Midterm evaluation of the project:

Improving Health for Women in the Netrakona Region in Bangladesh

Applicant organization: Internasjonal Dugnads Kvinnegruppe (ID), (the Norwegian branch of Service Civil International) and FOKUS (Forum for Kvinne- og Utviklingsspørsmål).
Co-operation partner: The Norwegian Association of Midwives (DNJ).
Project number: GLO-01/413-19-BDG
Norwegian project designation: Forbedring av helseforhold i forbindelse med svangerskap og fødsel i Netrakona området.
Name of local partner: Sabalamby Unnayan Samity (SUS).
Project duration: 2005–2007
Midterm evaluation: October–November 2006
Evaluation visiting-team: Ms Mirjam Lukasse and Ms Marit Heiberg. Ms Lukasse wrote the report, while Ms Heiberg used this visit as a follow-up visit. All important issues in this report were discussed between them. A concise verbal evaluation was given to all the staff at the Health Project, together with Mr Dillo on the last day of the evaluation visit.

Ms Lukasse (RN, RM and MSc in Advanced Clinical Practice in Midwifery) works as a consultant-midwife at the Rikshospitalet in Oslo. Mirjam Lukasse was part of the final evaluation team in November 2004.

Ms Heiberg (RN, RM) works at the Norwegian Association of Midwives (DNJ). Ms Heiberg has been involved in the project from the beginning. Ms Heiberg was part of the midterm evaluation team in 2003. This was her 4th visit to the Health Project of SUS in Netrakona.

Objective and Focus for the Midterm Evaluation

The purpose of the midterm evaluation of the Health Project was to find out if SUS reaches its goals, performs the activities it planned, reaches the target group, delivers good quality health care and has worked with the recommendations given at the final evaluation of 2005. In addition, we looked at the organization and administration of the Health Project, its place

within SUS and the gender issue within the Health Project and SUS. Finally, we wanted to find out how the two Bangladeshi midwives who, as part of an exchange programme, had been in Norway for a period of 9 months, had settled back into work at the Health Project in Netrakona.

History of Previous Follow-Up Visits and Evaluations

This project was started in 2002. During the first period from 2002–2004, several follow-up visits were organised and performed by representatives of the Norwegian Association of Midwives (DNJ) and Internasjonal Dugnads kvinnegruppe (ID). This first period was evaluated by a midterm evaluation in 2003 and a final evaluation in 2005.

The second and present period had a follow-up visit by the two Norwegian midwives who worked at Netrakona as part of an exchange project between Norway and Netrakona for a period of 9 months during the first period of the project. Ms Kathrine Raaen, one of the two midwives mentioned above, wrote an informative and detailed report about this visit.

Presentation of Sabalamby Unnayan Samity (SUS)

SUS is a local NGO established in 1986 by Mrs Rokeya Begum. The organisation is located at the outskirts of Netrakona. SUS works with underprivileged and marginalized women, children, adolescents and the disabled through a holistic and participatory approach based on the needs of the community, with a prime focus on livelihood development. SUS is committed to bringing about positive changes in the quality of life of the deprived by making available education, comprehensive health services, micro credit as well as other social services that enable them to exercise their socio-economic rights. SUS firmly believes that the quality of women's lives is enhanced by emphasising an inclusive gender approach, community participation and collaboration with governmental and other relevant organisations. SUS has been working in the health sector since 1998 and been financially supported by ID/FOKUS since 2002.

Brief Description of the Comprehensive Health Services and Reproductive Health Care Project

SUS's Health Project is primarily a community development project. This involves community meetings on health issues, satellite clinics, identifying and treating the disabled and the training of traditional birth attendants (TBA). SUS also runs an outpatients clinic mostly for women and children with a focus on reproductive health and vaccination. This

Static Clinic is based in a three-storey building, hereafter called the Health Centre, which was built with the purpose of starting both outpatient activity and a small maternity unit. At present there is only outpatient activity. The Health Centre has its own laboratory, a small drug store, meeting rooms for staff training and a physiotherapy room. Most of the rooms meant for the maternity unit stand unused for a large part of the year.

