Doctors	26602
▪ Persons per hospital bed	3307
▪ Persons per physician	4915
▪ Population per nurse	8879

The number of personnel trained in EmOC through the joint initiative of UNICEF and Bangladesh Government till December 2004 are:

- 136 medical officers trained in obstetrics
- 117 medical officers trained in anaesthesia
- 488 nurses – on safe delivery
- 186 lab technicians – on blood transfusion

In addition

- 265 doctors and nurse have been trained on management of violence against women
- 143 UHFPO's (upazila health and family planning officer) and RMO's (Residential medical officer's) have been provided competency based training for EmOC
- 106 doctors and nurses have had special training (Ventose, safe delivery)
- Gender sensitization for 84 personnel
- Initiating transformation participated by 69 personnel
- Self esteem training for 57 participants

The aim of this project was to build the capacity of 190 teams comprising of 1 obstetrician, 1 anesthesiologist, 3 nurses and 1 lab-technician for comprehensive EOC and a pool to ensure that UHC has at least one medical officer and two nurses trained in Basic EOC. But while team training was attempted, it has not been possible in all cases due to differences in numbers and availability of personnel interested in training.

In Bangladesh more than 90 percent deliveries take place at home mostly attended by women living in the neighbourhood called *Dai* or Traditional Birth Attendants. The Government initiated TBA training program in late 70s with an ultimate goal of providing one trained TBA for each of the 68,000 villages. However, contrary to the expectations no significant decline in maternal mortality occurred. Moreover, several studies showed that the trained TBAs were not attending predicted proportion of deliveries in the communities; recently. Government had abandoned the TBA training as they were not found to be effective.

Ministry of Health and Family Welfare piloted a six-month competency based Skilled Birth Attendant (SBA- at a level of auxiliary midwife) training programme in 6 districts from March 2003 to August 2003. WHO and UNFPA Bangladesh provided the technical and financial support while Obstetrical and Gynaecological Society of Bangladesh (OGSB) provided the technical assistance. Ninety basic health workers (FWA and Female Health Assistants) were trained at district level in selected essential midwifery skills and abilities (WHO 2004) with training curriculum/manuals enabling them to provide antenatal care, conduct normal home delivery, post natal care and newborn care and also to early identify and refer obstetric complications at community level. FWA and FHAs having minimum SSC with ≥ 2 years experience in basic or family welfare health services and residing in the place of posting were selected for the training. The trainees were evaluated through examinations and certified and registered by Bangladesh Nursing council as Skilled Birth Attendants (SBA, community auxiliary midwife). The evaluation of the pilot program showed that the SBAs are already contributing to 29 percent of the deliveries, 52 percent of the ANCs and 44 percent of the PNCs performed. An SBA is performing 3-4 deliveries per month which could easily be raised to 5 to 6 with further strengthening of the field program. MoHFW already decided to scale up the training programme and also simultaneously provided importance to establish supervisory mechanism and accreditation system of the training programme which is in process.

The Family Welfare Visitors are the female paramedics in the national program. One FWV is posted in each union. They are also posted in the Maternal and Child Welfare Centers (MCWC) and the Maternal and Child Health (MCH) unit of the Upazila hospitals. They are involved in providing antenatal check-ups and in conducting normal deliveries, besides providing curative treatment and contraceptives. The SSC pass trainees undergo an 18-months training course in 12 FWV Training Institutes. On completion of the training they receive midwifery registration from the Nursing Council.

Medical Assistants (MAs) receive a four-year course that provides training to SSC graduates in basic healthcare, EPI, anti-natal, post natal and intra-natal care, childhood illness, and general health services. The Director General of Health Services (DGHS) is responsible for delivering this training service through 8 institutes.

In the non-government sector, Bangladesh Red Crescent Society is providing a one-year program on midwifery training. This training is mainly related to delivery, antenatal, intra-natal and postnatal care.

There is severe lack of health care providers (especially personnel trained in EOC) at the primary and secondary level hospitals, which limits its capacity to provide effective health care. Doctors do not want to remain at the remote areas as they lose in competition with others in the urban area and are not able to develop their carrier. In many places their quarters are almost ruined and unliveable. There is also lack of social security, which makes the lady doctors shrink from the idea of posting in rural areas. The lack of female physicians is a major cause for the women's' not coming to the facilities. The patient and the family do not like the idea of a male doctor's examining her. They take it as a violation of privacy and dignity.

The Government does not provide any allowance to compensate the problems doctors face. The Government doesn't even provide minimum social facilities (good schools for children, good quarters for living, society to mix with, occupation for wives etc.).The doctors do not even get equal chances to flourish their career due to political reasons. The doctors don't get any non-practicing allowance and their pay is very poor to sustain a family. So, the doctors practice privately whenever they get chance, even neglecting their duties. If they would get such compensation, the Government will be able to be tougher on their marinating the service rules and will be able to get much more effective service from the service providers.

3.3 FACTORS LIMITING THE IMPLEMENTATION CAPACITY

3.3.1 Cultural, religious, social, environmental and other factors

In the three delays model widely used in policies related to safe motherhood in Bangladesh, the first and in most cases the major delay is in decision making at home which eventually leads to delay in transportation and getting treatment in emergencies. The main cause behind this is the general social discrimination of women. Women are generally viewed as economically non-potential and so any investment on them is seen as wastage.

