RESEARCH BRIEF

Manoshi

July 2009 Issue 2

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Bangladesh is a country of 56,977 square miles with 150 million people, 25% of whom currently live in urban slums. Despite success in population control, the size of the population is expected to stabilize at 250 million by 2085. One of the very striking features of the future population of the country is that nearly 60% of the population will live in urban slums by 2030. In the absence of appropriate health services, the health of the newborn, infants and their mothers is likely to suffer. This makes urban health issues, especially of the slum dwellers, of high priority. Keeping this in mind BRAC has started a Maternal, Newborn and Child Health (MNCH) programme, known as Manoshi (*Ma O Nobajatak Shishu*), in 2007 in Dhaka slums which may gradually be extended to all the slums of Bangladesh by 2011. The major goals of Manoshi are to ensure safe motherhood by way of safe delivery and newborn and child care. Various researches are being carried out in support of Manoshi since its inception. Manoshi Research Briefs are a fast track mechanism devoted to sharing the findings to various stakeholders interested in the health of the urban population especially of the poor.

Beyond the Inception Phase of the Birthing Centres: Acceptance within the Community

Living conditions in a Manoshi slum

Manoshi, endeavours to provide community based essential maternal, newborn and child health services as well as timely referral to comprehensive emergency obstetric care at facility level for the urban poor. At the community level, birthing centres were established to provide the urban poor an option of safe and clean delivery within close proximity. Pregnant women of the community are encouraged to give birth at a BRAC birthing centre under the supervision of a trained urban birth attendant (UBA) or community midwife. This research brief aims to explore the acceptability of the birthing centres within the community and the perspective, knowledge and suggestions of the slum dwellers regarding the Manoshi programme. A study was conducted between July and September of 2007 in the areas of four birthing centres. In-depth interviews of pregnant women, women who had recently given birth and had availed the services of the birthing centre, had opted not to or had been referred to a higher facility for complications during delivery and their relatives e.g. mothers-in-law and husbands, were carried out in the areas served by each birthing centre.

Insights from the community

Findings from the survey reveal mixed views of the programme in its early phase of implementation. There is evidence that the birthing centres are striving to establish themselves within the slums. The study provides insights related to issues surrounding the programme from the perspective of

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the community. The problems faced by the women in the slums when availing services and the views and suggestions of the community regarding the program were identified. The problems and issues if addressed adequately will enrich the programme and enhance its success.

It was evident that most women preferred their homes for birthing purposes, especially if they had other children to take care of. Some respondents had expressed their confidence in traditional birth attendants and were not willing to or did not think it necessary to use birthing centre services unless in situations of emergency. However, for the poor and helpless women of the slums, especially those without support from neighbours and relatives, the birthing centres were a convenient option. In addition, the perception of lower costs involved for referrals is a reason for which women in the community said that they would opt for the birthing centres. It was also evident from the study that there were quite a few women who were not aware of the birthing centres or the services offered by the programme.

Awareness and knowledge about the services of birthing centres

The majority of the women were aware that normal deliveries are assisted by trained birth attendants (*dhatree*) at the birthing centres free of charge and if there is a need for referral to other facilities for complications then the costs involved are lower than usual. It was evident that although the programme reimburses the costs incurred, partially or fully depending on the need of the person, the details were not clear to the community. For example different respondents quoted different amounts required for caesarian sections. Moreover, many of the respondents were skeptical about whether the services are actually free.

Children playing in an urban slum

"Although they said that the birthing centre is free of cost, I do not believe it. In Bangladesh, nothing is free. Think about the TB hospital, they wrote on the walls that everything is free there, but once you are admitted, you have to spend a lot of money…" - A respondent

The majority of the respondents were aware that the birthing centres are open at all times, even during the night. Quite a few said that the centres only provided services for normal deliveries. Interestingly, in Shobujbag area, the birthing centre is considered to be a miniscule hospital as all kinds of health advice are provided at the centre. Some mentioned that even MR and abortion services are provided, however, this was not confirmed on further investigation.

It was a common belief amongst the women and their mothers-in-law that the birthing centres would be more meaningful if a 'doctor' was present to attend the birthing process and if proper medicine and equipment were made available. The *Shasthya Kormis* (SKs, health workers) and *Shasthya Shebikas* (SSs, health volunteers) of the birthing centres were also aware of the existing demand for the presence of doctors in the birthing centres. Interestingly, the underlying reason behind the dissatisfaction with and refusal to use the birthing centre by the respondents for delivery purposes was the fact that the centre did not have medicine or other medical supplies. Almost all non-users and their mothers-in-law expressed dissatisfaction for this reason.