Brief Description of the Project Area

Ms Kaosar Afsana in her article on the tremendous costs of seeking obstetric care in Bangladesh writes:

"Bangladesh is primarily an agrarian society with an annual GDP per capita of US$ 370, and a very slow economic growth. At least 47 million people live in extreme poverty, of which women are the most disadvantaged. Government expenditure for health is about US$ 3 per person per year, yet an estimated US$ 12 is required to provide a minimum level of health care. In Bangladesh maternal mortality is among the highest in the world, 320 per 100.000 live births. Each year approximately four million women become pregnant and 600.000 develop complications. Although some 15% of pregnant women require life-saving obstetric services, only about 8% of all births take place in medical facilities. Women with obstetric complications fear to seek hospital care for various reasons, one of which is the tremendous cost" (Reproductive Health Matters 2004;12(24):171–180).

The prevalence of child deaths is also high. According to WHO the neonatal mortality rate for Bangladesh was 42/1.000 live births in 2002. The neonatal mortality rate is the number of deaths registered per year of infants under the age of 28 days per 1.000 live births.

Method Used for Evaluating the Health Project

The evaluation is based on interviews with a variety of different health workers, observations of health promoting activities and a TBA forum, and the investigation of some of the records kept and various reports written by SUS.

Goals of the Health Project

The overall aim is improved reproductive health in the Netrakona area in Bangladesh.

The following goals were recorded in the application for financial support of 2006 (from "Søknad om støtte til project for 2006"):

a) Awareness building through counselling about existing diseases, their causes and consequences among 11.500 general mothers.
b) Focus on greater solidarity to create potential awareness for preventive diseases and to mobilise the community for taking steps for 100% coverage on sanitation and safe drinking water among 30% of the targeted households.
c) Provide intensive theoretical and practical training for 172 TBA's to ensure pregnancy control and safe home delivery.
d) Provide consultation to the 30% of the targeted pregnant mother for improve antenatal, natal and postnatal care.
e) Introduce 100% pregnant card among the participated pregnant mother and ensure its regular practice to realize the importance of the card.
f) Introduce improved 10% of the targeted adolescents care (i.e. for adolescent. prevention of early marriage and early pregnancy is most important because this is very common).
g) Ensure 100% vaccination for children and mothers within the participating working area.
h) Provide support to the 990 disabled for their rehabilitation according to the need of physiotherapy, assistive device, operational support and introduce disability prevention care

Activities planned to reach these goals:

a) Arrange 276 community meeting/year to disseminate knowledge on personal hygiene/safe water/common health hazards of adolescents/prevention of early marriage/importance of pregnancy care/safe delivery/baby-care/breastfeeding among 11.500 households
b) Arrange 72 meetings by the social communicator to aware the community about the causes of disability and identify the disability among 30% of the targeted population
c) 172 TBA's will attend 24 times a year in the field based discussion meeting in the targeted working area on safe delivery, pregnancy care, breastfeeding and newborn baby care
d) 80 untrained TBA's will attend 3 days intensive training course

e) 120 trained TBA's will attend 2 days long intensive training course
f) 6 TBA forum (6 times 21 TBA's in each area) will meet together quarterly to collect information about pregnant mother, safe delivery status, complications as well as reorient them for their role as TBA
g) Refresher training for 6 social communicators and advance training for physiotherapy for 2 staff
h) 20 times 6 areas cerebral palsy children mothers 2 days training on disability rehabilitation
i) 20 community youths times 6 areas trained them on disability care volunteer
j) 120 satellite clinic for unserve and under serve areas only in Netrakona to provide counselling and curative care for average per day 12 pregnant mother and 30 general clients
k) 264 Static Clinic will provide pregnancy control, pathological test, diabetic test, preventive and curative services
l) 96 times 6 areas Static Clinic will be held on disability rehabilitation and prevention care
m) 11.500 (in 6 areas) fertile couples (age group 15–45) will be directly under the SUS for family planning service
n) 96 vaccination day for providing vaccination for 0–5 yrs old children
o) teaching of staff at the Health Centre
p) follow-up of recommendations from evaluation