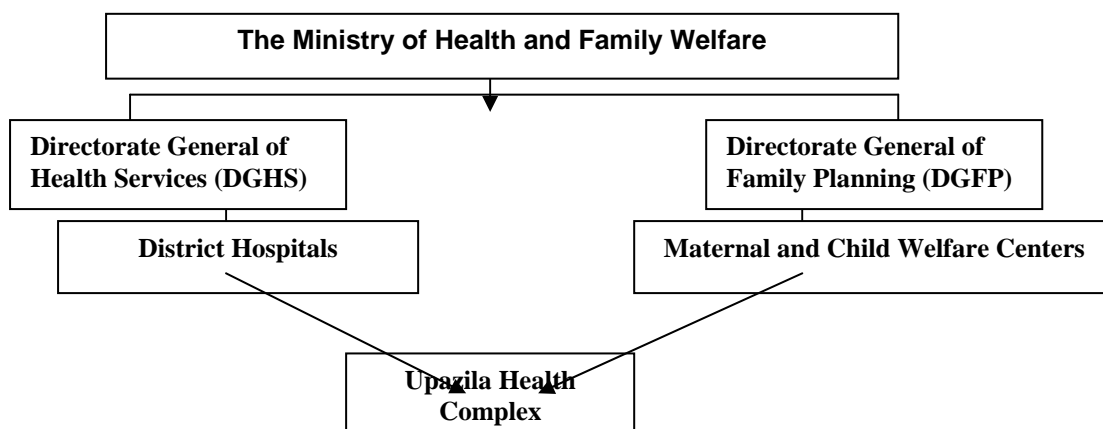
Women are malnourished; less educated, less empowered and get least share of resources and services as a result. The safe motherhood program cannot succeed if the danger to a women's life is not viewed as a matter of concern; if the spending on hospitalization of women is concerned as wastage of resources. Moreover, the religious, cultural and social attitude towards pregnancy and reproductive health of women as discussed in chapter 2, suggests that a profound change in attitude is needed to make the policy successful.

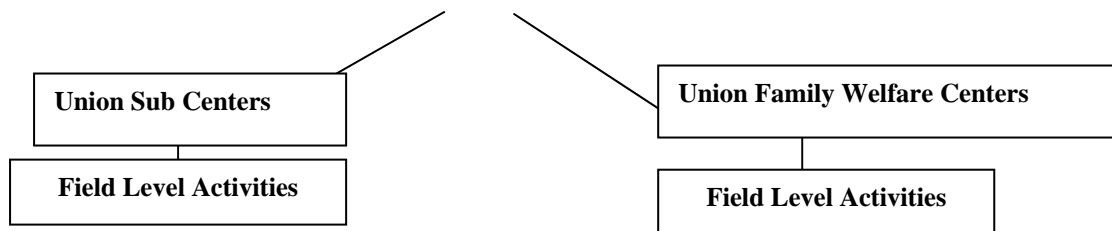
Among the environmental factors, we found that geographical distance and communication to the facilities largely determine the maternal death and obstetric complication rate. The case fatality rate is higher in those areas where communication is difficult. It is also difficult to spread awareness in these areas about using EmOC facilities. Special programs are needed for these areas.

3.3.2 Structural reform or adjustments that influence the implementation of the policy

As a state Bangladesh is not currently under any structural reform or crisis that may influence the implementation of the policy. The health sector went through a reform under the Health and Population Sector Program (HPSP). The Ministry of Health and Family Welfare (MOHFW) is responsible for health policy formulation, planning and decision making at the macro level. Under MOHFW, there are two implementation arms: the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP).

The present health structure of Bangladesh is as follows:





The DGHS is responsible for implementation of all health programs and providing technical guidance to the Ministry. The DGFP is responsible for implementing Family Planning (FP) programs and providing FP related technical assistance to the MoH&FW. Field level observations revealed that the FP service delivery is very poor at all levels and thoroughly neglected at the grassroots. The DGFP is well provided with staffs (three times more than DGHS almost) and has trained service providers even in the Union level FWCs, but these facilities are mostly non-functional, which affect proper ante-natal and post-natal care of pregnant women and quick referral of obstetric emergency cases like eclampsia.

Under HPSP the separate directorates of DGHS and DGFP were merged together to promote a sector wide approach in health care to provide one-stop service to people. This disrupted the chain of command; the Upazila Family Planning Officer became financial manager while the responsibility for human resources management relied on Upazila Health and Family Planning Officer. There were conflicting orders regarding the management of cases of ANC, safe delivery, referral, obstetric emergencies etc. The whole program suffered from non-cooperation between the staff of the DGHS and DGFP, which made the sector wide approach difficult to execute.

One other point of HPSP was that it limited the door-to-door services provided by the FWAs and Health Visitors and made community clinics, one for 6000 people, to provide regular health services and EPI services. These clinics even had provisions for normal delivery. But this endeavour failed inter-departmental conflicts. HNPSP promoted the door-to-door service again but on a smaller scale than before.

As HPSP ended in 2003, the two directorates has been separated. This puts the 3275 Union Health and Family Welfare Centers (UHFWCs) under the DGFP, which are the grassroots center to spread awareness, provide ANC, do normal delivery, provide PNC and immunize the mothers and children. On the other hand the management of crisis remains in the hands of Government doctors in the hospitals.

3.3.3 Lack of coherence between the policies and programs

The Government seems to give priorities to maternal health care and safe motherhood and has launched several ambitious programs (i.e. the health voucher) to achieve the goals. But as we have discussed earlier, the main source of funding for these programs is foreign aid. Only the Government provides a negligible portion. This puts the chance of sustainability of these programs in questions.

