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An Overview of the Safe Motherhood Services and Its Utilization Status in Bangladesh

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Abstract: Safe motherhood is a current discussing issue in health problem and health care as well. Both GOs and NGOs are concerned with this crucial matter and have been taking many initiatives to reach the ultimate goal. But these initiatives are not also out of question in terms of its function and services. The present study will discuss existing safe motherhood services in Bangladesh and the reflections and responses toward those from an anthropological point of view.

Key words: Antenatal, childbirth, delivery, gender sensitivity, maternal mortality and morbidity, postpartum, pregnancy, quality of care, safe motherhood

INTRODUCTION

Safe motherhood means creating the circumstances within which a woman is enabled to choose whether she will become pregnant and if she does, ensuring that she receives care for prevention and treatment for pregnancy complications-has access to trained birth assistance-has access to emergency obstetric care if she needs it and receives care after birth so that she can avoid death or disability from complications of pregnancy and childbirth. In fine, safe motherhood means ensuring good health for women and their babies during pregnancy, delivery and in the postpartum period.

The World Health Organization (WHO) estimates that 585,000 women die each year from complications of pregnancy, childbirth and unsafe abortion-about one death every minute. Nearly all of these deaths could be prevented. Ninety-nine per cent of the deaths occur in the developing countries. A women's lifetime risk of dying from pregnancy-related complications or during child birth is one in 48 in the developing world versus only one in 1800 in the developed world. The risk of dying from pregnancy-related causes is highest in Africa. Because of the much larger population, however, each year the majority of maternal deaths take place in Asia.

In Bangladesh, about 28,000 women die every year due to causes related to pregnancy and childbirth. Maternal nutritional status, practices during pregnancy and delivery and availability of obstetric care are factors that not only affect the survival of both mother and child, they also influence subsequent growth and development of the newborn.

Though many GOs and NGOs have been taken initiatives yet the desired achievement has not been seen in reducing maternal mortality, which remains stubbornly fixed at around 450 deaths per 100,000 live births. Access to the essential elements of safe motherhood-antenatal care, clean and safe delivery and essential obstetric care-remain inadequate for the majority. Only one quartet' of women in Bangladesh receive antenatal care, while only 8% have an assisted delivery.

As safe motherhood is an important part of life Government Organizations (GOs) and some Non-Government Organizations (NGOs) has taken massive programs to ensure safe mothering. But only initiatives are not enough. There are problems from both providers and receivers part. And that is why safe motherhood services are being questioned from some sectors. The study is to determine the present status of the running service programs and studies regarding with this issue.

The main objective of the present study is to determine the present status of safe motherhood services and studies associated with this issue. It will also examine the role of some GOs and NGOs which are working in this field.

The specific objectives of the present project as follows:

- To identify safe motherhood services provided by some government and non-government organizations.
- To identify the utilization status of those services.
- To explore the causes behind the existing utilization status identified by the organizations involved.
- To assess the actual causes of inability or difficulty in providing quality services.
- To examine the organizational roles of that GOs and NGOs which are working for safe motherhood.

The present paper is made on the basis of some research reports and the author's personal experiences while working in some research projects on the same issue.

RESULT AND DISCUSSION

Institutions involved in maternal health improvement, research and development: In Bangladesh many institutions both Government Organizations (GOs) and Non Government Organizations (NGOs) are involved in maternal health improvement, research and development. These organizations include the National Institute of Population Research and Training (NIPORT), the Bangladesh Association for Prevention of Septic Abortion (BAPSA), the Bangladesh Institute for Promotion of Essential and Reproductive Health Technologies (BIRPERHT), the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), BRAC and some other organizations. Most of these carry out their activities with financial assistance from donors. International and bilateral organizations including WHO, UNFPA, UNICEF, UNDP, UNHCR, World Bank, ADB and DFID are also playing a vital role providing policys guidelines, implementation support and infrastructure development for improvement of the health sector.