A respondent from Korail slum mentioned, "It is pointless to go to a birthing centre. If I have to go out of my house, I will go to the hospital as they can help me if anything goes wrong"

Acceptance and level of satisfaction

Most women who had delivered at the birthing centres were satisfied with the quality of services and the behaviour of the staff, especially the UBAs.

Manoshi rapid monitoring team visiting a study household

> "I am new in this area. I am poor. I don't have anyone close here. When my labour pain started, Allah sent the SK and SS to me and they took me to the delivery centre. The *dhatree* was very gentle and I felt that they were everything for me and my baby at that time" - A respondent from Korail

It was mentioned by a respondent that the presence of a 'doctor' (FWV) at the delivery centre makes a difference. "A *dai* from outside is not generally polite or gentle with the patient. But, at the delivery centre the *dhatree* is always nice in front of the doctor *apa*".

Some respondents of Kamrangirchar mentioned that they preferred the birthing centres for antenatal check-ups (ANC) rather than for delivery. As the deliveries may take place during the night it is inconvenient for the mothers to leave their homes and as such they preferred their own homes for delivery purposes. However, they said that they would go to the birthing centres if complications occur. Women who were referred for complications were dissatisfied with post natal care (PNC) services. Many reported that even after three weeks of delivery, nobody had visited them for post natal care.

Birthing centres made the delivery process safer and convenient for the poor women of slums. However, sometimes pregnant women are subjected to improper internal (P/V) examinations. For example, it is common practice among the UBAs to examine the patient repeatedly without gloves in the birthing centres during labour. Some mentioned that they had received multiple injections/saline to expedite the pain. Findings from the survey suggest that the intravenous administration of Oxytocin with saline to induce or hasten uterine contractions during labour is a widely accepted practice in the community. Some even prefer to take it based on the belief that it is beneficial. The Manoshi programme will benefit from raising awareness in the community about these unsafe practices highlighting their harmful and sometimes life threatening consequences. The programme needs to pay special attention to the provision of sufficient supplies and its proper use.

Perception about referrals

In Manoshi, hard-core poor women receive a basic package of services free of cost. The services include maternity care at community level and partial treatment costs of caesarean sections and neonatal complications in hospitals. However, there seems to be quite a lot of confusion about how much will be provided to cover referral costs. A woman from Kamrangirchar said, "They told me that they can give us TK 1,200 only for my caesarian operation. But we needed Tk 20,000. So my husband did not take any money from them." In most of the referral cases, the major reason for dissatisfaction with the birthing centre services was insufficient financial support. Almost all referred mothers mentioned that they were informed of financial support from the centre. However, further enquiry revealed that in most cases, the SS or SK used financial support as bait and influenced the mothers into using birthing centre services. Some reported that they had not been informed earlier about referrals and the fact that they may have to seek assistance from other places if delivery complications occur.

Some of the women and their husbands said that the money given by the delivery centre was beneficial for them although it was only a portion of the total expenses. A poor respondent quoted her husband, "Don't question them. It is better that they have given us TK 800; if they had not given us that, we could not have done anything to them."

It was apparent from the interviews that the respondents depended on the programme for referrals and the assistance they receive during this time. Most of the time the husbands disappear from the scene abandoning the pregnant women to escape financial responsibilities.

> "My husband left me when he came to know that we needed money for the delivery. After one month he came back." - A poor woman from Korail

Most respondents said that they had to borrow the major portion of the money needed for the payment of hospital bills.

Services received from the delivery centre

Only a few of the mothers who had given birth at the centres were accompanied by an SS to the centre and the presence of an SS during delivery was also infrequent. Almost all respondents said that the UBA had taken care of the baby after delivery. Most of the mothers were satisfied with the behaviour of the staff at the delivery centre, especially the UBAs. When the women were referred to higher facilities, many reported that the SS had accompanied them to the hospital and in some cases, when nobody was available, had stayed with them at the hospital for 2-3 days. In most cases the women were referred to Dhaka Medical College for complications.

Most of the respondents suggested that the birthing centres could be more useful to the slum dwellers if more services are available.