Moreover, the policies focus on establishing EmOC facilities and to train personnel to handle those. But a plan of providing a complete team of personnel to all the EmOCs and provide infrastructural support to use and maintain the equipments of EOC is absent. Many EOCs are not functional at present because of the lack of anaesthesiologists/doctors trained in caesarean section and in some due to the infrastructural problems like irregular supply of electricity.

3.3.4 Governments' political will to implement the policy

The Government certainly seems to have strong political will to implement the policies. A separate wing in the DGHS has been created to monitor the EOC services and run different programs related to safe motherhood. But the Government spending on health and on reproductive health in particular seems to be so low that the intention could be easily questioned as to whether this priority to maternal health is due the pressure to fulfil the MDGs; because otherwise getting foreign aid will be difficult. There are several other facts, which trigger this doubt:

- ❑ Though the commitment to ensure safe motherhood in present at the ministerial or secretarial levels it does not seem to be conveyed down the chain.

- ❑ The DGHS or DGFP do not effectively monitor the quality of services provided at the delivery points, neither have they seemed to bother about making the service providers accountable.
- ❑ The Government does not have any law to incriminate the providers whose negligence may be responsible for maternal morbidity and death.

Chapter: 4 **THE IMPACT ON HUMAN RIGHTS**

In this chapter we will focus on the ways health rights are affected through problems in implementation of the policies and programs related to safe motherhood. Violations of these rights endanger women with life threatening obstetric complications like eclampsia which may cause maternal and/or child morbidity and/or death.

4.1 The right to get timely and appropriate health care

Above all the met need of EOC facilities is still very low (13% on average) indicating the need of expansion of the facilities. EOC services are provided in all medical college hospitals, 88.2% District hospitals, 44.1% UHCs and 46.8% MCWCs. Though there are grassroots level facilities called Union Health and Family Welfare Centers that provide ANC and immunization facilities to patient and are supposed to do normal deliveries, none of these have trained personnel or relevant instruments to tackle obstetric complications, not even the necessary life saving medicines. So, the patients have to go to the district hospitals or MCWCs (also located in the district headquarter), which may be a day's journey from the remotest villages and in some cases, the transportation is also bad. This physical distance and also the mental anxiety of travelling to the unknown health facilities have negative effect on the patient and her family. The policy doesn't discuss these issues and does not provide any suggestion to improve it.

In most cases the Upazila Health Complex doesn't have enough doctors or nurses to fill up the sanctioned posts, which affect the quality of health care service provided. The doctors and nurses are over burdened with work and obviously they cannot provide 24 hours service which increases the delay in getting treatment for emergency patients, especially who come at night. There is also lack of monitoring of service provided so the providers neglect their duties some times (i.e. the doctors are not very willing to come to the hospital at night even for emergency cases, the nurses do not observe the condition of patients duly etc.). From field level finding in the Kolapara Upazila of Potuakhali district of Bangladesh, we found a case where the nurses of the UHC did not observe the patient properly even when she was admitted with intense labour. The local FWA, also a neighbour of the patient, had to wake the nurses up when she felt the head of the child was almost coming out.

To ensure proper and timely care for all pregnant women, it is most important to provide them with good quality care at home. Due to several factors discussed above as well as the cultural practices in Bangladesh women do not feel encouraged to go to the hospital. So, it will be more fruitful produce skilled personnel to provide them with ANC, skilled attendance at normal delivery and PNC. Ensuring good quality ANC should also prompt referral to reduce the fatal delay to take emergency patients to the hospital.

4.2 Lack of relevant determinants that hamper the implementation of the policy

The lack of determinants like proper sanitation facilities in the hospital, supply of good quality food in the hospital, cleanliness, proper renovation of hospital building, proper supply of electricity to keep the

emergency equipments running, well trained and complete group of personnel to run effective EOC services, properly equipped and well maintained EOC facilities, proper supply of life saving drugs etc. certainly hamper effective implementation of the policy.

The overall picture of the UHCs in Bangladesh is very disappointing. For example, in the Pathorghata UHC in Borguna district, the sanitary system of the hospital and the building itself is completely ruined and dangerous for patients to live in. The Kolapara UHC also has problems with sanitary systems. Doctors complained that the generator of the hospital doesn't work making it difficult and dangerous to perform caesarean section as the OT¹⁶ light goes off in the frequent power failure. Patients complained about the diet provided in the hospital.

Though the policy expresses high ambitions to improve the quality of women's lives, it does not address the issue of social subjugation of women (specially the poor, non-educated and rural women), which hamper timely and proper health care, and how that can be addressed.

4.3 Lack of participation of the client group in development and/or implementation of the "Bangladesh National Strategy for Maternal Health"

Women of Bangladesh and their families have many reservations, cultural norms and superstitions guiding their health seeking behaviour. To change the attitude of people and to make them prompt in decision making in case of obstetric emergencies awareness programs are being run. But the dissemination of knowledge is most one way. The problems and demands of the patients or their families are not taken into account. There has not been much public discussion or participation in the development of the policy. Mostly health care providers and persons related to health administration were consulted. The similar personnel are involved in the implementation of the policy. There is no scope for participation of service seekers in the implementation of the policy. Moreover, different mode of the program is necessary for different cultural settings and type of people. As the FWAs and SBAs are not prepared to take these issues into account, they largely fail to convince people to take ANC and go to the hospital when they observe one or more of the five danger signs of pregnancy including signs of pre-eclampsia.

4.4 Violence Against Women

Domestic violence on women is an important factor in maternal death or morbidity. Bangladesh Government has formed detailed laws to prevent violence against women (VAW) and there is a separate Family Court for the cases of domestic violence. The Government prioritizes VAW cases and has given order that such cases will have to be solved within shortest possible time. But the Government does not have effective measures to overcome attitudes, customs and practices that perpetuate violence women. Moreover, the commitment towards this issue remains only in paper but the Government officials related to it are not at all motivated. The issue of VAW need proper collaboration between the medical, judiciary and police departments which is largely absent in Bangladesh.

