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Community Based Skilled Birth Attendants Programme in Bangladesh; Intervention towards Improving Maternal Health

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Community Based Skilled Birth Attendants Programme in Bangladesh; Intervention towards Improving Maternal Health

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Abstract

Aim
To review the strength and weakness of a community based skilled birth attendant (CSBA) program in Bangladesh.

Specific Objective
To explore perceptions of the providers, decision makers and community regarding newly trained community based skilled birth attendants

To understand challenges, gaps and obstacles and recommend potential solutions for programme improvement.

Design
A descriptive study, using a qualitative approach was chosen to elicit the views and experiences of different stakeholders and the beneficiaries of the program was undertaken. The study intended to enhance understanding on gaps and challenges during program implementation by getting insight into different views. The data were captured through different methods including in-depth interviews (IDIs) and Focus Group Discussions (FGDs). In addition, the initial review of the existing literature and other related policies and documents were also employed.

Participants
Nine in-depth interviews were conducted with graduate CSBAs, 10 with Key informants including government, donor agencies and CSBAs' trainers. Three FGDs were conducted with two groups of community women and a group of CSBAs trainees.

Finding
In general, the role and scope of work of CSBAs found to be uncertain; with no clear consensus on their job description or clarity of their role. Most of the respondents appreciated the role of the CSBAs in reducing maternal mortality; however, the real impact was still uncertain due to many barriers. The main barriers was low job satisfaction, lack of supportive work environment, supportive policies and low acceptability at the community which had led to the provider being demoralised and resulted in low productivity.

Conclusion
To achieve the MDG's targets related to maternal and child health, the health systems cannot function without competent and well trained skilled providers who can provide quality services. The CSBA program may not be the best solution in the long term but it could be a temporary option for emergency response to the crisis of human resources in health system but in long term government of Bangladesh needs to revise their policies and strategies to train more qualified health providers.

Keywords

Community, skilled birth attendants, midwives

Introduction

More than half a million women die each year from pregnancy related causes, a majority of which occur in the developing countries and are preventable [1-3]. Globally, the Maternal Mortality Ratio (MMR) and the proportion of skilled attendants at birth are the most important indicators to measure progress towards the achievement of millennium development goal 5(MDG5) [4].

Universal access to reproductive health services and the presence of a skilled care provider during pregnancy and birth was introduced as the main strategy for better health outcomes and for achieving the MDG5 by 2015[2, 3]. The recent midwifery series in the Lancet indicated the effectiveness of investment in midwifery as a potential intervention to improve maternal and child health especially in low resource settings [5]. However to provide such skilled care during childbirth is a challenge and many countries have not yet been able to meet[3]. In order to achieve universal access to skilled birth attendant in Bangladesh, midwifery services need to meet the needs for almost four and a half million pregnancies per year. [6]

To increase the coverage of skilled providers during birth most developing countries have upgraded the skills of existing community and traditional health workers[7-9]. However, experience shows this type of quick solution might lead to lack of attention to the quality of care [5].

Despite, some achievements in maternal health indicators in Bangladesh these are still far lower than the international standards for improving maternal and child health[10]. Bangladesh has a serious shortage of health providers, especially nurses and midwives. The 2014 State of World Midwifery Report, indicates that in Bangladesh the existing recognized skilled providers only meet the needs of 41% of women during childbirth [6]. The combination of a lack of human resources for health and inequity of distribution are recognised as some of the main obstacles in achieving MDGs in Bangladesh[3, 10-12]. In Bangladesh Majority of women who are poor and disadvantaged seek health care from unqualified providers [13]. Most women in rural areas have no access to maternal health services and most of the births take place at home without trained birth attendants [11, 14, 15]. A huge disparity between the urban and rural use of skilled birth attendants, the poor availability and the quality of care during birthing is of significant concern [11, 14-16].These disparities in access to maternal health services between the rich and the poor need to be addressed if MDG5 is to be achieved. [17, 18].

Bangladesh adopted a number of strategies to accelerate the progress in achieving MDG5 [19]. Since 1970 the government has trained different categories of human resources for maternal healthcare including 40,000 TBAs who were supposed to provide antenatal care, postnatal care and delivers in the community [20]. However despite this huge investment, this intervention did not reduce maternal mortality in Bangladesh [21, 22]. Hence in 2003 the government of Bangladesh took a new initiative by training a new cadre of community based skilled birth attendants (CSBAs) [20, 23]. CSBAs are the Family Welfare Assistants, Female Health Assistants and/or other similar community health who are employed by the government, NGOs or private sector. They have completed six months competency based training so as acquire proficiency to managing normal birth and to have the skills to detect possible obstetric complications at an early stage of labour [24]. The primary aim of the program was to improve coverage and access to professionally trained birth attendants at

community level and improve referral to emergency obstetric care (EOC) [23, 25]. Positive results after the pilot phase led to a national roll out of the program [23].