The main issues that were considered as major barriers

- Lack of medicine and supplies and 'doctors' at the centre.
- Only a portion of the costs incurred when referred to facilities are reimbursed in the programme.
- The people in the community are interested in the financial assistance provided by Manoshi.

Prepared by Tania Wahed. Source: Khan MA. Birthing hut facilities of the MANOSHI Programme: Looking Beyond the Inception Phase. Unpublished.

Providers' Perspective on Manoshi: Issues and Their Recommendations

Service provider examining a pregnant woman at a birthing centre

Manoshi has been functioning in Dhaka slums since January, 2007 and has already established a tangible existence within the community. A study was undertaken between July and September of 2007 to explore the service providers' perspective about different operational aspects of the programme. The study included four birthing centres for observation. Two of the birthing centres, one in Shobujbag and the other in Korail, had the advantage of a head-start and had started functioning as pilots from July 2006 whilst the other two birthing centres in Uttara and Kamrangirchar were relatively new and had only just started from March 2007. In-depth interviews with the providers included discussions with the Team Leaders, Programme Organizers (PO) *Shasthya Kormis* (SKs) and *Shasthya Shebikas* (SS).

An overview of the Manoshi programme

An overview of the programme as it had been originally planned is necessary to comprehend the issues and changes that have evolved in the process of adaptation.

At the community level the birthing centres were established to provide the urban poor an option of private, safe and clean delivery within close proximity. Pregnant women are encouraged to give birth at a BRAC birthing centre under the supervision of a trained Urban Birth Attendant (UBA) or community midwife. The field activities of the programme are carried out by community health workers, namely *Shasthya Shebikas* (health volunteers), *Shasthya Kormis* (health workers), Urban Birth Attendants and community midwives. The *Shasthya Shebikas* are women selected from the community. The *Shasthya Kormis* are the second frontline workers who are involved in various operational aspects of the programme. The UBAs are the traditional birth attendants in the community who have been provided training by BRAC on maternal and neonatal care. The community midwives are selected from existing women practicing in the locality of each birthing centre who have training as Family Welfare Visitors or in nursing-midwifery. In the programme, the UBAs are supposed to assist the birthing process. The existence of community midwives for each birthing centre was not a proviso. Initially it was suggested that only 5% of the total birthing centres will be serviced by community midwives.

Referral linkages between the community and health facilities are developed with the assistance of *Shasthya Kormis*, Programme Organizers and local MNCH committees. Two to three referral centres are selected on the basis of accessibility from slums and availability of required services at fixed low prices.

Shastya Kormi on duty at a Manoshi birthing centre

The details of the main responsibilities of the community health workers, SS, SK, UBAs and community midwives have been provided below.

The main responsibilities of *Shasthya Shebikas* (SSs) are to:

- Visit households and collect information regarding family planning, pregnancy, birth, immunization, and illnesses
- Identify pregnant women and immediately notify SKs and UBAs
- Motivate and accompany pregnant women to antenatal care sessions
- Accompany birthing woman to the birthing centre for delivery
- Assist UBAs in birthing centre for clean delivery and care of neonates
- Inform mothers of low birth weight babies about kangaroo mother care or maintenance of body temperature and feeding
- Provide postnatal care of neonates and basic treatment and proper referral of neonatal complications
- Deliver services related to simple treatment of common illnesses and sell health commodities at doorsteps

The main responsibilities of *Shasthya Kormis* (SKs) are to:

- Confirm all suspected pregnancies (identified by SS during household visits)
- Register confirmed pregnancies and inform mothers about and create demand for BRAC's pregnancy care package
- Perform clinical examination during antenatal care sessions, ensure TT injections, provide iron-folic acid, educate on danger signs and health, nutrition and hygiene and motivate for birth preparedness
- Organize one antenatal care session each month for 200 households
- Visit pregnant women along with UBAs to check for birth preparedness, specifically place of birth
- Establish an effective referral system by maintaining liaison with local service providers
- Record all births in registers and maintain a follow-up system for all children till they are 5 years old
- Inform mothers about immunization dates and keep records of immunization and Vitamin A intake
- Organize health education forum, e.g. educate mothers on diarrhoea and acute respiratory infections (ARI)

The main responsibility of Urban Birth Attendants (UBAs)/community midwives are to:

- Assist the SKs in ANC sessions
- Conduct safe delivery and provide post-partum care to mothers at birthing centres
- Provide immediate management of haemorrhage and eclampsia and immediately refer complicated cases to referral facilities (UBAs and community midwives provide misoprostol for post partum haemorrhage. For eclampsia, UBAs provide rectal barbiturate and community midwives provide magnesium sulphate.)