4.5 Accessibility of Services, Goods and Facilities

The health care facilities are more or less physically accessible as there are Health and Family Welfare Centers at the Union level and Health Sub Centers in some Unions. But the EmOC or basic EOC services are not provided in these so that is less accessible and even more so in geographically remote (hills, islands etc.) areas. Among total 406 UHC only 120 have EOC facilities at present. But the main factors affecting accessibility is the attitude of family members towards getting EOC services causing delays to take decision to move the patient to hospital or to get help from trained personnel, and the lack of convenient transportation to move the patient to hospitals in good time. Moreover there is no structured referral system and the doctors in the hospitals do not take references from the FWVs seriously. This negligence increases the fatal delay in getting proper treatment.

As per the Government system the services related to safe motherhood are affordable and the Government has started the health voucher program to increase affordability and make the services popular to people. But there is system loss which affects affordability. The doctors, FWVs, nurses and Health Assistants take extra charges to attend normal delivery and in more (including the anesthesiologist) for the caesarean section. Moreover, patients almost never get free medicines from the hospital. Buying costly medicines from the pharmacists make the services more costly.

¹⁶ Operation theatre

Regarding the accessibility of information, there is certainly a gap. Though the FWVs and Health Visitors are to aware and convince people to come to the facilities for health care and safe birth, they are not very keen to do so as that may hamper the private cases they handle at village level (which is not permitted by Government).

The Government is trying to increase the number of properly functioning EOC facilities and has taken several programs in that regard. But there is a need of a definite strategy to keep the present facilities running properly and monitor the quality of service provided. A strong monitoring system involving the local service seekers is needed to be established.

4.6 Discriminatory effect

The health system in Bangladesh as a whole function in such a way that Government facilities affect the aware, urban, educated and richer portion of the population. The main disparity is in health care services provided to urban and rural people. According to the data provided in a seminar on 'Health Rights Situation in Bangladesh' arranged by Population Services and Training Center, Bangladesh, the speakers said that 60% of people have no access to health care.

4.7 Gaps that Hamper Proper Improvement of Health Condition

- The Government has been unable to ensure that at least a good percentage of women with obstetric complications, specially eclampsia, get timely and proper treatment. The met need of EOC services is still 13% only.
- It has failed to ensure proper ante natal care that can prevent eclampsia to a great degree. The FP sector of the Government has failed to provide good ante and post natal care to reduce cases of morbidity. It is largely in the hands of the FWAs to provide door-to-door services including ANC to pregnant women. The FWAs are trained to refer patients with one of the five danger signs of pregnancy to hospital in due time. But due to those being almost non-functional, the job of providing ANC and PNC is being carried out by the Health Assistants only (who are under the DGHS) and the coverage is very low. Most of the FWCs, which are responsible for providing care in normal delivery at the Union level, are found closed and non-functional during field visits.
- There is lack of trained personnel and the human resource is not properly distributed to all facilities, which affect the proper functioning of EOCs in the Upazila Health Complexes (local level health facilities).
- The govt. health care service monitoring mechanism is mostly inactive.
- High rate of absenteeism especially in the rural areas. (Among 9 sanctioned posts for doctors in the Upazila Health Complexes, only 2 are filled on an average.)
- Our field level findings indicate that the providers at govt. hospitals are reluctant to increase the quality of services; they are keener towards their private practice.
- ⊕ Grassroots level people do not have proper information about where they can get treatment and which facilities they are entitled to.
- ⊕ The EOC equipments and medicines are not properly maintained and used. In many cases there are other problems in hospital infrastructure that hampers proper use of the machines.
- Though the Family Welfare Centers (grass root level health & family planning facility) at the unions are said to be able to perform normal delivery, but it does not peruse any such task the lack of initiative from the Family Welfare Visitors being mostly responsible.
- ⊕ It has failed to increase people's faith in Government facilities and promote information about the availability and importance of EOC services which causes delay in moving the patient to EOC facilities increasing the life-threatening danger of patients with eclampsia/pre-eclampsia.

- The main target group of the concerning policy are women, more specifically, pregnant women. But they don't have any way to contribute in the implementation of the policy.
- The policy does not provide any active mechanism to account people's complaints. Though there is a Government committee for monitoring the health services in general (UHAC) in most places it is non-functional or cannot function properly due to lack of political will and misuse of political patron ship.
- There is a severe lack of up-to-date and disaggregated data on health conditions and service delivery. Most of the data collected in the past was not from a right based perspective.

Chapter: 5 **Recommendations**

There have been several reviews and surveys on the health care delivery system in the Government facilities and its impact on the health seeking behaviour of people. The recommendations that came up in the Service Delivery Survey (2003) conducted by Community Information & Epidemiological Technologies (CIET) match our findings to some extent. These are as follows:

1. Strengthen *upazila* health advisory committees

Active health committees in *upazilas* should improve public perceptions of government health and family planning services.

2. Increase user-friendliness of facilities (like examination screens and separate toilets for women)

Even though only a small proportion of households use government treatment services, the experience of these service users seems to affect public perceptions of the health services.

3. Reintroduce training for unqualified practitioners

As the most common source of primary care, unqualified practitioners cannot be ignored. Training should emphasize referral to qualified practitioners as necessary. [This has been implemented. We have found newly trained Skilled Birth Attendants at work during fieldwork.]

