

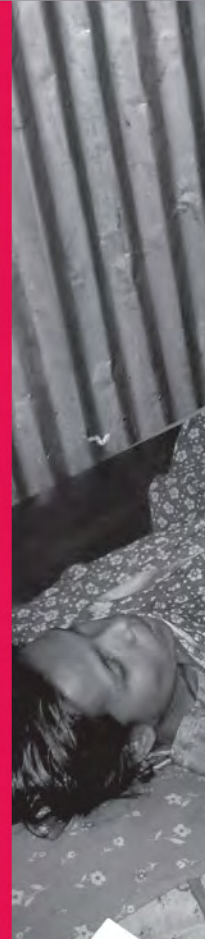
# MANOSHI

working paper

## The “Birthing Hut” Facilities of MANOSHI

A Two-Part Paper, Exploring  
the Inception and Post-  
Inception Phases of Urban  
Delivery Centres

Marufa Aziz Khan  
Syed Masud Ahmed



# **The “Birthing Hut” Facilities of *MANOSHI***

**A Two-Part Paper, Exploring the Inception and Post-Inception Phases of Urban Delivery Centres of Dhaka**

**Marufa Aziz Khan  
Syed Masud Ahmed**

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## EXECUTIVE SUMMARY

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BRAC's Manoshi programme, a community-based maternal, neonatal and child health intervention for this urban slum population of Bangladesh is aimed at improving the maternal, neonatal and child health practices. To increase the accessibility to such facilities in the slums, BRAC started a low-cost birthing hut project within the slums, which would provide a convenient, clean environment for pregnant women and new mothers to receive appropriate maternal, neonatal and child health services.

This is two-part study on the newly launched "birthing huts" facilities in the slum areas of Dhaka city under Manoshi. The first part of the study explored the birthing huts, in the slums of Korail, Shobujbag, Shampur and Tongi Ershad Nagar, specifically the facilities available and services offered for delivery at the birthing huts, its acceptability by the local people, and service providers' knowledge and perceptions of these birthing huts. The second part, a follow up to the inception phase, studied the status of the intervention after a period of time since the huts' establishment in Korail, Uttara, Shobujbag and Kamrangir Char. The study population consisted of pregnant women and their families, local leaders and BRAC staff working at the huts.

Qualitative methods were employed to conduct the study, which revealed that the community expects 'doctors' to be providing services in the formal setting of a birthing hut. They also expect a complete health package of one-stop services from birthing huts. Most of the mothers felt that if birthing huts had multi-dimensional services available such as Tetanus Toxoid (TT) vaccination and other medicines during pregnancy, it would be of better use for them. In addition mothers felt that referral points were not sufficiently active for the huts' patients.

Among the staff involved in services of the huts, Shasthya Shebika (SS) were not motivated to work for the huts and they expressed their dissatisfaction about remuneration. Urban Birth Attendants (UBAs) expressed similar feelings about remuneration. From the providers' side, Program Organizers (POs) had trouble motivating pregnant mothers because of registration and referral costs. Finally, in one area an existing NGO providing services for pregnant and lactating mothers was already filling the gap that the Manoshi programme aims to fill.

**PART I**

**The “Birthing Hut” Facilities of *MANOSHI***

**An Exploratory Study of the Inception Phase**



## INTRODUCTION

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Bangladesh, along with other Asian countries, is experiencing rapid urbanization in recent decades. Nearly a quarter of the total population (around 150 million) now lives in the urban areas. This rapid growth has been due primarily to migration by the rural poor, particularly to large metropolitan areas like Dhaka City. On arrival, these poor migrants routinely turn to slums and squatter settlements for shelter (Haaga 1992). The living conditions of these slums are very poor, sometimes worse than the most disadvantaged rural areas (Centre for Urban Studies 2005). Only 10% slums have sufficient drainage to avoid water-logging during heavy rains; over 70% of slums have no access to safe latrines. Around 90% of the slums had a monthly income below the poverty line (of Tk 5,000 per HH per month) (Centre for Urban Studies 2005). Thus, the slum population is most vulnerable to disease and has limited access to quality health care due to absence of public sector PHC facilities. Financial insolvency restrains them to access costly health care services such as delivery care services available in the urban areas (NIPORT 2003). In response to this situation, BRAC initiated a new community-based maternal, neonatal and child health intervention called “MANOSHI” for the urban slum population of Bangladesh. This five-year project is implemented in six divisional cities of Bangladesh, adapting the Essential Health Care (EHC) model of BRAC Health Programme. Manoshi programme aiming to improve the delivery system in slum communities as well as the knowledge of formal and informal urban health workers who are usually involved in child delivery and neonatal care. At the same time, an important objective of this programme is to increase the accessibility of health facilities in the slums. BRAC will also train community health workers to provide health care for children under five years of age. In the first phase of the programme, Dhaka city corporation area is being covered by the Manoshi programme. In the second year, the programme will expand to other metropolitan and municipal slums in the six divisions of the country.

### *The intervention*

For clean and safe delivery, “birthing huts” (these were nicknamed “birthing huts” by the staff) are established in the slums to cover a population of 10,000. The main objective of this centre is to encourage poor slum mothers to give birth in a clean and safe place, attended by trained personnel. In case of complications,

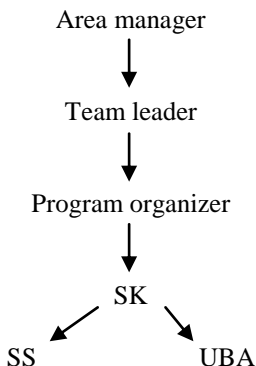
mothers are referred to nearby designated facilities for management of complicated deliveries. The programme emphasizes community empowerment and linkages with local stakeholders to continue health-related activities in the slums. In collaboration with UPCHP (Urban Primary Health Care Project), community health workers or SK will arrange immunization and vitamin A capsule distribution in satellite camps. Other than these services, SK will monitor growth of under-five children, and campaign for breastfeeding and complementary feeding. They will also detect danger signs for neonates and empower the community with knowledge regarding maternal and child health. Pregnant mothers who agree to take the services of the centre is registered at the birthing centre and charged a nominal fee.