CSBA programme provided six month basic midwifery training to existing community based health workers. Around 7,000 CSBAs were trained by 2007 which was less than 50% of the target. Most of those trained have reached their retiring age and have not been replaced [24]. It was estimated that if Bangladesh continues to produce CSBAs at the current rate and deploy them in the community, they would be able to cover only 5% of all births by 2015 [26].

Studies look at challenges, quality of care, and acceptability of program as important elements that need to be considered with any community based approach[8, 27]. The evaluation of this program recommended four major intervention to improve the image and acceptance of CSBAs in the community, by promoting their skills and ensuring supportive supervision and timely supply of logistics [28]. Similar studies[29] discuss that there was lack of community involvement and awareness during the rapid expansion of the CSBAs programme had created a confusion and mistrust.

Lack of a supportive environment was identified as the main constraint during the CSBA program implementation[8, 11]. Another study notes that the low level of literacy of trainees and inappropriate and unsuitable teaching methods make the training even less effective[30]. Several studies have emphasized that the community is the main consumer of services; so they deserve to receive services from a competent and well trained health care professionals (31, 32). But on the contrary, in most developing countries with a human resource crisis, attention is focused on the number of skilled attendants rather than on the quality of training and an enabling environment (4). Training without the provision of the necessary resources, infrastructure and enabling environment cannot ensure quality of health services[30, 33].

Though evaluation of the CSBAs' competencies and the effectiveness of the programme were outside the scope of this study. However this study has tried to look at the CSBA program from a different angle and has explored the perceptions of the providers and the key stakeholders and the community regarding obstacles and potential ways for programme improvement.

Methods

A descriptive study using a qualitative approach was chosen to elicit the views and experiences of different stakeholders and beneficiaries of the services provided by the community based skilled attendants program in Bangladesh[34, 35]. The study intended to enhance the understanding on the real challenges and experiences of program implementation by seeking insight into different views of those involved in the program[36]. Data were captured through different methods[35] to make it information rich and confirm the interpretation of data.

Ethical approval was obtained from the International Centre for Diarrhoeal Diseases Research, Bangladesh (ICDDRB) and the Bangladesh Rehabilitation Assistance Committee (BRAC) ethical review committee.

Study Participants

Nine in-depth interviews (IDIs) were conducted with graduated CSBAs and 10 interviews were conducted with key informants (KI) including those from the government, donor agencies and trainers, two focus group discussions (FGDs) with women from community and one FGD with

students were also conducted. The three focus groups provided the opportunity to engage with groups of 10-12 women from communities and one group of students to share their thoughts, feelings, experiences and ideas about CSBAs. In addition the existing literatures and other related policies and documents were reviewed.

Study sites

At early stage of study BRAC (NGO) and Ministry of Health and Family Welfare (MOHFW) were contacted to identify study sites and participants based on their availability and accessibility. The study was conducted in Rangpur division in north-west rural Bangladesh. Due to high density of CSBAs working on that area and access to a training site four districts within Rangpur devision purposively selected (Gaibandha, Rangpur, Nilfamari, Dinajpur). A total of four CSBAs employed by the government and five employed by BRAC were participated in this study.

Two focus group discussions where conducted in two villages in Nilphamari and Rangpur with women who received services by CSBAs. One focus group was conducted with student at Lutheran Aid to Medicine in Bangladesh (LAMB) training centre in Dinajpur district.

Data collection

All interviews and the focus group discussions with the CSBAs and the community conducted in Bangla language between October to December 2010 using a semi structured field guideline. All key informants interviews conducted in English. Data collection was information-rich and continued up to the meeting saturation point as no new data was being obtained [37]. Interviews were recorded; verbal consents were obtained prior to interviews and all identifying features were removed ensuring confidentiality of data.

The data transcribed verbatim by trained Bangla speakers. The transcriptions were translated into English and read several times by the principal investigator and the research assistant to identify common issues and patterns and relevancy to study objectives. The data were categorized and some categories were merged together as common theme and sub theme. Data were coded, categorized and grouped under each relevant theme. The process ended when no further information could identify under each theme. All findings were categorised and collated.

Findings

Socio-Demographic characteristics

CSBAs' age range was 24 to 45 years. The mean age was 26 for CSBAs employed by the NGOs and 42 for the CSBAs employed by the Government. The basic education level was 10-12 grade.

Their work experience as CSBA was between 6 months to two years. All CSBAs employed by the NGOs had worked with the community as community health workers (*Shastha Shubika/ Shsta Kormi*) for at least three to five years before joining the CSBA programme. All government employed CSBAs had worked as Family Welfare Assistant (FWA) or Female Health Assistant (FeHA) for 10 to 15 years before becoming a CSBA.

Perceptions about the scope of work and role

In general, there was a mixed understanding and a lack of awareness about details regarding the CSBA's role among the study participants. Most community women were confused and were not able to identify CSBAs from other lay health workers in their community. Women in the area served by the NGO employed CSBAs were able to differentiate CSBAs from other community workers by perceiving them to be more educated.

