

BANGLADESH

Strengthened Maternal and Newborn Care Services

INTRODUCTION

Almost two-thirds of infant and child deaths in Bangladesh occur in the neonatal period, and more than 90% of all births occur at home, generally attended by a traditional birth attendant.³⁶ With 36% of newborns estimated to be low birth weight (LBW), Bangladesh has some of the most elevated LBW levels in the world.

At the request of USAID Bangladesh, ACCESS and its partners³⁷ successfully implemented a program based on community mobilization and household counseling to improve MNH practices. ACCESS modeled its program in Bangladesh on Projahnmo I,³⁸ which demonstrated that early postnatal care can significantly lower neonatal mortality and that home-based management of newborn sepsis is feasible and effective. Working in seven *upazillas* of Sylhet District, ACCESS demonstrated—like Projahnmo I—that a phased implementation of home- or community-based management can offer an effective alternative to facility-based care in settings where the health system is weak and care-seeking is low.³⁹ Sylhet District, with administrative areas covering a population of 1.5 million, was chosen due to its particularly high maternal mortality ratio, estimated at 320 to 400 per 100,000 live births, as well as its high neonatal mortality rate.

PROGRAM STRATEGIES AND INTERVENTIONS

Strengthening Home Practices, Counseling and Utilization of Services

More than 280 local women, called ACCESS counselors (ACs), visited the home of each pregnant woman identified in the program area four times—twice during



KEY INDICATORS

Neonatal mortality rate (per 1,000):
37

Skilled attendance at birth: 11%
(Sylhet), 18% (National)

Modern contraceptive prevalence rate: 32% (Sylhet), 56% (National)

Unmet need for family planning: 26%
(Sylhet), 18% (National)

Total fertility rate: 3.7 (Sylhet), 2.7
(National)

Antenatal care attendance with trained provider: 47% (Sylhet), 52%
(National)

DHS 2007

³⁶ Bangladesh Demographic and Health Survey 2007. Calverton, Maryland; National Institute for Population Research and Training (NIPORT) and Measure DHS Macro International, Inc.

³⁷ The intervention was implemented by two national NGOs: Friends in Village Development, Bangladesh (FIVDB) and Shimantik. International Centre for Diarrhoeal Diseases Research Bangladesh (ICDDR,B) provided technical support in monitoring and evaluation. ACCESS also worked with the government at the national and district levels to promote improvement of referral services.

³⁸ Funded by USAID and Save the Children's Saving Newborn Lives Initiative, the Projahnmo I Program was implemented by Johns Hopkins University through national partners ICDDR,B and Shimantik from October 2003 to January 2006.

³⁹ Baqui AH, Arifeen SE, Darmstadt GL et al. for the Projahnmo Study Group. Impact of a package of community-based newborn care interventions implemented through two service delivery strategies in Sylhet district, Bangladesh: a cluster-randomised controlled trial. *Lancet* 2008; 371 (9628):1936–44.

pregnancy, once within 24 hours after delivery, and once from five to seven days post-delivery—to counsel her, the newborn care person (usually a family member) and the birth attendant on newborn health and hygiene. The majority of these women were young and resided in the area, serving approximately 800–1,200 households and covering a population of 5,000–7,000. Some of the ACs worked in remote areas with limited access to roads and transportation, and thus could cover a smaller population. ACs received a 10-day training course on basic MNH, including essential newborn care, clean delivery practices, basic counseling and negotiation skills, and recordkeeping/reporting.

ACCESS also introduced community-based kangaroo mother care (KMC), the practice of constant skin-to-skin contact between a caretaker and newborn, to Sylhet to ensure thermal care for LBW babies. Before this intervention, most LBW babies were referred to the only tertiary level health facility in Sylhet District, MAG Osmani Medical College, where they were managed using incubators. ACs coached mothers and other members of the household who care for newborns to use the KMC method, frequently breastfeed and refer any baby with a danger sign to the nearest health facility.

Mobilizing Communities

A community mobilization initiative further supported and facilitated the work of the ACs by working with women’s and men’s groups and locally identified formal and informal leaders (referred to as Community Resource Persons or CRPs) to identify and address specific barriers to improved MNH in their communities. Typically, after analyzing and prioritizing the key barriers influencing MNH household and care-seeking practices, community groups developed plans that encouraged appropriate care-seeking. This included preparing birth and newborn care plans, establishing emergency transport, securing financial resources for treatment or transportation and facilitating reactivation of MNH services. This approach, called the Community Action Cycle (CAC), aimed to develop sustainable, community-led solutions to improve the health of mothers and babies, and to strengthen the capacity of community members to act collectively to address future community needs that may arise.