The Organisation of the Health Project Itself and It's Place within SUS

Previously the Health Project had its own programme director. Since the last director left the job no new person has been appointed to this function. For the time being this job is being done by Mr Dillo, who is also the programme director for the financial department at SUS. The Health Project needs its own programme director. This will give the project a better representation at a higher organisational level. No doubt Mr Dillo attempts to give the Health Centre the attention it needs, but he is a busy man whose primary job is the financial department. To be director for the Health Project is a full-time job.

At present the Health Project's doctor has the role of project manager for the Health Project. The doctor has an important role within the Health Project. However, at present there is only one doctor connected to the Health Project, which means this one doctor has many other duties beside management. Clearly the doctor together with all the staff should be

involved in planning the activities for the Health Project. However, it would be better use of the human resources to free the doctor of as many management duties as possible and appoint another person to the job of project manager.

The programme director as well as the project manager are key persons in developing the Health Project. It seems a good idea that these persons would have a background in health care. Without these persons the project will keep doing what it has been doing. To develop new strategies, ideas and plans and to execute them, these key persons must be in place.
The Health Project has three main branches:

1) disability rehabilitation
2) community development
3) reproductive health

Both the disability rehabilitation and the community development work have had stable leadership in the past few years. Ms Shilpi Biswas leads the rehabilitation work, and Ms Diluara Begum leads the community officers (CO). The reproductive health team consisting of four midwives and one doctor has seen a great turnover, both in staff and in leadership. Their leader has been the doctor, who at the same time is project manager. This means that the reproductive health team in effect doesn't have its own leader. The reproductive health team needs their own leader to ensure a service that is effective, of high quality and one which develops according to the needs of the population and the possibilities offered. At the moment the midwives take turn at being in-charge. However, this is not a leadership function but more or less the assignment of certain practical and administrative duties.

The Gender Perspective

During this short visit it was impossible to get a complete overview on the gender distribution within SUS. The general impression is that there are significantly more men than women in leading positions. All the programme directors are men. The doctor acting as project manager for the Health Project is also a man. In order to create more gender equality we suggest that the programme director as well as the project manager for the Health Project should be women.

Reaching the Target Group

The overall aim of the SUS Health Project is to improve the health of the people in Netrakona and the surrounding area. The focus is on reproductive health. The desire of both SUS and the

funding agency is to reach the extreme poor. Two things need to be looked at in this respect, fees and location.

Fees:

From the article quoted earlier in this report it is clear that poverty is a major barrier to good health. On the other hand, it is a generally accepted truth that people don't appreciate things and services if they are free of charge. This truth is usually mentioned when fees are discussed.

SUS charges for its services, and the fees don't appear high. However, for the really poor, these fees are too high. It has been suggested earlier that the fees should be adjusted or cancelled when necessary. During our visit, we observed that in effect only the doctor had the authority to reduce or cancel fees. We suggest once again that SUS takes a critical look at their fee-system. SUS charges for the delivery packs which are fully financed with money from abroad, which is sent in addition to the support to the project in general.

Location of Care Provided:

From our observation, it was clear that more poor women and children would be reached by visiting the villages with satellite clinics. It costs time and money for women to travel to Netrakona to the Static Clinic. Our suggestion is therefore that SUS increases the number of satellite clinics. While visiting a satellite clinic, we observed that women who consulted the midwife for the first time during their present pregnancy were encouraged to visit the Static Clinic as soon as possible. In general, they did not receive an antenatal card at the satellite clinic. To force women to visit the Static Clinic is unnecessary, as was explained in the follow-up report by Kathrine Raaen. One argument for encouraging pregnant women to visit the Static Clinic was the blood test which should be taken routinely. These routine blood tests will be discussed under the evaluation of the antenatal care.

There is good reason to believe that the Health Project could improve its care for the really poor by changing their fees system and providing more care there where their target group lives, i.e. in the villages.