### *The staff*

At the core of this programme model is the community health volunteer (*Shasthya Shebika*, SS) who provides preventive and limited curative services at door steps of the community (BHP 2008). The SSs and birth attendants are trained to offer antenatal care, essential new born care and management and referral of birth asphyxia, and safe delivery respectively. The SS and the urban birth attendant are in turn supervised by the community health workers (*Shasthya Kormi*, SK), community mid wives, and BRAC Programme Organizers (POs). Two trained Urban Birth Attendants (UBAs) are assigned to work in a birthing hut. For every 10,000 population, there are 10 SS who are responsible for identification of pregnancy and subsequent health education, besides their routine EHC-related work. One SK supervises 10 SS and 2 UBAs to monitor their activities. Each PO supervises 10 SKs and in turn, is reportable to the Team leader.

Pregnant mothers are encouraged to give birth at the ‘**birthing centre**’ (**birthing hut**) for maintaining privacy and ensure hygienic delivery under the supervision of a trained birth attendant. The birthing hut is usually established at the centre of the community to cover a population of about 10,000 people. These were nicknamed “**birthing hut**” by the staff but is formally called ‘**delivery centre**’. In case of complications, mothers are referred to designated huts for better management and care. It is expected that the cleanliness, maintenance of privacy and assistance with trained birth attendant (UBA) in normal deliveries will make birthing huts a popular option in the slum.

**Manoshi organogram at area level of program administration.**



**Steps in programme implementation:**

Identification of pregnant women by SS



Immediately communicate to SK and UBA



Confirm pregnancy and disseminates pregnancy related messages



Name noted down in family card by SK



At least 3 ANC check-up up to delivery by SK



Delivery by UBA accompanied by SS at birthing hut  
(FWVs are appointed to supervise the UBA in some of the huts)

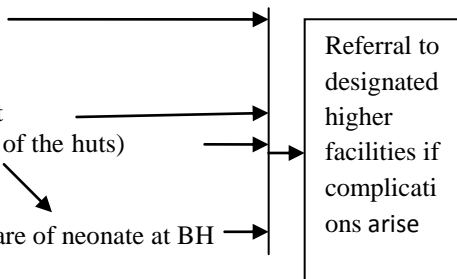


UBA attends delivery at BH

SS takes care of neonate at BH



SKs offer home visits at 3, 7, 21 and 28th days after delivery to check mother and neonate.



## **OBEJCTIVES**

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The general objective of this study was to explore BRAC's urban birthing hut facilities in the slum areas of Dhaka city.

The first phase of the study aimed to explore:

- The facilities available and services offered for normal child delivery at the urban birthing huts under Manoshi programme of BRAC in Dhaka city.
- The acceptability of the birthing centre to the local people and the community perceptions and expectations regarding the birthing centre.
- The service providers' knowledge and perceptions about these facilities.

## **METHODOLOGY**

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This phase was based on the preliminary exploration of birthing huts. Qualitative methods of data collection were employed such as observations and in-depth interviews using check-lists.

### **Study Area**

The first four birthing huts were launched in four slums of Dhaka city namely Shobujbag, Ershad Nagar, Korail and Namashampur during the first part of 2006.

### **Study Period**

The field activities were completed during mid-Oct. to Nov. 2006.

### **Study Sample**

We included pregnant mothers and their families, local leaders, and relevant BRAC staff of the birthing huts. We interviewed programme organizers (PO), Shasthya Kormis (SK), Shasthya Shebikas (SS), and urban birth attendants (UBA). We chose only those service providers who were directly involved in delivering the birthing centre's services for interview. Additionally the sample population included a mother who was registered or gave birth at the centre,

another mother who was did not register at the centre, and their mothers or mothers-in-law from catchment area of the respective birthing huts were conveniently selected for in-depth interview (Table 1).

**Table 1: Number of interviews by centre and type of respondents**

Individuals	Name of the birthing centre				
	Shobujbag	Namashampur	Tongi: Ershad Nagar	Korail	Total
Programme Organizer(PO)	1	1	1	1	4
Shasthya Kormi (SK)	1	1	1	1	4
Shasthya Shebika (SS)	1	1	1	1	4
Urban birth attendant (UBA)	1	1	1	1	4
Registered mothers	2	2	1	2	7
Non-registered mothers	2	1	2	1	6
Mothers/mothers-in-law/husbands of pregnant women	2	1	1	1	5
Local leaders	1	1	1	1	4
Total	11	9	9	9	38

## Methods and Tools

### *Observation and Checklist*

A checklist was prepared to assess the physical facilities and services offered at the huts. Each birthing centre was observed to make a list of the logistic supplies and state of physical environment. The number of deliveries was recorded from each centre's register and crosschecked with the urban birth attendants (UBAs).

### *In-Depth Interviews*

In-depth interviews were undertaken with the selected participants. The topics covered were knowledge, acceptability, cause of non-enrolment, and community expectations. We also collected information from the service providers about knowledge gathered from training, job responsibilities, and barriers to discharging the responsibilities and community expectations.

### *Consent*

Verbal consent was obtained from all study participants before interview.

## RESULTS

The results are organized according to the objectives outlined.

- The facilities available and services offered at each facility for child delivery at the urban birthing huts are presented in Table 2 and Table 3.

**Table 2: Physical environment at four ‘birthing huts’**

<b>Name of the birthing center</b>	<i>Shampur</i>	<i>Korail</i>	<i>Shobujbag</i>	<i>Ershad Nagar</i>
<b>Name of referral point</b>	UPCHP	Mowlana Bhashani Hospital	Mugda clinic	Mowlana Bhashani Hospital
<b>Center’s distance from the referral point (approx.)</b>	5 kilometer	20 kilometer	4 kilometer	3 kilometer
<b>Transportation from center to referral point</b>	Rickshaw	CNG/Taxi/Bus	CNG/Taxi/Bus	Rickshaw
<b>Structure of the center</b>				
<b>Floor</b>	<i>Pacca</i>	<i>Pacca</i>	<i>Pacca</i>	<i>Pacca</i>
<b>Roof</b>	<i>Pacca</i>	<i>Tin</i>	<i>Tin</i>	<i>Pacca</i>
<b>Wall</b>	<i>Pacca</i>	<i>Bamboo</i>	<i>Bamboo</i>	<i>Pacca</i>
<b>Water source</b>	Deep tub well (Stored in a plastic container and changed once after 3-4 days regularly)	Tap (Stored in a plastic container and changed regularly)	Tap (Stored in a plastic container and changed regularly)	Tube well (Stored in a plastic container and changed daily)