4. Open dialogue with doctors about unqualified practitioners

Unqualified practitioners can and should refer to qualified practitioners. The referral procedures can be worked out with the doctors, as part of their being included in discussions about policy.

5. Give explanations of condition and treatment to service users

Patients are not satisfied with government health and family planning services because they do not feel they are treated well. This is epitomized by their feeling of not having adequate explanations.

6. Reduce system leakage of medicines and manage expectations of therapy

A combination of these two strategies, which must go together, will increase availability and perception of availability of essential drugs.

7. Reduce waiting time

Management of patient flows is an issue worldwide. A number of strategies are possible. For example, triage can designate priorities (and inform patients of their status) and group appointments for chronic diseases (e.g. hypertensive attend on Monday afternoons) can relieve congestion and manage expectations.

8. Implement the Patients' Charter

Beginning with consultations with the medical profession, this tool can provide a basis for improved care, and a clearer understanding of patient entitlements.

9. Introduce a providers' charter

Beginning with consultations, the existing version of this charter can be revisited and redeveloped as a step towards including service workers in policy development.

10. Right to information on prevention

A carefully crafted and appropriately financed communication strategy should inform citizens of their rights to and the benefits of prevention services.

11. Implement real pro-poor strategies

These rest on two pillars: (a) improved interaction between service workers and the very poor and (b) reduction of system leakage that affects the poor disproportionately.

WE PROPOSE TO ADD THE FOLLOWING WITH THE ABOVE RECOMMENDATIONS:

- **Activate the accountability mechanism** for the health service providers in which the grassroots level service seeker may participate. [The Government can activate the 'Stakeholder Committee' formed during HPSP and proposed in HNPSP]
- As the greater portion of women give birth at home and prefer it culturally, it is more important to **ensure trained care at home** than to motivate them to come to health facilities. The Government facilities cannot provide all pregnant women anyway. So, if trained care is available from the ante-natal stage and an effective referral linkage can be established, then the proper management of eclampsia and other obstetric emergencies will become easier. Moreover, it will ensure safe childbirth and post natal care at home.
- **The traditional birth attendants should be included in the SBA training** through a screening procedure and the educational requirement may be lessened for them. As they have an established good will in their area, the training they get will reach the grassroots households.
- **Activate facilities in the FWCs to attend normal delivery** and empowering the providers to provide at least the first aid to patients with obstetric complications when possible.
- **Introduce an effective referral system** to ensure proper detection and time transfer of the complicated cases to the hospital in due time.
- **Address the physical and infrastructural problems of the facilities** hampering the proper functioning of the EOC equipments and services. [Proper electricity supply, well maintained building, proper sanitation facilities etc]
- **Introduce emergency health care during natural disasters** to handle pregnant women, child birth and obstetric complications.
- **Increase the number of trained personnel to run the EOCs and their proper distribution** to all facilities.
- **Introduce a nation wide awareness building program** to increase people's knowledge and change their attitude about the importance of seeking proper and trained care for pregnant women.
- **Introduce laws to incriminate providers** whose negligence causes maltreatment, morbidity and death.
- **Introduce cheap and fast means of transportation** in the FWCs for the emergency patient referred to UHCs.
- **Introduce laws of non-discrimination for women** and include domestic violence in the *Nari O Shishu Nirjaton Domon Ain* to ensure that such cases are solved with priority.

Annex: 1 List of Abbreviations

ANC : Ante Natal Care

CEmOC	:	Comprehensive Emergency Obstetrical Care
EmOC	:	Emergency Obstetrical Care
EOC	:	Essential Obstetrical Care
FPI	:	Family Planning Inspector
FWA	:	Family Welfare Assistant
FWV	:	Family Welfare Visitor
MCWC	:	Maternal and Child Welfare Center
MMR	:	Maternal Mortality Ratio
MO	:	Medical Officer
MoH&FW	:	Ministry of Health and Family Welfare
PNC	:	Post Natal Care
RMO	:	Residential Medical Officer
SBA	:	Skilled Birth Attendants
TBA	:	Traditional Birth Attendants
UH & FWC	:	Union Health and Family Welfare Center [used as FWC in the text]
UHC	:	Upazila Health Complex
UHFPO:		Upazila Health and Family Planning Officer
UMIS	:	Unified Management Information System

Annex: 2
Literature Review: HeRWAI

■ ***Policy Relevant Documents***

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6. **HNP Strategic Investment Plan: July2003-June-2010**, Planning Wing, MoHFW, 2004.
7. **National Health Policy**, MoHFW, Govt. of Bangladesh, 2000.
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9. **Women's Right to Life and Health**, Govt. of Bangladesh UNICEF & Columbia University, 1999.
- **Documents of Data Relevant for Advocacy**
12. **Annual Budget (2003-04, 2004-05)**, Ministry of Finance.
13. **Consolidate Fund Receipt 2004-05**, Ministry of Finance.
14. **Statistical Year Book of Bangladesh**. BBS, 2000.
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30. **Safe Motherhood (Issue-29)**. WHO Newsletter, 2002.
31. **Safe Motherhood Information Kit**. UNICEF.
32. **The Averting Maternal Death and Disability Program: Improving the availability, quality and use of emergency obstetric care in developing countries**. Columbia University, 2003.
33. **The Voice of UMIS (Issue 2 & 3)** DGHS, Dhaka, 2003.
34. **Women's Rights to Life and Health: Annual Report- 2002**. GOB, UNICEF and AMDD.