Engaging Traditional Birth Attendants and Village Doctors

Basic emergency obstetric and newborn care (BEmONC) remains out of reach for the majority of women and their families in Sylhet. ACCESS worked with traditional birth attendants (TBAs) and village doctors to improve home birth practices by providing focused training to reduce harmful practices, ensure clean delivery, better identify maternal and newborn danger signs, and provide timely and appropriate referrals to facilities to obtain EmONC.



ACCESS counselor, Bangladesh

Strengthening Linkages with Health Services

ACCESS worked with district health centers to improve knowledge and skills on essential obstetric and newborn care and BEmONC. The program also provided clinical updates on safe birth services and newborn care to medical doctors, nurses and paramedics of the Upazilla Health Complex. Using a variety of data sources to monitor and evaluate program work, a population-based survey was conducted at the start of the program, and the preliminary results were disseminated. Qualitative data, including mapping of community health resources, was used to assess the current capacity of community groups, service provision and utilization. Routine monitoring data were used to inform program progress.

RESULTS

Routine program data shows that ACCESS succeeded in reaching thousands of women with antenatal care, delivery care, postpartum care and family planning services. (See Table 8 below, organized by selected USAID Operational Plan Indicators.)

Table 8: Results for Selected USAID Operational Plan Indicators in Maternal and Newborn Health

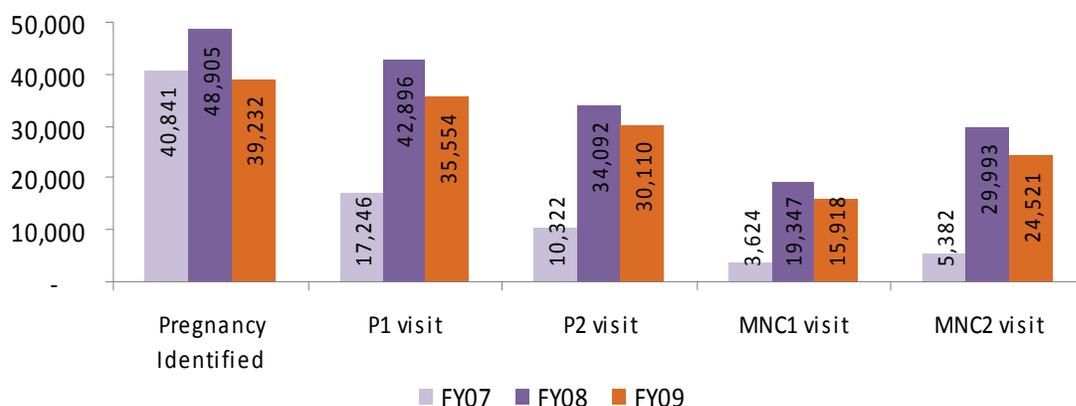
INDICATOR	FY07		FY08		FY09	
	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT	TARGET	ACHIEVEMENT**
Newborns receiving essential newborn care through USG-supported programs	n/a*	2,098	11,695	21,391	26,804	22,834
Postpartum/newborn visits within three days of birth in USG-assisted programs	5,845	4,120	25,989	26,294	31,579	31,597
Counseling visits for FP/RH as a result of USG assistance	11,500	7,099	25,989	29,993	29,381	32,431
People who have seen or heard a specific USG-supported FP/RH message	11,500	7,099	31,095	32,711	35,119	36,211
People trained in maternal/newborn health through USG-supported programs	826	1,849	3,767	4,022	7,778	2,456
Number of women	769	1,790	2,776	3,927	6,248	2,343
Number of men	57	59	991	95	1,530	113
People trained in FP/RH with USG funds	426	1,849	3,767	4,022	7,078	2,456
Number of women	369	1,790	2,776	3,927	5,748	1,330
Number of men	57	59	991	95	2,343	113
Institutions with improved management information systems, as a result of USG assistance	3	3	3	3	3	3

* No baseline available for this indicator.