<b>Condition of ventilation</b>	Good, plenty of air	Enough airy	Enough airy	Enough airy
<b>Lighting</b>	Enough light at day, An emergency charge light, Torchlight	Not enough light at day and tube light was not working An emergency charge light /Torchlight	Enough light at day An emergency charge light Torchlight	Enough light at day An emergency charge light Torchlight
<b>Drainage</b>	Proper drain	No drain (beside the center there was a cow shed and they gave objections to drain the dirty water)	Proper drain	Proper drain
<b>Delivery materials</b>	Delivery kit <sup>1</sup>	Delivery kit	Delivery kit	Delivery kit
<b>Other logistic supports</b>	Bed on floor (2), Plastic, Blanket, Pillow Bathroom scale, Salter scale, Stove for sterilization, Gloves, Sanitary Napkin, Mask, Wall clock	Bed on floor (2), Plastic, Blanket, Pillow Bathroom scale, Salter scale, Stove for sterilization, Gloves, Sanitary Napkin, Musk	Bed on floor (2), Plastic, Blanket, Pillow Bathroom scale, Salter scale, Stove for sterilization, Gloves, Sanitary Napkin, Musk	Bed on floor (2), Plastic, Blanket, Pillow Bathroom scale, Salter scale, Stove for sterilization, Gloves, Sanitary Napkin, Musk
<b>Available medicines</b>	Iron tablet, vitamin A capsules	Iron tablet, vitamin A capsules, glucose	Paracaetamol, Iron tablet, vitamin A capsules, glucose	Paracaetamol, iron tablet, vitamin A capsules, glucose
<b>Other ANC service centers at that slum</b>	Marie-Stops clinic	UPCHP, Marie-Stops clinic	Jubok, UPCHP	TDH, FOB

<sup>1</sup> The delivery kit includes a blade, thread, white paper, gauze and soap

**Table 3: Number of registered deliveries at the huts\***

Name of the centre	Time period		Registered deliveries			
	From	To	Centre	Home	Referred	Total
Korail	01.07.06	27.11.06	11	12	2	25
Shampur	01.08.06	27.11.06	2	11	4	17
Shobujbag	01.07.06	04.10.06	2	0	3	5
Ershad Nagar	01.07.06	27.11.06	3	3	0	6

\*The huts started functioning at different times

- To gauge the acceptability and community perceptions of the birthing huts, IDIs with mothers, husbands and mothers-in-law of the pregnant women and local leaders identified 3 themes.

### **General Knowledge about “Birthing Hut” Services**

Most of the registered mothers said that they had general knowledge of the birthing huts and were satisfied with the services of BRAC providers during delivery, but when they had registered with the centre in the early stage of their pregnancy, they thought BRAC would provide all the support they would need during delivery. When they were asked about the referral system of the birthing centre, they could not answer clearly. The majority of the registered mothers were unclear about the services that were available for them. One of the husbands from Korail said, “It is better to go to BRAC birthing centre, otherwise it is risky to handle it at home.” Another husband from Shampur said, “As we don’t have any health care facility in our slum, it is better to go to the BRAC birthing centre for delivery.” Additionally, it appeared that husbands knew that they had to go to a nearby hospital when complications arose.

### **Community acceptance of “Birthing Hut” Services**

Most of the registered mothers who had a normal delivery were satisfied with the ANC care and home visits by the SK/SS and generally accepted the services available. Almost all of them reported that a UBA was present during their delivery period, even at 2 o’clock in the night. However, one mother from Shobujbag complained about the expertise of the UBA of the birthing hut. She expressed dissatisfaction and complained that she had to spend a lot of money to



treat the injury during delivery. A few mothers mentioned that lack of people to help them during delivery at home and lack of healthcare facilities nearby induced them to avail the services of the birthing huts, while others in spite of being registered at the birthing hut faced some barriers related to their ability to come to the birthing hut during labour pain and perception of lack of skill among the service providers. One of the registered mothers mentioned, “I did not receive any services from the birthing centre, because my labour pain started at mid-night and the communication facilities from my home to centre is not good.” One of the mothers of Shobujbag complained about perineal tear. She thought that the injury occurred as the UBA was unskilled.

### **Reasons for non-registration at “Birthing Huts”**

Almost all non-registered mothers met the BRAC SS/SK/PO. They said that SS or SK or PO sometimes came to their house and told them about physical care. However, almost all of these mothers were unwilling to pay Tk. 300 for delivery when there were no doctor and medicine facilities at birthing huts. A few mothers did not register with the birthing hut because they did not plan to deliver in Dhaka. Some mothers did not have any faith in antenatal care (ANC) or TT or free service provided. One mother from Shobujbag said,

*“These injections are based on your belief; if you don’t take it, nothing will happen”,*

While another from Korail expressed scepticism about the services;

*“If doctor is good, will he/she come to home?”*

One of the non-registered mothers of Ershad Nagar expressed that she has no money for registration, but she could understand the necessity of the antenatal and delivery care. A few mothers expressed the belief that

*“Those who have nobody, they go there”.*

According to the parents of the non-registered mothers in most sites, the main cause of non-registration was unavailability of other health facilities which they have used before. At Ershad Nagar, the mothers of the pregnant women mentioned that they themselves were the members of the TDH availing its facilities in previous deliveries, so, they relied on their service, which was very

helpful for them. Though TDH has no birthing centre, they have trained many UBAs of Ershad Nagar who were providing door-step services. In addition, TDH has doctors for health check-up and provide medicine at half cost for both the mother and the newborn. At Shampur, mothers availed ANC care from Marie-Stopes clinic as it was well known to the community.

Some of the important barriers to registering with the birthing hut were related to the perceived lack of facility at the huts. Almost every non-registered mother mentioned it was better to go to other places to get services of the doctors. Many pregnant women said that they were not at all satisfied with the services of ANC of BRAC birthing centre as BRAC was not treating the problems during pregnancy and did not distribute medicine. One mother from Ershad Nagar said,

*“Even though I said about my severe abdominal pain during ANC, SK did not give me any treatment. At last I went to TDH, they treated me and I got relief from the pain.”*

According to one of the community leaders of Shampur slum, the people are not clear about the services provided by the birthing huts as they were new in the area. She suggested that if the birthing huts can expand their services to include EPI, polio and TT vaccination, it will help to make the huts popular. In Shampur slum there was no doctor it was suggested that providing a doctor will popularize the service. In general however, there was strong expectation about having a doctor present at the birthing hut for the 300 taka required for registration.

The service providers’ knowledge and perceptions of birthing huts were also gauged using IDIs. All involved personnel were interviewed to understand four major components of providing this service: their level of knowledge, responsibilities, their experiences related to barriers, and community’s expectations.