Service Program of GOs and NGOs: Maternal and Child Health (MCH) services have been given highest priority in the health policy of the government. The services are provided through the countrywide facility network. At the community level the Family Welfare Assistants and Health Assistants provide the services from the Community Clinics (CC). At the union level a Family Welfare Visitor (FWV) and a Sub-Assistant Community Medical Officer or Medical Assistants are mainly responsible for providing the services. There are also 250 Graduate Medical Officers posted in 3,275 UHFWCs for providing MCH services. At the Upazila level, the MCH unit of the Upazila Health Complex (UHC) headed by a Graduate Medical Officer is responsible for providing MCH services. Trained support personnel such as FWV and Ayas (female ward assistants) assist as well. There is also a position of junior Consultant (Gynaecological) who provides services in case of emergencies, attending all deliveries at the UHC and all referred maternal patients. The activities of the MCH unit and other maternal health care services are supervised by the Upazila Health and Family Planning Officer in the UHC. The MCWCs established mainly at the district level (with some also at the Upazila level) provide only the maternal and child health services under the direct control of Directorate of Family Planning. These facilities are expected to be equipped to provide basic EOC and obstetric first aid. The district hospitals (DHs) in the district headquarters provide maternal services through an outpatient consultation centre and a labor ward. Between 25-40% hospital beds are reserved for maternal patients in every hospital.

Like GOs, the NGOs working with safe motherhood have extensive service network at the community level. BRAC, ICDDR,B, CARE and many more national and international NGOs are working on this issue. They all have their own service model through which they are running their safe motherhood programs. These programs have been conducting research in critical and priority areas of reproductive health in various parts of Bangladesh. These include identification of determinants and consequences of reproductive ill-health, followed by appropriate interventions with the ultimate aim of improving reproductive health. They are providing Safe Motherhood interventions as a means of reducing maternal mortality and morbidity. They are working on the projects aiming to promote utilization of basic EOC (Emergency Obstetric Care) services at union level and comprehensive EOC services at the Upazila level by women in need of those services, particularly those with obstetric complications. These organizations have their community level workers who visit door to door and provide safe motherhood messages and services to the people.

Sometimes GOs and NGOs work together on this issue. Non governmental organizations often run some joint program in collaboration with Government to develop the maternal health status by using the govt. infrastructure at community, union and upazila level. The government UHCs (Upazilla Health Complex) is being used as referrals for comprehensive EOC services in case of obstetric emergency by the community level health centers.

Utilization Status of Maternal Health Services: In Bangladesh personal beliefs, social responsibilities and community norms shapes many aspects of maternal health seeking behavior. Childbirth is an important factor that influences social environment and normal life style of people. Traditionally, pregnancy and birthing is considered a normal way of life that does not require hospitalization. In Bangladesh, the majority of women go to their own parent's house for childbirth. This is the normal place for her where she gets the normal environment. The hospital has an environment, which is diametrically opposite. This is seemingly an artificial and mostly unfavorable environment devoid of her known people etc, which often she dislikes. As a result, especially the poor are reluctant to visit a hospital in obstetric emergency. Most of them do not visit the health centers during the postnatal period. Sometimes when they feel urgency to go to hospital it in most cases is too

late. It has been observed that local beliefs and customs often lead to preference for TBAs (Trained Birth Attendants) as an initial choice of delivery attendant. Yet some supernatural views are also found to delay uptake of professional care when complications arise.

Cultural and social norms have been shown to affect preference of location and attendant for delivery. They also may lead to unnecessary delays in seeking care, especially if danger signs are not recognized or understood. However, there have been further examples of cases where such factors may have also led to women refusing referrals, even when potential complications have been professionally identified Fear of medical intervention, evil spirits, shame and delivery at home as all rooted in the specific cultural background of the women-although it is observed that the percentages of Muslim and Hindu women refusing referral are similar, which seems that religious norms and regulations also plays significant role in decision-making.