Reaching the Numerical Goals

SUS has many numerical goals. It was impossible to evaluate whether all the numerical goals are going to be reached. Even though it is good to have numerical goals, it is easy to get distracted by them. The content of the activities is as important, if not more important.

It appears SUS will not reach their own goals regarding the teaching of TBA's and the teaching of their own staff.

In the final evaluation 2005 it was pointed out that the statistics provided by SUS were difficult to interpret and impossible to compare to national statistics. SUS has stopped the recording of details from the eligible couples. Instead they now collect information from the TBA's. At the time of our visit, no calculation had been done with the data gathered from the TBA's. Reliable methods for finding out maternal and perinatal mortality do exist. However, it requires specific expertise which SUS does not have and probably doesn't need.

The Quality of the Care Provided

Disability Rehabilitation:

There was not enough time during this visit to observe the work of the disability rehabilitation unit. We were provided with information about their work and visited some successfully treated children at their homes. This unit has since 2005 become very involved in finding persons (age 1–25) with un-repaired cleft-palate. Another funding organisation pays for free operation of these defects. The operations are performed in Dhaka. SUS assist the families of these persons, mostly children and youngsters, with travel and accommodation.

From conversations with the staff, one gets the impression that they believe that most, if not all congenital abnormalities (abnormalities the baby is born with) are caused by the behaviour of the expectant mother. For example by carrying heavy things or wearing tight clothes etc… This is a terrible misunderstanding which must create a great deal of anxiety to the mothers of these children. Most congenital abnormalities have genetic origins while some are caused by drugs (medication). Very few can be directly linked to the mother's behaviour. An example of this is the use of alcohol in pregnancy, which is rare in Bangladesh. It would be good if the staff at the Health Project could realize this and stop giving wrong information.

The Laboratory:

As a midwife I am unable to evaluate the quality of this work. On visitation the laboratory appeared clean. The lab-technician has worked at SUS for 10 months at the time of the evaluation. He stated the he definitely could be busier and looked forward to the day a maternity unit would be established. We failed to find out if the technician was vaccinated against Hep-B. He did show us the gloves he used to handle samples.

The Vaccination Programme:

Due to limited time, evaluation of the vaccination of newborns was not prioritised this time, since this was evaluated as satisfactory both by the final evaluation and the follow-up visit in February 2006. Some of the good suggestions made in the rapport from the follow-up visit in February 2006 have not yet been realized.

Family Planning:

SUS depends on the government for their supplies of contraceptives. During our visit, no injections were available. This of course is a problem for both patients and staff. Contraceptives are free of charge, except condoms. It may be possible to buy the contraceptives in town when the government has run out of them. It would be good for those who regularly receive injections to be able to continue with this method. In February the possibility of the midwives learning to insert Copper-T (Intra Uterine Device) was discussed. The midwives didn't think women want this method. I suggest that the reluctance is on the part of the staff. But clearly without proper teaching and training the midwives won't able to perform this. However, if SUS found a course on family planning that some of the midwives could attend then they should send as many of their staff as possible.

Antenatal Care:

Ms Heiberg did most of the observation of the antenatal care provided. Ms Lukasse only observed one consultation at a satellite clinic.

As was reported in the follow-up report from February this year, the quality of the care given by the midwife has improved greatly. The number of antenatal visits per women was reduced in accordance with WHO's recommendation.

Going through the doctors register (in which all patients he sees are recorded on a daily basis), it is clear that many pregnant women are referred to the doctor. When the midwives were questioned about this, they mostly answered that this is the women's wish. From the women's records it was obvious that most women didn't have a medical reason for seeing the doctor. A doctor has a much higher status as a health worker than a midwife. However, this practice of referring women who do not need referral only confirms this conception. As the present doctor is not specialised in gynaecology and obstetrics it could be argued that the midwives in effect are more qualified and have more experience in caring for pregnant women than the doctor.

In the counselling room we observed a film being shown to pregnant women and their relatives (usually mother-in-law). It was a locally produced film which seemed very relevant. So far no action plan/guidelines have been made to help midwives cope with complicated pregnancies.