### **Knowledge gathered from Training**

The POs were interviewed to assess how much of the theoretical knowledge they retained. While they did not have any difficulty, they cited that a majority of them were unmarried and felt they lacked the necessary experiences about pregnancies and births. The MNCH training at ‘Radda Barnen’ for the POs did

not include any practical or observational training of delivery which they felt would have provided a better understanding of the delivery process and delivery related injuries. The POs found the monthly meeting at BRAC for sharing experiences helpful but mentioned the need for refreshers training. SKs from Ershad Nagar mentioned that they needed better knowledge about the dressing of ‘caesarean mothers’ and ‘torn perineum’. UBAs mentioned that they learnt about the necessity of ANC, danger of sepsis and pregnancy danger signs from the BRAC training sessions. However, all of them mentioned that they would have liked to know about using drip during delivery to shorten the duration of labour. During their prior practices they pushed saline to the patient (with the help of a doctor), which increased labour pains and consequently induced birth and helped shorten the labour period. However, BRAC discouraged this procedure, and some were unsure as to why.

## **Responsibilities**

POs described their responsibilities related to the MNCH programme with ease. However, when they were asked about the referral procedures, none of them were clear about the services provided by the referral facilities, or where the patients were sent from the birthing huts. Each group of providers could name the referral points; however, they could not describe properly the services and the cost of services to the pregnant mothers. A Korail slum PO mentioned that they were rejected openly when they reached the referral hospital (Mowlana Bhashani Hospital). At that time she could not protest because she was unclear about the agreement between BRAC and hospital. Most of the SKs identified pregnant women, motivated them to come to the birthing huts and provided ANCs. Almost all SKs complained that their SSs were not motivated enough and they had to take all the ANC, PNC and delivery related responsibilities upon themselves.

In most instances, with the lack of motivation, the SS were not performing their duties adequately. They could not identify what their responsibilities were during ANC and PNC. One SS from Shampur described her duty only as bringing the pregnant women to birthing huts for delivery. They had very little understanding about the remuneration policies to which they were entitled. Moreover, they considered attending delivery an unproductive and time consuming job. When asked about their lack of interest many of them said that during trainings they failed to get a clear idea about the remuneration of the work, and when they started they realized that it was not easy to motivate the women to use delivery

huts. Considering the dropout rate of SS, at Shobujbag 7 out of 26 were working. At Korail according to the PO 5 out of 45 were doing their work. At ‘Shampur’ almost all SSs were de-motivated. Contrarily, UBAs were well motivated. An UBA in Shobujbag area mentioned that she learned a lot of things from BRAC training, especially about the handling of labour pain, for example while general practice dictates using intravenous saline to increase pain and shorten the period of labour, it is a practice that is against BRAC training and therefore impermissible. One UBA from Korail said,

*“We can understand that some of the delivery pains were not severe, which could be increased by giving them saline, under the supervision of a doctor. But we were instructed in our training not to give it. For this reason, many times we waited for 12 hours and then referred the patients to other places, for which patients spent lot of money, if there is a caesarean section.”*

### **Providers’ Barriers**

The POs highlighted motivating the pregnant mothers or their families for registration with the birthing huts as the most difficult job. They mentioned that the lack of knowledge about the birthing huts and availability of other health facilities as important barriers. They also mentioned that only a few women could pay the registration fees at a time; however, in case of partial payment many women did not pay the rest even after the delivery was over. When pregnant women were referred to other places, it was a common expectation of every pregnant woman’s family that BRAC would bear the major portion of the expense. A PO from Korail mentioned that it was sometimes difficult to make families understand that BRAC only provides the transportation cost. The main problem of the SKs was that the majority of the SSs were not motivated to work with only 3-4 SSs were doing their work properly. SKs also mentioned that it became difficult for them to motivate the pregnant women to register at the centre because of the absence of a doctor on the premises. In the community there was a perception that the ANC services of BRAC birthing huts were unreliable as there were no doctors present.

The common problem of the SSs was dissatisfaction in that they did the work for the birthing centre without adequate remuneration. Some of them wanted to work, but asserted that their families forbade them to work for so little money. One Korail SS, who has been working for more than three years, said that earlier

they could earn money by selling medicine in their slums but now there were many medicine stores and no one wanted to buy from her. The new SSs from Ershad Nagar and from Shampur said that other SS from their area were not motivated to do their work because they had other employment options. One SS from Shampur said that she was not clear about her responsibilities during training but once the work started and she had to visit other houses, she faced street teasing. As an unmarried girl from a conservative family it was difficult for her to do the work. UBAs also cited problems with remuneration. Many of them mentioned that the money they were receiving was inadequate and lower than their previous occupations'. Almost all UBAs explicitly expressed about their family's discontent about the nature of their jobs. The main reason was their 24 hour duty at the centre with nominal remuneration. One UBA in Ershad Nagar resigned because of low salary. Another said that if she knew that she would have to spend almost the whole day at the centre, she would not have joined. However, one of the UBA from Shampur said that she thought that providing service through birthing hut was more prestigious than providing services door-to-door. She felt that facility based service provision was convenient for her.

### **Community Expectations according to the Providers**

The responses of POs, SKs, SSs and UBAs about what the community expected from the huts were very similar. A common expectation of the slum community from the centre was provision of complete set of birth care service including a doctor, TT (Tetanus Toxoid) vaccine, medicines and postnatal care. According to the PO from Ershad Nagar if BRAC did not provide medicine and doctors at the birthing centre then it will not be able to compete with TDH in that area. The PO from Ershad Nagar mentioned that the majority of the pregnant women and their families preferred their own homes for delivery. The SKs explained that pregnant women came for ANC because of some physical complaints and sought medicine and doctor's advice. When these services are not available, women were unhappy. The PO from Korail mentioned that in the areas congested with people, the pregnant women preferred ANC service provided at a specific facility.

## DISCUSSION

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Our study results show that at the community level people expected birthing huts to be staffed with doctors. They also expected comprehensive services during delivery when they paid a registration fee. The staff face various challenges, the SSs and UBAs especially were not motivated as they felt remuneration was inadequate. In one area the birthing centre was not necessary because a well-established foreign NGO already provided the services there. These findings are discussed in detail below with programmatic implications. All the huts except one were conveniently situated and had uniform facilities. Other researches have shown that to increase safe motherhood services' use, the facilities need to be placed within a convenient area so that they are accessible to pregnant women and their families (Bloom 1999). According to the non-registered mothers and their families, these huts were not complete service providers, which could manage all types of healthcare during delivery period. Other important main causes of non-registration at the huts were financial incapacity, dissatisfaction with the huts' services, and traditional beliefs regarding safe motherhood services. People have also reported poverty as a reason for not receiving any care for maternal health problems in previous studies (NIPORT 2003).