In the question of the quality of care, in fact, it is a great matter of regret that satisfactory caring does not prevails both in government and non government organizations. Disappointing with undesired below standard and low quality of services, service seekers do not feel its inevitability. Providers of government organizations also feel no necessity and interest to attract and inspired the people to be hospitalized by their services. They are indifferent with these services. Providers of non government organizations are sometimes enthusiastic and some NGO services are good but beyond the reach of the lay community. Providers and patients interaction is another important influencing factor to the service. Alike the quality of care providers and patients interaction is not friendly as required in such a crucial health problem and caring. Service seeker could not be assured by such an unfriendly relation which is not desirable from such humanitarian centers. Because of unwanted barriers and poor performances of the providers, safe motherhood has become a myth. In most cases people do not feel homely and friendly atmosphere at hospital and that is why they love to avoid so called safe motherhood services provided by both GOs and NGOs, specifically during pregnancy period, delivery time and postpartum period as well. It is not unlikely that rural and urban scenario is different. Though services from provider's part is almost same in both urban and rural areas, urban mother like to give birth her child at hospital with trained obstetric attendant. Rural-urban beliefs, norm and tradition play an important role in this regard. Norm and values are also changing in Bangladesh. New modern identities are important parts of the narratives given by women. The rural woman links modernity with attitudes of the younger and educated generation, some women even embarrassed to admit traditional norms and practices. These changes in attitudes are significant as they are influencing health seeking behaviour. But the problem is about the quality of service.

In Bangladesh, there exist many barriers that significantly influence the use of health facilities. Some of these are: cultural stigma, distance to the facilities, cost of accessing services and perceived quality of services. Cultural barriers are particularly important for women trying to access services. First, it is often considered shameful for women to visit hospitals to be examined by male healthcare providers. Second, women prefer to deliver in the comfort of their relatives and not in the hands of strangers in health facilities. Third, the delivery position and the short delivery-beds used at home appear to be very convenient to them and to the traditional midwife. Fourth, when a pregnant woman attends a clinic, she is never shown around to see what facilities are available for her eventual confinement and delivery.

Causes behind Non-utilization or Lack of Utilization Identified by the Organizations: It is important to the organizations, to attempt to understand the reasons behind the low utilization or/ non-utilization levels of facilities and professional attendants. There are a number of published and unpublished works that explores women's experiences, views and beliefs in relation to delivery in Bangladesh. These studies have found a wide range of factors that may contribute to low levels of use of professional services, to delays in the decision to seek care, or to refusal of referrals for service[1] Donabedian, etc.). From some research studies and from personal experiences through field observation by the author some main reasons of the lack of utilizations are identified include poverty, cost, ignorance or lack of awareness, negative cultural belief, negative role of the husbands and elder females in the family. The first biggest reason for under utilization and non-utilization of existing health care services by the people studied is poverty. The second biggest reason is the negative attitudes of service providers. The third reason of under utilization/non-utilization of health care facilities is the lack of awareness on the part of the patients. They do not utilize healthcare services during pregnancy and lactation because they are not aware about the need of utilizing such services. Some of the people do not utilize the health care services because of their traditional beliefs and values about pregnancy, which is fourth reason. They think that pregnancy is simple, normal and god-gifted natural process and so they believe that dependency on supernatural power is more effective than health care

services. The elder female members of the family sometimes do not allow the pregnant women to receive any antenatal care from centers. The reason behind such behavior is related to their own experiences about pregnancy. They perceive that as they themselves did not go to the health care centers during their own pregnancies, so it is unnecessary for their present juniors to do so. Gender sensitivity and power relations are also plays a significant role in decision making whether hospitalization is permitted or not. The women seemed less empowered in deciding the place of delivery. She in most case depends on her husband's decision. Without his consent she could not think of taking effort to go to hospital even she feels it safer place for safe delivery. However, even if hospital care is desired, there may be barriers to access and utilization from a number of unrelated factors. Difficulties in transportation are also significant.