The quality of taking a history from the pregnant women can still be improved.

Care in Labour:

The midwives working at SUS have little experience with the care of women in labour. They have previously been advised to attend some home deliveries to gain experience. Experience of caring for women in labour and doing deliveries will give them natural authority when teaching TBA's. It will also make their teaching more relevant to the TBA's daily practice, and if a maternity unit is started, the midwives need to know where the patients come from and have seen some normal labours before having to deal with complicated cases.

During our visit, we observed no home deliveries attended by the midwives from SUS. But a record of all the deliveries attended by SUS midwives is kept. Ms Lukasse went through this record together with Ms Kulsum. From January 2006 til our visit 10 deliveries were attended. On the basis of this, the following recommendations are made:

1) Better records need to be kept. It was impossible to find out whether the woman in labour was a primiparous (giving birth for the first time) or multiparous. This is important information in labour. All babies were recorded with a weight of 2,5 kg. But the babies are not weighed and this is just an estimate. Maybe a correct Apgar Score and a note about the size of the baby (small, normal, big) are more relevant?
2) More restricted use of antibiotics. Several women received antibiotics after a perfectly normal delivery. The unnecessary use of antibiotics creates resistance, which is becoming a worldwide problem in the provision of health care.
3) The midwife needs to be aware of the fact that she acts as a role model while giving care at home. She needs to think carefully about the action she takes as deeds speak louder than words. Several women received an intravenous drip of oxytocin which stimulates contractions. Others received a drip of "strengthening Gluc 5% and IV vitamins". If the TBA's get the impression that such is needed to attain a spontaneous vaginal delivery, they will adjust their practice accordingly.
4) The midwives should make an effort to attend more deliveries in order to gain experience.

Community Meetings:

Two community meetings were attended by Ms Lukasse, one specifically for pregnant women and their mother-in-laws and one general one. These meetings were well attended, mostly by women, but also by some men. It seems wise to combine these meetings with a satellite clinic as is often the case. Also in this case the midwives would be capable of doing more teaching when the subject is pregnancy, labour and breastfeeding.

Satellite Clinics:

These clinics are a great service to the community which SUS serves. The midwives run these clinics. The antenatal care they provide has been amply commented on elsewhere in this rapport and in the rapport of Kathrine Raaen. As stated in previous reports and evaluations, these midwives are not general practitioners. Once again we ask SUS to assure that the midwives receive the necessary teaching to deal with general patients. The records kept from these clinics can form the basis for weekly discussions on the care for general patients. It would also be useful for the doctor to attend some of the satellite clinics to take time to do some practical teaching. As stated earlier in this rapport, the number of satellite clinics could be increased and the geographical area covered could be increased.

The TBA Training

This consists of three types of training.

a) TBA intensive course: involves teaching of untrained TBA's over 3 days
b) TBA refresher course: involves teaching of trained TBA's over 2 days
c) TBA forum: a one day meeting with trained TBA's to collect information from them and discuss their experiences

The programme from the TBA intensive course for untrained midwives was verbally translated in an interview with the midwife Ms Kulsum. During our visit we observed one TBA forum. The programme started late even though all the TBA's were there on time. The main reason for starting late was the time it took to collect the information from the TBA's. Ms Diluara led the day. She has a natural authority with the TBA's and is known to them. She did a great job in leading the programme.

Time was used to allow the TBA's to share some of their experiences. This is a very good. The TBA's did share experiences. These were written on a board and later commented on by the doctor. Much time was used on writing the presented cases down. Most of the TBA's have

limited literacy skills. Perhaps just verbal presentation and immediate discussion of each case would be a better way. Contradictory advice was given. The doctor taught that women should be referred to hospital after 6 hours of spontaneous rupture of membranes (SROM). The TBA's didn't question this, but we did. We then found out that all previous teaching had been referral to hospital after 12 hours of SROM. We explained that the practice in Norway is induction at the earliest after 24 hours of SROM as long as the liquor is clear and the woman does not have signs or symptoms of infection. We stressed the importance of no vaginal examination after SROM with the absence of uterine contractions.