Insights from the in-depth interviews: Providers knowledge and their perceived responsibilities

Shasthya Shebika (SS): SSs were trained to assist in the delivery process and neonatal care. However, the SSs mentioned that the training was not sufficient and that the mothers preferred the *dhatrees* (UBAs) for delivery and neonatal care.

> "*Dai apas* are more of an expert in doing everything. Thus we do not do anything to take care of the baby. We only help the mother to have a comfortable position during delivery" - SS from Shobujbag

The interviews with the SSs revealed that at times they provide detrimental advice such as vaccinations for the neonate for jaundice. However, they were not able to provide a source for the information.

The SSs complained that the remuneration received for all the trouble that they have to go through is quite inadequate and a reason for which their husbands object to their involvement in the programme. It seems that the initial plan to involve the SSs in a substantial number of responsibilities was overambitious. The SSs seem to carry out their responsibilities of identifying possible pregnancies, for which they receive 30 Taka, and to accompany the patients to the referral centres, for which they receive 100 Taka as payment.

In addition, the SSs mentioned that visiting 200 households in a month was quite an impossible task and quite time consuming. An interesting approach undertaken in Kamrangirchar should be mentioned in this context. The pregnant women in this particular slum have formed support groups and are known to provide advice and assistance to their neighbours when required.

Shasthya Kormi (SK): Most SKs said that the door to door provision of basic ANC was more convenient and less time consuming than the ANC sessions that were originally planned. Interestingly most of the SKs had incorporated additional responsibilities to the routine tests included in the basic ANC care that they were supposed to provide. For example, they were checking the colour of the eyes for jaundice. An SK from Uttara said, "If the woman's eyes look pale, then I advise her to go to the doctor to check for jaundice".

SKs also provide detailed instructions to the mothers on neonatal care, particularly those with low birth weight babies. Despite being quite efficient in carrying out their responsibilities, they sometimes provide controversial advice. For example, an SK of Kamrangirchar said that as they are not able to determine the position of the foetus they ask the women to go to the UBAs, who would through oil massage be able to position the baby properly. However, in Shabujbag, the SKs have mentioned that they are able to refer the pregnant women to Shimantic, an NGO clinic in the locality, where free blood tests and ultrasonograms are done. The SKs mentioned that their involvement in the household surveys refrain them from providing ANC services properly to the mothers.

Urban Birth Attendant (UBA): Almost all UBAs were well aware that their responsibilities were to assist in the birthing process. The UBAs were also involved in neonatal care after delivery. As the UBAs provided neonatal care when they practiced as TBAs in the community, they believed that they were more skilled than the SS in neonatal care.

The UBAs were not adequately aware of the fact that the surgical blade and the thread included in the delivery kits provided by the programme were sterilized. They used the delivery kits, but sterilized both the thread and blade. In Korail, the UBAs did not use the thread in the delivery kit as they doubted the quality and believed it to be too soft. They used normal thread from a thread ball which they boiled once initially and used whenever needed.

The UBAs took pride in the fact that most birthing women did not have perineal tears during delivery as they considered tears to be a sign of incompetence. Some UBAs reported that they used their bare hands without wearing gloves to examine the extent of dilation of the birthing-women with the consent of the programme. A few of them mentioned that they were permitted to do so just once during the delivery process. Upon further probe, an FWV

of Korail said that as UBAs are not able to understand the dilation properly, they examine the mother repeatedly. It was also mentioned that gloves are not provided by the programme and had to be bought and as such is an issue of affordability.

Family Welfare Visitor (FWV): The three FWVs of the study were new appointees who had started work at the birthing centres from April 2007. The FWVs mentioned that they had not been given any specific directions about their responsibilities. The FWVs said that they usually observe and, when needed, rectify the UBAs during the delivery process. According to the FWVs, the UBAs have overcome many of their traditional practices due to training but do occasionally revert to traditional practices. An FWV of Kamrangirchar said, "We always try to observe and correct them …such as oil massage, tying the abdomen, hair in mouth etc. I never object to things like feeding *pora pani* because these are not harmful for mothers".