35. Internet resources on international treaties, country reports, MDGs etc.

Annex: 3 Field Based Findings

The field work included semi-structured interviews, Focused Group Discussions, and case studies. Four facilities have been visited among which one is run through public-private partnership, and the other three are Government facilities. Among these Government facilities NGOs working on health rights have influences on the Kolapara Upazila Health Complex and the Potukhali District Hospital, whereas the UHC at Sirajdikhan do not have any outside influence and the differences in the performance level of these two types are indeed remarkable. Here is a summarized form of our findings.

Focus Group Discussion – 1

Place: Dholpur (Jatrabari, Dhaka) Maternity Center and One Satellite Clinic under the UPHCP program of GOB, run by BWHC.

Date: 31st March, 2005.

Participants: The project director, Clinic Manager and Doctor, Paramedics, Outreach workers, Traditional Birth Attendants.

Principle Findings

- ❑ The Urban Primary Health Care project is a format provided Government of Bangladesh and run through the joint collaboration of LGRD ministry and NGOs. This is an initiative to try out public-private partnership in the health sector. This project is funded by Asian Development Bank.
- ❑ This project tends to offer quality health care for the urban poor who have been neglected by the present health structure of our country which focuses on providing care to the remotest villages.
- ❑ Under this project the city is divided into areas, which are divided into wards and specific health care settings are provided for each group.
- ❑ The Dholpur Maternity Center is one of the centers established for every ten Lac population. There are several satellite clinics under this Maternity Center and some outreach centers that provide EPI and ANC services. There are also door-to-door visitors who provide advises and referral linkages to the patient.
- ❑ The Maternity Center has every facility to treat Eclampsia and does so when situation arises. Though it doesn't have any blood bank, relatives of the patient donate blood if necessary and there is arrangement for cross-matching in the clinic. The clinic has separate silent and dark room for eclampsia patients. The project manager informed us that serious cases of eclampsia i.e. in which there is a chance of renal failure, heart failure; are sent to Dhaka medical hospital.
- ❑ By talking to the clinic manager and the project manager, it became apparent that Government has definite target to prevent maternal death and Government hospitals up to district level has arrangements to treat eclampsia i.e. separate room, emergency drugs, options for caesarean section. But the problem is in the implementation level.
- ❑ The project manager said that though Government always emphasize three delays in a. decide to seek care, b. reach medical facility, c. receive adequate treatment; but there are no arrangements at the remotest spot to minimize these delays. She mentioned that there are Family Welfare Centers at the union level which has provisions for delivery i.e. a 24 hours paramedic who live in the quarter provided there, equipments, medicines etc. In these centers there should be arrangements to transfer the eclampsia patients quickly to the Upazila Hospital.
- ❑ Regarding delays in receiving adequate treatment, the main dilemma is around issuing orders. In cases of eclampsia, time is very crucial, but as there are two separate wings of family

planning and health under separate authorities, the decision of admission and treatment becomes delayed. But once the doctors get a chance to treat the patient, they usually succeed.

- ❑ The program manager suggested that the traditional birth attendants do much harm to pregnant patients. They ask the patient to try to force the baby out when the cervix has not been properly dilated. This results in prolapse and other fatal morbidities in the woman and child.
- ❑ If the authority structure of the hospitals could be unified and patient's lives are taken as the first priority, then situation will change. At different Union and Upazila levels the severe shortage of personnel is needed to be met. A strong monitoring body is required to supervise the administration and service.
- ❑ Another important finding which the project manager shared with us is that they have developed a feeling of ownership in the community members which is a component of BWHC model. The community leaders now see the clinic as their responsibility. There is a monitoring committee in each area having the ward commissioner as the head. This mode of work has helped in sustaining the project and running it smoothly. This model can also be adopted by Government at large in the health sector which can make the people more willing to come to the hospitals and improve the hospital conditions.

Focus Group Discussion: 2

Place: Kolapara, SSDP office

Date: 3rd April, 2005

Participants: Executive director of the NGO, project officer, Family Welfare Inspector, Family Welfare Assistants (2), Village doctors (2), Trained Birth Attendant, Traditional Birth Attendants (3), Relatives of patients who suffered from eclampsia (2)

Principal Findings¹⁷

1. The two cases of eclampsia which we discussed in details proved that though the main delay occurs in decision making in the household and moving the patient to the hospital, delays in getting admission and treatment also remain a major problem in emergency.
2. The relative of one patient has remarked that the doctors do not care for poor patients and there is serious disregard in area about one of the doctors of the health complex who seemed to us hypersensitive and restless about dealing with the patients. This certainly denotes the negligence and misbehaviour of the doctors towards the patients (specially the poor).
3. When we talked to the UHFPO of Kolapara Upazila Health Complex, he urged us to meet the in charge of the gynaecological ward. We spend almost an hour (and it was duty hour for the doctors) in the hospital in which period the UHFPO sent messages to the doctor who was practicing in his residence, but we couldn't meet him as he told the messenger that he was very busy and could not come at that time. It is clear that there is no monitoring mechanism in the hospital which can ensure the doctors maintaining the duty hours.
4. There was a serious complaint of mistreatment of an eclampsia patient in the UHC of Kolapara. Jorina, the pregnant woman, had TT vaccines but the providers did not examine her blood or urine during pregnancy. In the date of delivery she developed serious convulsion but her family members gave her *pani pora* (holy water) and *tabiz* (holy pendant to prevent evil spirits) instead of taking her to the hospital. When the condition deteriorated, the relatives of the patient decided to take her to hospital. The mother of the patient said that the patient was brought to the UHC in a very serious convulsive stage of eclampsia and she had a stillbirth. But for the following month the

¹⁷ It would be better to remember that Naripokkho, with the help of its partner NGO Sankalpa Trust and SSDP, is working in Kolapara in order to make the Upazila Health Advisory Committee: a Government structure to monitor the service in the hospital, effective. This has a positive effect on the present health condition and is indirectly responsible for many positive findings which would not be found in an area without any initiative from outside.

doctors gave her treatment of Tetanus. When she was taken to the Barisal Divisional Medical College and Hospital (which is 6/7 hours journey by bus from Kolapara), the doctors declared that the patient had eclampsia and had been given wrong treatment which caused much damage to her condition.