Use of medical care services for child delivery can contribute to safer motherhood. Unlike many other countries, however these services are under-utilized in Bangladesh (Akter, 1994). According to the community people maternal and neonatal services at birthing huts may be used if they provide one-stop services. This was highlighted in all the interviews by their demand for a doctor at the centre. The programme may think of posting a doctor on a rotation basis in the slums to attend the identified high-risk cases at least once in a month. This may motivate people more to use the birthing centre services. Health services should be located as close as possible where women live, and services should also be responsive to women's needs, preferences and cultural beliefs (Akter, 1994). We found that in Korail slum the birthing centre was not ideally situated as some parts covered a large distance and as such was inconvenient for the patients. For this reason pregnant women did not go to the centre during their delivery.

In some cases mothers expressed dissatisfaction about the postnatal services of the birthing centre. In developing countries, postpartum death was the most

prevalent (61%) compared to other periods. The main reasons were postpartum haemorrhage, hypertensive disorders, and sepsis during the postpartum period (Safe motherhood action agenda, 2006). In one incident, one mother's complaint of perineum injury during the postpartum period was not properly addressed by the UBAs after delivery. Incidents like this may erode the credibility of birthing huts. The PNC services should be strengthened at birthing huts as it provides opportunities to identify the delivery complications and counsel mothers on how to care for themselves and their newborns (Nasreen et al. 2006).

To ensure safe delivery practices in the context of slums of Bangladesh, proper training of UBAs is important. UBAs at birthing huts attended almost all registered deliveries and sometimes the delivery of non-registered mothers. Almost all the UBAs were trained, experienced and sometimes they were very well known in the slum community. From BRAC training sessions, UBAs gathered new messages that were not always found acceptable to them. Sometimes they preferred to handle the delivery in traditional ways which were prohibited by their training knowledge and the restricted environment of the birthing huts. In other instances they were found not properly motivated by their knowledge gathered from the training. To make effective use of human resources, the programme needs to improve training in a culture sensitive way by providing better preparation for the trainers, better supervision of the UBAs post-training, helping UBAs publicize their improved skills, and providing necessary compensation for their services (Kamal, 1998). Experience shows, however, that the training of birth attendants needs to be part of a broader strategy, including functioning referral systems and back-up professional support.

**PART II**

**The “Birthing Hut” Facilities of *MANOSHI***

**Looking Beyond the Inception Phase**



## **INTRODUCTION**

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This study focuses on the different operational aspects of the ‘birthing hut’ (BH) activities of BRAC’s Manoshi programme. Having provided sufficient time for set up and being well established, fully staffed with trained personnel and tangible in the community, the formative research group considered this time to be appropriate for exploring the community acceptability and functioning of birthing huts as a new intervention for the slum population.

## **OBJECTIVES**

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To explore the urban birthing hut facilities in the slum areas of Dhaka city, operated by the Manoshi programme of BRAC.

Specifically,

- Explore the acceptability of birthing huts by the local people and community perceptions about the birthing huts.
- Explore the service providers’ knowledge and perception about the birthing hut facilities and services.

## **METHODOLOGY**

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This study used qualitative methods such as observation and in-depth interviews for collecting relevant data.

### **Study Area**

Four ‘birthing huts’ were selected for the study

1. South Manda, Shobujbag
2. Boubazar, Korail
3. Bamnartek, Uttara
4. Ashrafabad, Kamrangir char

The first two birthing huts ('Old') were operational from July 2006 while the other two ('New') from March 2007.

### **Study Period**

The study was conducted from July to September in 2007.

### **Study Subjects**

Study subjects included both service receivers and providers.

From the community, two pregnant women and two mothers who had used the services during their delivery were included from each centre. Additionally, one mother who was referred to a higher facility for complications, and one who did not use the birthing centre during her delivery, were also taken as subjects from each centre. The mothers-in-law and husbands of the respective women were also interviewed.

To explore the providers' perspectives, different levels of staff who are directly involved in programme implementation were included. Team leaders, Programme organizers (PO), *Shasthya Kormis* (SKs) and *Shasthya Shebikas* (SSs) of each BH were included as study subjects. First, after an initial listing of all the SSs in the programme, each SS area was visited by the researchers who then examined the actual engagement between the SS and the community about their activities. Those SSs who were very active during that interactive period were included in the new list for the purposes of this study. Mothers who are first mentioned were also selected from the same areas of active SSs.

### **Methods and Tools**

A participant observation method was followed to prepare a logistical list of the supplies and physical environment. All existing facilities and service related to the delivery preparation, ANC and PNC services were observed. A checklist was prepared to assess the physical facilities and services offered at the huts. Additionally, all study subjects were interviewed in-depth guided by checklists.

The topics covered to address the first and second objectives were: knowledge about birthing hut services, acceptability, perception about referral services, community expectations from birthing huts, and suggestions for improvement of

services. To cover the second objective more concretely, the staffs of the birthing huts were questioned regarding the MNCH issues, their individual responsibilities in the programme, current barriers to accomplish those responsibilities and satisfaction with remuneration received.

### ***Consent***

Verbal consent was obtained from all study participants after explaining the purpose of the study.

## **RESULTS**

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Results are presented according to the objectives of the study. The results pertaining to the first objective are presented according to the following themes:

- Perceptions of ‘birthing huts’ as a place of choice for the next delivery
- Knowledge of the community about birthing centre services
- Acceptance of ‘birthing huts’ by the community
- Perceptions about the referral systems of ‘birthing huts’

To address the second objective results are presented under the following themes

- Providers’ perceived responsibilities and knowledge about MNCH
- Present barriers to accomplish the responsibilities
- Suggestions for improving the birthing huts’ services

### **Community Perceptions and Acceptability of “Birthing Huts”**

#### ***Perceptions of ‘birthing huts’ as a place of choice for next delivery***

Mothers were asked about their preferred place of delivery for the current pregnancy. Most of the mothers answered that they preferred their home for delivery. They referred to their previous experiences which found home delivery as the better option,

*“Who will take care of my children, if I go another place for this delivery?”*

(A mother of two children)

Many of them explained that if they want to have some hospital care during delivery it will be expensive for them. Some of them said that they learned about the birthing centre, when others from their locale who had visited them.