One of the midwives who stayed some time in Norway as part of an exchange programme, did some teaching. She did an excellent job, using visual aids and drama to teach. Ms Shahana, from the teaching department of SUS, taught the 5 danger signs in pregnancy.

In accordance with the recommendation from the final evaluation, the number of days these training sessions go over has been reduced and more interactive teaching methods are used. The midwives should be used even more in the planning and execution of the programme. There seems to be no good reason why Shahana from the teaching department teaches at the TBA training course. She does a lot of teaching about syphilis and other sexually transmitted diseases. This seems of little use to TBA's. The teaching she does on pregnancy and labour she is not qualified for. This reduces the quality of the teaching. Ms Shahana's only practical experience with obstetrics is the delivery of her own child. The programme has too much repetition because different people teach the same things. If only the midwives did the teaching with Ms Diluara leading the day the midwives could extend the teaching into practical teaching on vaginal examination, first aid in a haemorrhage situation resuscitation of the newborn, a difficult shoulder delivery, an unexpected breech delivery, care for engorged breast etc…

The Staff

Turnover:

At the time of our visit one of the midwives, Ms Rokeya, who had been in Norway for 9 months. had left the Health Project and was now reported to be working in Saudi Arabia. This was extremely disappointing to both SUS and the Norwegian partners. The other midwife who had been in Norway, Ms Kulsum, was still working at the Health Project. It appears that her time in Norway has taught her a good deal.

The midwives and as well as the doctor stated that although they enjoy the work they are doing and are content with the pay they are getting, they still wish for a job provided by the government, as there is more security in this kind of position. This makes it difficult for any NGO, including SUS, to retain their staff, something which is clear from the high turnover observed. The personal without a formal education does not have the same opportunity to get a job with the government. There is subsequently less turnover among them.

Qualification and Ongoing Education/Training of the Staff:

Beside a one day workshop, on obstetrics and gynaecology, organised at the Health Centre for the midwives and doctor, no other ongoing education seemed to have been provided for the staff at the Health Project.

As mentioned before, the midwives need teaching in how to deal with general patients. This should happen regularly with real situations as the basis for learning. If courses are available within Bangladesh on family planning, then all the midwives should attend in turn. Also the community organisers need new teaching on a regular basis. To be able to go on a course or even to have a course organised locally, has a positive effect on the employees, both on their commitment to the work and the quality of the work provided.

The lab-technician has a very lonely job with no colleagues. He needs to be able to meet colleagues and keep up his skills on those tasks he doesn't perform often at the Health Project. Dr Maksudur Rahman is a general physician with a diploma in anaesthesia. He has little experience of obstetrics and gynaecology. It would be good, if an opportunity arose, for him to gain more knowledge and experience in this field.

The Future

All the staff interviewed by Ms Lukasse expressed the wish for a maternity unit to be established. There is no doubt a local need for a maternity unit which can deal with complicated deliveries. At present, neither the midwives nor the doctor is qualified to take care of complicated obstetric cases. Dr Maksudur Rahman could administer anaesthesia, but he has no experience in obstetrics.

Starting a maternity unit would require hiring personal which are qualified and experienced in dealing with complications. The costs of the Health Project would rise dramatically as personal would need to work evening and night duties and weekends.

In short, starting a maternity unit is a major job which requires money, qualified employees, its own project leader and close follow-up.

Conclusion

The Health Care Project is doing a valuable and important work. The quality of the activities is improving. In order to reach the target group of the extreme poor, SUS needs to look at the fees they charge and the geographical location they provide care at. The midwives should be given still more responsibility in the teaching of the TBA's. For the health care project to move on and develop, it is necessary to appoint a project director as well as a project manager, both of them should preferably be women. All the staff regularly needs to be offered ongoing teaching and training, both to ensure the quality of their work and to encourage interest and commitment to their work. Starting a maternity unit would require a lot more financial support, new and more qualified staff, its own project leader and close follow-up.