5. In another case, a pregnant woman of Kolapara Upazila developed oedema at the third quintile of pregnancy. She did not take vaccine against Tetanus Toxoid as she was afraid of injection. She started to have waist-pain in the last month, to treat which the family members gave her holy water, "*pani pora*" from a religious healer. At the night of the second day of developing pain, convulsion started and the woman fainted. The family members then went to the village doctor (quack) who gave some medicine and suggested that the patient should be left alone in a dark room (certainly he suspected eclampsia). Though the patient regained sense after having the medicine, she again had convulsion within a few hours and fainted again. This was the third day of her developing pain. Her condition was same throughout that day. On the fourth day, the family member realized that her condition was serious and then they transferred her to the Kolapara Upazila Health Complex. The doctors operated the patient and her life along with her baby's life was saved. But due to the delay, the patient has developed several gynaecological complications and infection at the point of caesarean section (hernia).
6. The village doctors said that they identify eclampsia cases by oedema and lesser amount of urine passing. It can occur to pregnant women before or after childbirth. They agreed that in years when there was no hospital or trained doctors nearby, they used to treat eclampsia patients but now-a-days they realize that they don't have enough medicines or provisions to treat eclampsia and advise the patients to go to the hospitals.
7. The village doctors declared that they do not give any medicine to eclampsia patients (though according to them antibiotics can be given) even when the case is serious. One of the doctors said, "We cannot give medicine without any tests which is required to identify whether it is a case of Tetanus or eclampsia." According to them the awareness of people regarding eclampsia has increased. In the past the general conclusion people drew from convulsion was Tetanus, but now they are more aware of the danger of eclampsia.
8. According to the village doctors the poor pregnant women are more vulnerable to eclampsia. They cannot even have the minimum amount of nutrition needed in pregnancy and they have to do all the heavy works in spite of the prohibition doctors make. But on the whole the rate of maternal death has lessened in the area because of the new facilities in hospitals and better communication.
9. One of the Traditional birth attendants (Josna Rani, age 32) said that once she had a woman with sever oedema. She asked the mother in law to consult with doctors but both the mother in law and the patient said that it happens in pregnancy sometimes and everything will be alright after delivery. The patient gave birth four days later without any further complications. She said, "We refer the patients to hospital in case of severe bleeding, apposition etc. We visit the pregnant women who consult us during their pregnancy and advise them about food, work, rest and taking vaccine."
10. The other two Traditional Birth Attendants (one of them almost 52-55 years of age) said that they didn't encounter any problem in the births they attended. Though they said that they ask the patients' family to arrange all necessary things foe delivery beforehand, they did not mention about boiling the blades, thread or any other equipment necessary for delivery. They didn't seem to know that these need to be boiled.
11. The Family Planning Inspector of Kolapara said that the Family Welfare Assistants always prioritize the pregnant women and children during their filed visits. They advise the women and their family to visit the Family Welfare Center (FWC) at least three times during their pregnancy, but most of the patients ignore their advice. If they come to the FWC, the Family Welfare Visitor takes their weight, checks the blood pressure, and check the position of the baby if it is time. The women are told about their expected date of delivery and when they should take vaccine.
12. The FWAs work in 24 centers in each Union. There they advise the pregnant women to take vaccine but many of them don't come to the centers even after pursuing. The FWAs give advice about ante natal care of the patient to their family members. Some meeting are also arranged to

make the family members, specially the decision maker aware about the emergencies of pregnancy and willing to take the patient to hospital in due time.

13. The FPI and FWAs complained that the Traditional birth attendants take risk every time they attend a birth as they are not trained to do so and do not recognize the danger signs. Even when they see that the birth cannot be a normal one, they keep trying and make the delay. When the patient is taken to a health facility, it is usually too late.
14. The FPI said that Government recently has taken an initiative to produce some “Skilled Birth Attendants” by giving them 6 months training in a District hospital. These women (15-20 trained at a time) will then be able to replace the traditional birth attendants which will minimize the risk. The FPI also added that it’s risky to handle childbirth after a certain age. For the training of “Skilled Birth Attendants” women of age 25-35 are considered only as strong muscle power, good eyesight etc. is needed for the job.
15. The FWI also let us know that an initiative of the Government facilitated by WHO has now been launched under which the Government will provide costs for operation of some patients who cannot afford it (monthly income under Tk.1500/-). The eligibility is decided through a reviewing committee at the Upazila level.
16. The FWI said in the FWCs at the Union level, there is provision for delivery but very few pregnant women avail it. The FWI and FWAs seemed remarkable vague about the TT coverage, rate of childbirth and number of pregnant women in the area. Though they emphatically said that they keep these records, they did not seem to have even an idea of the scenario.
17. One FWA said that she is called by family members of the pregnant patients in her area in case of emergency, especially when they have to go to the hospital. “I haven’t seen any doctor on emergency duty at night whenever I went to the UHC. Even the nurses go to their room to sleep and we have to call them when pain becomes acute. In one eclampsia case, the doctor came after giving several calls and he was quite annoyed.”
18. The pregnant women get two doses of TT during pregnancy but most of them don’t follow up¹⁸. The other FWA said that whenever she finds a patient showing some danger sign of pregnancy she advises her to go to the doctor. “Recently I had a mother having breach and I took her personally to the hospital” said she.
19. The FWAs said that the main cause of delay in decision making in the family is that the husband or the mother in law is afraid of the costs of the treatment of hospital. The women also are not very willing to go to the hospital.
20. The Skilled Birth Attendant said that she was new in the job being recently trained but she seemed to have good knowledge about the emergencies. “I pay ante natal visits to pregnant women in her area and when ever I find a patient having high blood pressure, oedema, blurred view or severe headache, I understand that this is a case of pre eclampsia and pursue the patient to visit the doctors. When I find a case of severe eclampsia, I will give her relaxant and medicine to control blood pressure and then transfer her to the hospital as soon as possible.”
21. We found that the FWV also handle childbirth going to the house of the pregnant women and takes fees for it.