*“I will go to that place because I don’t have to pay anything for my delivery. I have nothing to manage my delivery. My father and brothers are all here. So I don’t feel any privacy here. That place is broad...”*

(A woman from Sobujbag)

In all the areas, we also found some women who were not informed about the birthing huts. Some of the respondents who had knowledge of these facilities preferred them. As they had no support at home during delivery, (i.e. close neighbours, relatives etc.) they were prepared to go to the birthing huts.

In Uttara, we found two pregnant women who were daughters of a traditional birth attendant who were also respondents to the IDIs. They mentioned clearly that they were not interested in going to the birthing huts, though they knew that the services of the huts were good. They did not feel confident outside their homes with issues related to childbirth. However, they said that they would go to the birthing huts if there was some emergency.

### ***Knowledge of the community about ‘birthing hut’ services***

Pregnant respondents were asked what they knew about the birthing centre’s services in their area. Most of them said that the services at birthing centre were free of charge, with trained birth attendant (Dhatree) handling the delivery, and during emergencies they would tackle everything. Moreover they said that if they needed a C-section, only Taka 2000 would have to be paid for that service. For poor people, all costs would be borne by the centre. However, many of the poor responded saying that they did not think any of the services were free.

*“...however the people knows that delivery centre is free of cost. But once you go there they will charge you”*

(A pregnant lady of Kamrangir char)

*“I was anxious to let her stay in the delivery centre. Though they are saying that it is free of cost, I could not believe it. In Bangladesh, nothing*

*is free. Think about TB hospital. They wrote on the wall that everything is free, but once you get admitted there, you have to spend a lot of money.....”*

(Husband of a pregnant woman of Korail slum)

A majority of the respondents knew that birthing huts were open all the time, providing 24 hours service. Many of them said that these huts were only for normal deliveries. Some of the pregnant mothers from Shobujbag area perceived the birthing centre as a mini hospital. They said that the delivery centre was also good for all other kinds of health advices. They also commented that sometimes the huts provided MR and abortion services which they could not confirm upon further questioning.

In Uttara, we found some respondents who were not interested in going to the birthing huts though they were aware of it. They said that the huts do not have any doctors and medicine. There is no use in going to the huts:

*“If I have to go out of my house, I will go to the hospital. They can help me if anything goes wrong with me”*

(A pregnant woman from Uttara)

Respondents were also asked about who first informed them about the birthing centre and what information they had shared. Most of the mothers from all areas mentioned the Shasthya Kormis (SKs) as the first informant, while a few of them also mentioned the Shasthya Shebikas (SSs) as the first informant.

### ***Acceptance of ‘birthing huts’ by the community***

Mothers who went to the huts during their last delivery were asked about the services of the birthing huts they had received. Most of the mothers said that they were warmly welcomed by the staff:

*“As I am a poor lady and I am new here I don’t have any close one. One day during my pain Allah sent them (SK & SS) to me and they took me to the delivery centre. Dhatree behaved with me very softly and I felt they are everything for me and my baby.”*

(A woman from Korail)

Many mothers shared their experiences with us. They mentioned that the UBAs examined them with bare hands, when their pain increased gradually after being

admitted in the birthing centre. Some mothers said that they were tested by the ‘doctor apa’ (FWV) and she wore gloves.

*“When I did not have sufficient pain after admission into the delivery centre, they gave me an injection to increase my pain and said that my time had come closer and the baby will be born soon. During that period ‘Dai’ and ‘Doctor apa’ both of them repeatedly examined me with their hands and that was a painful experience for me.”*

(A mother from Uttara)

We found one woman from Uttara and one from Korail who were reportedly given saline to increase the delivery pain.

*“...after a few minutes they gave me 2-3 injections....then my pain increased and after half an hour the baby was born”*

(A woman from Shobujbag)

In Shobujbag, most mothers said that the staff at the delivery centre behaved softly, especially the UBAs. Respondents from Korail said that the delivery centre was working much better since the appointment of a ‘doctor’ (FWV).

*“If we call a ‘dai beti’ from outside, generally she does not talk in a good manner. But at the delivery centre a ‘dhatree’ always behaves softly; they behave better in front of doctor apa”*

(A mother-in-law from Shobujbag)

Mothers who gave birth at the huts were asked whether SS accompanied them during delivery. In all four areas, very few mothers responded positively saying that the presence of SSs were occasional. Almost all the mothers said that following delivery, the baby was given care by the UBAs.

In Kamrangir char, most of the mothers preferred the centre for antenatal check-up (ANC) rather than delivery. Most of the mothers stated timing of delivery as the major reason behind not going to the birthing huts. These deliveries occurred very late at night, and such mothers and their respective families preferred their own home to the birthing centre for delivery. Only in cases of emergencies, they would go to the birthing huts.

Women who were referred to higher facilities for management of complicated deliveries, expressed dissatisfaction about post natal care visits (PNC). Many of

them said that even after 20 days, no birthing centre personnel visited them, not even for taking the birth weight.

Some mothers did not use the birthing centre for their delivery and mentioned non-availability of medicines and saline as the underlying reason. Almost all non-users and their mothers-in-law expressed dissatisfaction for this reason:

*“Why shall I go to BRAC? They don’t have any medicine there; not even saline!”*

(A woman from Korail)

***Perceptions about the referral systems of ‘birthing huts’***

*“They told me that they can give us TK 1200 only for my caesarean operation. But altogether we needed Tk 20,000. So my husband did not beg for any money from them.”*

(A woman from Kamrangir char)

In most referral cases, the major reason for dissatisfaction about the birthing huts services was insufficient financial support. Almost all referred mothers who were interviewed mentioned that they were informed about financial support during emergency from the centre. Further questioning revealed that in most of the cases the SS or SK attracted the mothers and their families by assuring them about financial support. Some of the mothers were completely dependent on the delivery centre’s services, and reported that they were not informed initially that they may have to go to other places if they had delivery complications.

Some women and their husbands said that the money given by the delivery centre was helpful for them though it covered only a portion of the total expenses.

*“Don’t ask anything from them. It is better that they have given us TK 800; if they did not give us that, we would not be able to do anything.”*

(A poor man said to his wife)

During the referral process, a majority of the families depended completely on the birthing centre’s guidance. There have been cases where the husbands of pregnant women disappeared to escape the financial responsibilities.