It is found that the study population has a definite pattern of concern for the pregnant women in relation to manual work, physical exercise or movement[1]. The elder female members of the family encouraged reduction of physical movements of the pregnant mothers, which does not necessarily mean less work. Pregnancy is regarded as being in a frangile, vulnerable state. Various suggestions provided by the elder women of the family during pregnancy are not related to the scientific healthcare. Elder women of the family do not allow them to take prolonged rest, suggested too much activity may lead to frequent movement and instructs to eat less food.

Reflection of the Services: Though both government and non government organizations are working with the aiming of safer motherhood, but their facility activities is not easy and accessible for the commoners. In relation to cost of services, NGO centers are not accessible for the poor. Similarly, Government hospitals are affordable by the poor, but it is structurally inaccessible or poorly accessible. Service provider's attitudes and behavior is reported as one big factor that influences utilization. All the above factors are responsible in non-utilization and under utilization of childbirth services. In addition fear of hospital, fear of misbehaving provider and fear of caesarian section are very strong factors that influence utilization of childbirth services. Extortion of money by hospital staff (nurses, ayas and miniature staffs) is a serious complain against hospitals that also influences utilization. Conditions in the labor room amounts to cruelty. Privacy of clients is violated in labor rooms in many occasions and providers often appeared abusive and negligent in labor rooms. In addition to all these issues, rumors also influence utilization. These rumors are about abduction of child, leaving surgical instruments inside abdomen etc. Distance is a big and separate factor in childbirth services, because childbirth services are not available in most of the smaller centers. This factor is even more so, in case of emergency obstetric condition. The comprehensive centers that can provide such services are often far from the residence of a patient.

It is importantly noticed that low perceived quality of care to be a factor influencing choice of service provision and quality of care regarding this is poor[1]. In order to assess the quality of maternal health care services, a number of aspects can be analyzed including the structure, process and outcomes of services. The structural dimension of quality includes physical resources, human resources and organizational structure. The process dimension is concerned with therapeutic and diagnostic procedures involved in providing services including interpersonal relations with the users. The outcome dimension can be seen to deal with change in maternal health status due to intervention, along with mother's satisfaction. Each of these factors affects the quality of services individually and collectively.

Some non government organizations claims that they are trying their utmost to ensure safer motherhood through community participation, consciousness program, dialogue, campaigning, etc. In fact, they are tied with their traditional organizational circle that only serve their organizational achievement rather than safe motherhood as they claim. They are whirling round with no fruitful implementation. Same results prevail in the government projects as well. The gap between providers and users are also remarkable which should be eliminate to gain the desired result. Miserably, it is revealed that the community leaders are practically doing nothing themselves to improve the reproductive health care or safe motherhood services for their own community. But they are aware about the problems and lack of facilities. They also confessed their own inactivity in this relation, which they attribute to lack of fund and lack of communication. If all existing barriers behind the service would be eliminate, the wide gap between the service providers and receivers would be ejected and if it is possible to maintain standard quality of care, the concept safe motherhood will become a successful health phenomena.

CONCLUSIONS

Bangladesh has achieved important health gainsover the last decade. However, quivalentprogress has not been realized in the area of maternal health. Thematernal

mortality ratio as an indicator of maternal health in Bangladesh remains unacceptably high. In many ways the existence of a high MMR (Maternal Mortality Rate) represents the failure of the health system to effectively respond to the needs of women in the country, yet it must also be seen as the end point in a life time experience of gender discrimination, negligence and deprivation for Bangladeshi women. From a health systems perspective, maternal mortality is an indicator not only of women's health but also of access, quality and effectiveness of the country's health sector. Despite the presence of an impressive establishment of health infrastructure in the country to date, the maternal health situation remains poor, even though most maternal deaths are avoidable if adequate preventive measures are taken.

In fine, it can be said that safe motherhood services are mostly incomplete and very inadequate both in quality and quantity. There are many barriers to the inability to utilization of services. The barriers has been identified, therefore, these should be addressed. Ultimately, poverty is the greatest barrier. Poor cannot afford NGO services and they cannot often even purchase access government services to. It is recommended that there should be policy and program review on the basis of these findings. Further more study is needed to decide on the modification and improvement of safe motherhood services at the national level.

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