It is evident that the FWVs are willing to improvise when needed by adding to their regular duties. It was mentioned that they attend ANCs with the SKs when they are free as it helps to develop rapport with the mothers and increase the number of clients at the birthing centres. According to the FWVs they have to adjust to the different circumstances and are not always happy about it. As one of the FWVs mentioned it was awkward for her to assist the mothers who are usually lying on the floor during the birthing process. The FWV in Kamrangirchar expressed her despair by stating that at times the pregnant women insist for UBAs because of their experience. Almost all FWVs acknowledged that they felt helpless in situations where they are unable to use skills that they have been trained to apply.

> "The programme has not given us permission to use instruments for delivery, and we do not have the facilities here. Sometimes we could have handled the delivery easily. But the programme does not permit us." - FWV from Korail

It was evident from further discussions that patients are frequently referred to the facility mainly because supplies such as saline or injections to hasten labour and necessary medicine to stop haemorrhage are not readily available; because the FWVs are not permitted by the program to provide services other than normal delivery, not even stitching of tears; and apparently because of the risks involved for the programme in handling any complications. The FWVs said that the SSs were not functioning properly in any of the areas and that the SKs and the UBAs were the major actors of the programme.

Programme Organizer (PO): The POs appreciate the presence of FWVs in the birthing centres as they believe it eases the challenge of managing complications during delivery. As mentioned by the POs they are mainly involved with supervising the SKs and the activities of the birthing centres. The POs added that it was always difficult to engage the SSs in their respective areas.

Branch Manager: Most branch managers, except those in Shobujbag, had been recently transferred to their current working area and were not well-informed about the target population in their areas. However, they appreciated the short training provided and their involvement in the household survey. The managers felt that there was a need for a clearer perception about the services available at the referral centres to facilitate proper and timely utilization of referral services.

Present barriers to accomplish responsibilities

Some of the problems faced in the programme are specific to an area. In Kamrangirchar, as the slum dwellings are scattered and the area is full of factories, the branch managers said that it was difficult to find a conveniently located accommodation to set up a birthing centre. In addition, for this reason they sometimes found it difficult to identify users as well. The people in the area also found it difficult to go to the centre because of the distance and as such preferred to go to Dhaka Medical College for emergency management. In Uttara, people were comparatively better-off economically which may be a reason for which they were not willing to go to the birthing centres for delivery. The branch managers said that they felt helpless when they were faced with more than one emergency at one time as they were the only male members in the Manoshi field team. However, they mentioned that the programme intends to use POs for referral purposes.

The study revealed that most of the time, space is not available in the facilities. It is difficult for the POs to get referral patients admitted to the facilities for this reason as well as the added complications of having to deal with the health brokers who are mostly private sector middlemen whose livelihoods are dependent on getting patients admitted to the facilities. Furthermore, it is difficult at times to arrange blood for the patients even though family members of all pregnant women are informed to arrange donors ahead of time. In addition, the distance to the referral centres is an encumbrance to access as transport is not always available and the birthing mother is forced to walk quite a distance to get to the referral centre. The POs mentioned that the doctors at the hospitals are very annoyed if they come across any perineal tear cases, which is a cause of major discomfort to the PO/SK/SS accompanying the patient. It

Outside a birthing centre in Shobujbag slum, Dhaka

was also mentioned that more than half of the patients have to be referred to the facilities to repair perineal tears.

Upon further probe it was evident that the SKs and the SSs generally provide advice for the overall health of the mother and child and are able to provide basic clinical examination of the women. As supplies are not adequately available, the iron and vitamin tablets that they are supposed to provide are not always provided. As such, even though they advise the women to have the supplements, the women are generally not able to afford the essential supplements. A similar trend is also observed for Tetanus Toxoid injections.

Almost all UBAs and SSs complained about the low remuneration, mentioning that it was a major barrier making it difficult for them to depend on the profession in which they devote most of their time.

The main issues that were considered as major barriers included:

- Lack of medicine and 'doctors' providing necessary services at the birthing centre
- Low remuneration of the community health workers
- Inadequate supplies

Prepared by Tania Wahed. Source: Khan MA. Birthing hut facilities of the MANOSHI Programme: Looking Beyond the Inception Phase. Unpublished.

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Manoshi is supported by the Bill and Melinda Gates Foundation

Published jointly by BRAC and ICDDR,B for Manoshi

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Designed by Md. Abdur Razzaque | All photographs in this issue by Razib Chowdhury