*“My husband left me when he came to know that we need money for my delivery. After one month he is now back at home with us.”*

(A poor woman from Korail)

The mothers and the in-laws said that they had to borrow the major portion of the money to pay hospital bills.

When they were asked about the services they received from the delivery centre, many of the mothers reported that the SSs accompanied them while going to the hospital. Furthermore, they informed that sometimes the SS stayed at the hospital for 2-3 days with them, when there was nobody to attend to them. It should be mentioned here that in most of the cases referral point was Dhaka Medical College, with whom BRAC has a MoU regarding patients from slum birthing huts.

### **Providers’ Knowledge and Perception of “Birthing Huts”**

To address the third objective, we focused on interviews with the different levels of staff of the birthing centre. The main topics about general MNCH knowledge, barriers and programmatic advice are outlined below.

#### ***Providers’ perceived responsibilities and knowledge about MNCH***

*Branch Manager:* Most of the managers except in Shobujbag said that they were recently transferred to their present working area and they were trying to organize their designated activities. Many of them did not have sufficient ideas about the target population in their working areas, or the additional services available for MNCH in those areas. They added that before March 2007, the MNCH programme varied largely from its current structure. Then, there was no training for the branch managers. At that time, they were designated as ‘team leaders’ and they had overall superficial knowledge about the MNCH issues, and their duties were not specifically defined. Now, programme administrators have arranged 10 days of training for them, including doing a household survey, which helps them better understand their responsibilities. Branch managers also appreciated training about the management of referral cases. However, they added that they should have a clear idea about the services of all referral points to avail appropriate services on time.



*Family Welfare Visitor (FWV):* We found three FWVs in four birthing huts. They started their work from April 2007. They said that they did not have any specific directions about their responsibilities. They only observed the UBAs and if the UBAs did something wrong, then they intervened to try and correct those wrong practices. All of them had formal training in family planning and delivery procedures. In addition, they received a special training on the MNCH programme structure. One of them expressed that they felt uneasy to handle the mothers on the floor.

When FWVs were asked about the performances of UBAs, they said that after training they have managed to overcome many of their traditional practices, but still at times they revert back to their old habits.

*“We always try to observe them and correct them....such .as oil massage, tie on the abdomen, hair in mouth etc. I never object to things like feeding ‘pora pani’ .....because these are not harmful for mothers”*

(FWV of Kamrangir Char)

FWVs said when they did not have any work at the centre; they attended the ANC with SKs which helped them to develop a stronger rapport with the mothers. They identified this as necessary for increasing the number of clients in the birthing huts. They also highlighted that the SSs were not functioning properly in any of the areas. Instead the main SSs activities were done by the SKs and the UBAs. FWV of Kamrangir char added that sometimes mothers were coming for the UBAs only, as they exhibited the most experience. Almost all FWVs said that they felt restricted and helpless when they could not utilize knowledge from their other non-BRAC trainings

*“Programme did not give us any permission to deal the patient with instruments and we do not have any facilities here. We are going to forget everything.....Sometimes we could have handled the delivery easily. But programme does not permit us.”*

(FWV from Korail)

FWVs said that SKs were very busy with the household survey till March 2007, but now they are concentrating on their own duties. It was later discovered that during the IDIs the SKs in Korail were still carrying out household surveys.

*Programme Organizer (PO)*: They said that in the beginning, it was a challenge for them to manage emergency situations like deliveries without any doctors. Their main responsibility was to supervise the SKs and their activities at the birthing huts. They added that it was always difficult to engage the SSs in their area; however, they argued instituting some incentives that could be motivating for the SSs.

*Shasthya Kormi (SK)*: Most of the SKs said that basic door to door ANC was convenient for them, because it was less time consuming. SKs were asked to describe their duties during ANC, and most of them added that testing of 'jaundice' by checking the eye colour along with their routine other tests in basic ANC was also carried out (Table 1).

*"I checked the woman's eyes; if it looks pale then it is jaundice. In this situation we should advise them to go to the doctor"*

(SK from Uttara)

They explained how they generally convinced the mothers to come to the centre by telling them about the cleanliness, privacy, and referral system of the centre. Sometimes mothers were not attracted by those messages; instead mothers and their families were more interested in getting the services free of cost.

SKs were asked to explain the specific instructions they had to give to the mothers whose babies had low birth weight. Many of them explained properly, all the instructions they learned from their training. Many of them said that at that stage, they instructed mothers to take baths three days after delivery. One of the SKs said that they did not have any idea about the position of the foetus during ANC,

*"When mothers complain about their pain, at that time we advise them to go to UBAs at the delivery centre since they are experts; by oil massage, they would be able to position the baby properly."*

(SK from Kamrangir char)

SKs from Korail mentioned that from March 2007 to June 2007 ANC services were totally ceased in their area. At that time they were fully engaged in household survey and mapping. We found that during our study period, SKs from Korail were comparatively busy with both ANC and house hold surveys compared to those in the other three areas.

*Shasthya Shebika (SS)*: When asked to describe the new knowledge they had gained from the training, most of them knew very clearly that their presence was needed during deliveries at the birthing huts, though they found that the UBAs were doing everything after the delivery of the child. However, they came to know about neonatal care in the training. They said that mothers also preferred ‘Dhatree’ (UBAs) to handle their baby.

*“Dai Apas are more expert in doing everything than us. So we do not do anything with the baby. We only help the mother to have a comfortable position during delivery”*

(SS from Shobujbag)

A few of the SSs said they advised about the ‘jaundice’ vaccine if they found any child with jaundice. We asked them about the source of this knowledge, but the SSs could not give us any credible answers to the question.

*Urban Birth Attendant (UBA)*: We found that almost all UBAs knew about their responsibilities in the programme very well. Additionally, they perceived that neonatal care just after delivery was their responsibility. They explained that previously, when practicing as TBAs in the community, neonatal care was also their responsibility and consequently, they thought of themselves as more of an expert than the SSs to handle the newborns.

On the knowledge about the use of ‘delivery kit’, we found that UBAs both in Korail and in Uttara did not have any accurate idea about the sterilization procedure. They used the delivery kits supplied from BRAC, but sterilized both the thread and blade supplied in it. They were unaware that the blade in the delivery kit is a surgical blade and was also sterile. We found in Korail, UBAs did not use the thread from the delivery kit because they thought it to be soft and not of good quality. Instead, they used normal threads by boiling the thread ball to sterilize it.