** Results represent partial year achievements due to transition to MCHIP Program.

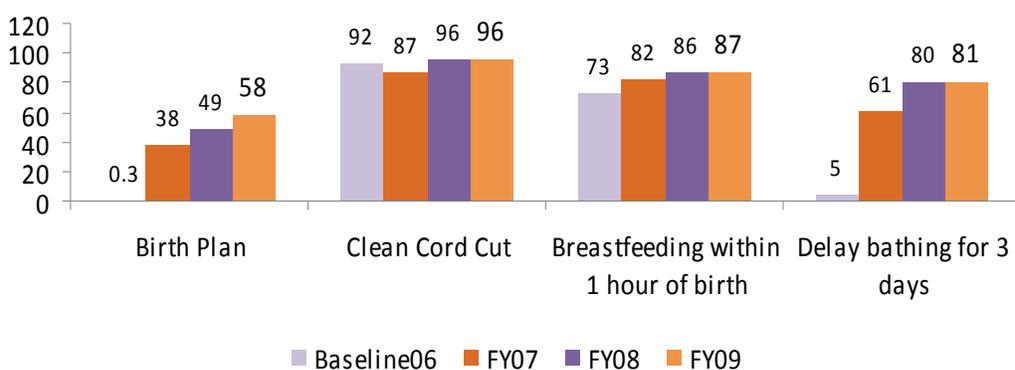
During the life of the project, 128,978 pregnant women were identified and registered, 95,696 pregnant women received a counseling visit at three to five months of pregnancy, 93,653 pregnant women received a counseling visit at seven to eight months of pregnancy, and 73,704 births were notified. Moreover, ACs reached 38,500 (52%) of these births within 24 hours and 59,205 (80%) within five to seven days. (See Figure 16.)

Figure 16: Counseling Coverage



Of the 59,596 women who gave birth and received postnatal visits during the project, routine data revealed increasing trends in healthy maternal and neonatal behaviors. (See Figure 17.)

Figure 17: Levels of Selected Maternal and Newborn Health Behavior



ACCESS established 1,174 CAGs in 614 villages through 73 trained community supervisor mobilizers and 40 community mobilizers who helped promote health practices and care-seeking behavior.

MAJOR PROJECT OUTPUTS

- Trained 286 ACs to identify pregnant women and conduct home counseling visits.
- Used ACCESS-established pregnancy surveillance system to register 245,982 married women of reproductive age and 128,978 pregnant women as of May 2009.
- Trained 73 community supervisor mobilizers and 40 community mobilizers, who are working with 1,904 CAC committees in 614 villages. Over half of the villages in the ACCESS intervention area have a functional CAG.
- Completed village mapping in 1,789 villages and seven upazillas in Sylhet.
- Conducted 237,446 home counseling visits and distributed 79,953 clean delivery kits.
- Developed training manual on community-based KMC, and conducted training of trainers.
- Trained 691 TBAs and oriented an additional 3,000 TBAs and 2,000 CRPs.
- Trained 32 village doctors and conducted training of trainers for paramedics.

LESSONS LEARNED AND SUSTAINABILITY

Community Mobilization Impacts Behavior Change

Health service facilities in some communities were often either very limited or entirely absent, creating frustration in the community. To address this situation, CAGs used their local capacity to advocate for health services. Some of these groups succeeded in reactivating community-based satellite clinics and immunization centers.

One example of this is Majanpur, a disadvantaged village in the Deokalash Union of the Bishwanath Upazilla where there were no satellite health or immunization centers for pregnant women and babies seeking antenatal care and immunizations. To remedy this situation, the CAG contacted local representatives and government health officials to formally apply to the Ministry of Health and Family Welfare (MOHFW), which has the authority to set up satellite centers. In February 2008, the MOHFW's local representative established an immunization center in Majanpur. The local newspaper reported on the establishment of the center and concluded, "If people in disadvantaged communities take initiative, most problems can be easily solved by community members and will remain a part of the community forever."

Working with All Members of the Household Influences Family Decision-Making

ACs worked to change perceptions of family decision-makers despite initial resistance. Nazma Begum delivered her baby at home with assistance from an untrained family birth attendant. Her husband, Masuk Mia, informed the 20-year-old AC, Hafsa, after the birth took place. Hafsa visited the mother and newborn immediately and discovered that the mother was continuing to bleed heavily postpartum.

The AC, who had discussed danger signs with Nazma and her husband during the pregnancy preparedness visit, stressed to Masuk Mia that his wife needed emergency care. He was initially reluctant to take her to the health center because he believed that bleeding is a common birth phenomenon. However, the AC succeeded in persuading Masuk Mia to take his wife to the nearest health center, where she received emergency care for postpartum hemorrhage. Nazma's husband and the attending service provider at the facility both recognized the timeliness of the AC's referral.



Woman, her husband and their baby, Bangladesh

WAY FORWARD: FROM ACCESS TO MAMONI

Based on ACCESS results and learning, USAID has funded a follow-on project, MaMoni, which will continue until early 2013. With an estimated 26% unmet need in FP, FP was added as a major component of MaMoni. Similarly, the follow-on project added sick newborn management and newborn infection prevention through handwashing, as these interventions are critical to ensuring the survival of newborns. The use of project-paid ACs, although successful, will be discontinued and instead the existing government infrastructure will be mobilized and strengthened in the expansion district, Habiganj.