¹⁸ The Government program for vaccination presently concentrates on immunizing all women of reproductive age (15-49), especially focusing on adolescent girls.

Facility Visit

Place: Sirajdikhan UHC with EmOC facilities

* A Government facility running without any intervention from outside

In the year 2002 total number of patients admitted in the EmOC was 217 among whom 99 had pregnancy related complications. In total 89 cases was normal delivery, 24 cases of caesarean section and 4 cases of forceps delivery. Total 117 patients gave birth among which 105 was live birth and 12 still birth.

In the year 2003 total number of patients admitted in the EmOC was 176 among whom 94 had pregnancy related complications. In total 78 cases was normal delivery, 4 cases of caesarean section. Total 82 patients gave birth among which 76 was live birth and 6 still birth. 40 patients were referred to other places. There is no record of caesarean section after February, 2003.

In the year 2004 total number of patients admitted in the EmOC was 132 among whom 73 had pregnancy related complications. In total 59 cases was normal delivery, no cases of caesarean section. Total 59 patients gave birth among which 56 was live birth and 3 still birth. 39 patients were referred to other places.

In the year 2005, total 30 patients had been admitted from January to March among whom 7 has been referred elsewhere. Among these 16 cases were of complication. 14 case of normal delivery no caesarean section among which 13 were live birth and one still birth.

Remarks:

- Although this hospital has EmOC facilities with provision for caesarean section and all necessary equipments, no such cases has been handled since February, 2003.
- In 2003, 22.72% of total patients were referred elsewhere which increased to 29.54% in 2004 and 23.22% in the first three months of 2005.
- The number of patients admitted is clearly showing a declining trend, 217 in 2002, 176 in 2003, 132 in 2004 and on an average a number of 120 can be projected for 2005. The admittance of patients decreased 18.89% in 2003 than the previous year and 25% in 2004. This definitely indicates degrading performance of the EmOC as the number of patients is growing higher every year in the country.
- It has also been reported that an alarming percentage of patients who are admitted in the hospital, leaves it without consulting the authority. It may be because they loose faith on the facility and the providers. Another reason is the provocations to go to a nearby private clinic by the third and forth class employee. It is also known that the hospital staff nurse herself goes to patient's houses to attend deliveries privately, charging fees.

- ❑ The main reason behind the poor service of this facility is the lack of proper peer group to run an EmOC. The senior and junior consultants, who are posted, try to leave it as soon as possible, mostly to get posted where there is scope for good private practice. Even when there are consultants and anaesthetist, the management becomes difficult as the consultants ignore the RMO as he is a junior level officer.

Interview with:

1. Dr. Nurunnahar Shirin
Civil Surgeon, Potuakhali
2. Dr. Mahmudur Rahman
Consultant: Gynaecological Ward
Date: 4th April 2005
Potuakhali District Hospital, Potuakhali, Barisal.

Major Points Raised

- ❑ The Potuakhali District Hospital has comprehensive EOC facilities.
- ❑ Up to now there is no separate room to keep eclampsia patients separately. But according to the civil surgeon, now as a new building is being constructed, the EOC will be transferred to it and a separate room will be available.
- ❑ At present eclampsia patients are kept in the normal gynaecological ward surrounded by a black curtain only. As we have found, the ward is very crowded and noisy as there is no control over attendants of the patients.
- ❑ The hospital gets unusually large number of eclampsia patients. Most of them reach the facility in vulnerable condition at night after travelling a long way, as the transportation facility is quite bad.
- ❑ According to the register 34 cases of pre-eclampsia and eclampsia have been admitted all of whom have survived.
- ❑ The post of consultant in the gynaecological ward was vacant for 16 years before Dr. Rahman joined the hospital in 2001.
- ❑ To handle emergency cases of eclampsia and other obstetric complications, Dr. Rahman has prepared a guideline of immediate treatment for the Emergency Medical Officers (EMO). It is kind of checklist of necessary medicines and actions for the emergency cases, even before the senior consultant reaches hospital.
- ❑ Dr. Rahman has ordered that he should be called immediately in emergency cases, overlooking the practiced management of cases when the EMO admits a patient, observe her complications and then take decision to call the doctor. It causes some delay that can be fatal to the EmOC patients.
- ❑ Dr. Rahman is of opinion that a national level campaign [like the EPI campaign] for safe motherhood is needed and the personnel gap in the UHCs should be met to increase the level of care.
- ❑ He said that controlling visitors is a major problem in many hospitals that affect emergency patients seriously. A better administrative system and a change in people's attitude are essential to change it.