The UBAs said that none of the mothers delivering in their care faced perineal tear, and considered that a sign of skill and professionalism. Some of the UBAs reported that they tested the ‘dilatation of the uterus’ by using their fingers without wearing gloves, but with the consent of programme administrators. A few of them mentioned that they were permitted to do so just once during the delivery pain.

*“UBAs could not understand the dilatation properly. For this reason they used their fingers repeatedly”.*

(FWV from Korail)

### ***Present barriers to executing the responsibilities***

In Kamrangir Char, the branch manager said that it was difficult to find a proper accommodation to setup a ‘birthing centre’. The whole area was full of factories and the houses were scattered all over, thus it was difficult to find a house which was conveniently situated to be a birthing centre. He also added that sometimes it was difficult to trace the patients among these scattered settlements. Branch managers also expressed that they felt helpless when facing multiple emergencies since they were the only male personnel in the Manoshi field team. However, they said programme administrators were planning to increase referral MoUs with some hospitals, which would aid in emergency situations.

Most of the POs said that due to the ‘health brokers’, it became difficult for them to admit the patients in hospitals. Most of the time, they were met with shortage of delivery rooms and having to wait longer in the hospitals. Also, it became difficult to arrange blood for the patients. While family members of all the pregnant women were informed beforehand about arranging donors, for slum people it was difficult to do any blood grouping. Slum people thought that any close relative such as a father, mother, brother, or sister of a woman would have the same blood group, and they all could be a donor if the need arose. They also added that the doctors at referral hospitals became annoyed if they referred any ‘perineal tear’ cases. In those situations, the PO or SK or SS, whoever accompanied the patient, felt embarrassed in front of the patient.

The SSs complained about their low incentives and most of the time they faced objections from their husbands for this reason. Moreover, they added that even after training, they did not feel that this was a good profession for them.

Almost all the SKs and SSs said that it was difficult to attract mothers to the birthing huts when they came to know that there was no doctor. They added that mothers, who have had previous deliveries at the birthing huts, did not want to come there for their subsequent deliveries. As the mothers gained more experience in the delivery process, they were less afraid of their situation, and did not wish to revisit the birthing huts. Some of the SKs said that some POs behaved badly with them, as the POs were always suspicious about their work.

Almost all UBAs complained about low remuneration. As such, it was difficult for them to depend on this profession, solely for income, where they were giving so much of their time. This was the major barrier to accomplishing their responsibilities. When they were asked to share some experiences about their work, they said that mothers did not want to cut the umbilical cord before the placenta was released which kept them engaged in a single birthing process far longer and prevented them from undertaking other deliveries.

When FWVs were asked to comment on the barriers they faced, most of them said that without any medical instruments they could not perform, often feeling helpless. They also asserted that they could not do anything even after understanding the problem of the woman in labour.

### ***Suggestions to improve the delivery services***

We tried to take the suggestions from all level staff of the birthing huts. Most of them said that birthing huts could be more attractive to the slum people if we could arrange immunization facilities for both mother and child. People did not want to go to different places for this service. They talked about the ‘blood bank’ which could be very helpful in emergency. All of them suggested free supply of iron tablets and some vitamin tablets which could attract poor people. Some of the SKs suggested that if BRAC could arrange provision of some family planning materials in the birthing huts, it would be of great help to the slum people. They said that sometimes women come to the birthing huts for MR and help with abortion. If the birthing huts could provide these services, next time they would be attracted to avail the services of the centre.

## DISCUSSION

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The aim of this study was to catalogue and understand the users', and the providers' perspectives on 'birthing huts' in four different slums of Dhaka city beyond their inception phases. Findings revealed mixed perspectives in this stage of programme implementation. However, there was indication that these new entities were trying to position themselves in the slum society to appear more attractive and active. We explored the facilities and services available in birthing huts, community's knowledge and perceptions about these and the providers account to better comprehend the successes and shortcomings of the process moving forward.

Birthing huts made the delivery processes safer and convenient for poor helpless women of the slums. In our study, we found that mothers were satisfied with the behaviour of the service providers especially the UBAs. But sometimes, pregnant women were mishandled by them when they performed internal (P/V) examination without gloves. The programme needs to pay special attention to the provision of supplies and its proper use.

Interestingly, mothers usually did not have any complaints about the intravenous administration of Oxytocin to induce and increase uterine contractions. All pregnant women and sometimes the UBAs preferred it and regarded as beneficial. The use of I/V saline with Oxytocin is very common in these slums and also in rural areas. TBAs would call nearby doctors or drug shop attendants to administer this saline when they felt that the delivery pain should be increased to help induce delivery. The programme's IEC campaign should focus on this phenomenon highlighting its harmful and sometimes, life-threatening consequences.

Almost all women and their mothers-in-law expected steady medicine supply and the presence of a fulltime doctor in birthing huts. Slum people would not recognize health services without the presence of doctors and sought their availability as reassurance of a "complete service". SKs and SSs of the birthing huts also mentioned the community demands for a fulltime doctor.

The birthing centre in Kamrangir char is not well placed given its scattered housing environment. It is difficult to go to the centre because of the distance and much of that slum population prefers Dhaka Medical College in cases of

emergency management. Otherwise, they did not want to go out of their houses for delivery. Uttara is not a typical slum, and many people did not know about the birthing centre. A majority of them are homeowners within the slum (Bamnarteck area), and they are living in their own houses. Comparatively, in Uttara, people have better economic status to other slums of Dhaka. This could be a reason they do not want to go to the birthing huts for delivery. In all areas acceptance of birthing huts were not equal amongst the community. Slum people of Korail and Shobujbag knew more about the huts. A possible reasoning may be the duration of services' existence in those areas. Korail and Shobujbag were the first selected areas for birthing huts and the programme started its work there from July 2007. People from those areas knew more about the services of the huts.

There are some misconceptions about practices prevalent through all levels of staff at the birthing huts. Sometimes the main reasons behind these misconceptions were that the impacts of old practices were often exhibited during the caring process.

### **Key points to note from the study**

- A doctor's service at the birthing centre was highly in demand.
- One-stop services are expected during ANC, during delivery and PNC.
- Community was not adequately aware of the birthing centre facilities or services when registered with it.
- Service providers were not always satisfied with their remuneration so as to ensure better services.
- All the providers were not aware about all the services of the huts, specially the services at referral points.
- Sometimes selected area for the birthing centre was saturated with other health facilities.

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