Most CSBAs mentioned that their primary role was to supervise other community lay health workers, like TBAs, and to provide facility based services and attend clinical births.

> Shasta Shubica [BRAC community health worker] is working under me, my first duty is to monitor her movement within catchment area and check her register. She is supposed to identify TB patients, new pregnant women, and to provide ANC, PNC services to those mothers and if there is birth, she should refer to me at the facility. [CSBA]

CSBAs that were trained by NGOs were more likely to carry out follow up and outreach visits. A few CSBAs perceived providing counselling and health education to women as a part of their role. None of the CSBAs who participated in this study had received any document or orientation regarding their role and responsibilities.

Key informants assumed that CSBAs role was believed to be the management of most complications to reduce workload in health facilities. Key informants also emphasised the importance of post referral follow up by CSBAs. Data from the CSBAs' daily register indicated that the average home deliveries conducted during the previous month was four by NGO CSBAs and less than two by Government employed CSBAs. The number of referrals by NGO CSBAs was at least five cases per month and among the government CSBAs it was an average of two cases per month.

Perceived contribution to maternal health

The general perceptions about the contribution of CSBAs to maternal health improvement were positive. The CSBAs felt that despite their limited knowledge and skills they are able to contribute in the improvement of maternal health but they believed that their skills were not enough to save women's lives.

Some key informants believed that CSBAs can improve maternal and child health as they have mixed skills. However, most of the key informants perceived that the CSBA program was not cost effective as its progress was too slow. Few key informants critiqued the limited scope of the work and indicated that the contribution of improvement of maternal and child health was minimal.

Data from the community, trainers, and trainees indicated that they considered CSBAs more skilled and knowledgeable as compare to the previous categories of community health providers.

> Now I know that I can walk, drink, and eat during labour. The CSBA taught me these things. Before, I had to stay in bed for a long time when I was giving birth and the TBAs were not allowing me to eat or drink even for up to three days and I had no energy to push during birth. [FGD]

Challenges and Barriers

Recruitment, training, and deployment: Most interviewed CSBAs who were employed by the government reported they had been forced to attend the CSBAs' training and they were not interested in it. They mentioned that they were already employed by the government and would receive the same salary with more responsibility.

> Thana health authority selected me for the CSBAs' training and ordered me to join as I was already a government service provider. I felt I have to do this training because the government had asked me… but this job increased my responsibilities and problems [Government CSBAs]

The key informants also mentioned about inappropriate selection and recruitment, and emphasised that the deployment of CSBAs was not based on the community needs. The key informants and the women from the community who attended the focus group discussion reported that most of the government CSBAs were not residents of their catchment area and this affected their availability and accessibility.

> If a CSBA lives far away then we need to spend money for mobile and transport and it's not even guaranteed that she will come to our home. [FGD participant]

All respondents agreed that six months, training is not enough to fulfil community expectations. In addition it was also reported by both the trainers and the trainees that the language and the content of materials are comprehensive and advanced which makes it difficult for the students to learn and challenging for the trainers to teach them.

The key informants criticized the high number of student recruitments without considering the clinical capacity. Insufficient caseloads during clinical practice was pointed out by most of the CSBAs as a challenge. This meant that they had never practiced some of the essential skills as birth attendants. Most CSBAs cited they never taught about complications and had never independently practiced skills like episiotomy and newborn resuscitation during their training.

Low level of Job Satisfaction: Most respondents reported mismanagement as a leading cause for other challenges. Lack of supervision, lack of functional monitoring and evaluation, no clear policy or scope of work for CSBAs, no determined official working hours, no incentive system, insufficient salary, no leave policy, and lack of recognition from the government, community, and other health care professionals were repeatedly reported.

Some of the key informants were uncertain whether there was any job description for the CSBAs. Two key informants mentioned that NGOs have developed their own job description. Only one key informant reported that there is a formal job description in Bangla which was endorsed by the Government of Bangladesh.

Lack of skills and knowledge of CSBAs was reported by the CSBAs and the key informants. They mentioned they were not competent to identify diagnosis and manage complications during childbirth and they had to refer women more frequently to other services. This created an added financial burden for the poor community and was an issue that was always criticized by community. Moreover, the CSBAs reported that their refereed cases were being rejected by the health facilities due to caseload and lack of capacity of facility to manage the referrals.

> Once I had a case of retention of placenta and I referred the patient, so the family members were very annoyed and told me I am useless. I have got training but can't do anything for them. [CSBA]

In general lack of policy and guidelines, and no regular monitoring and supervision were reported as challenges by most key informants.

Students complained about the lack of clinical instruction during clinical placement due to the absence of the preceptor and some of the students mentioned that the preceptors delegated their tasks to other staff at the clinical site

Some of the key informants reported that the lack of retention of competent trainers is a challenge for the programme. The government rotates them between different divisions or they are lost by being attracted by the private sectors where they received a better salary.

A majority of CSBAs and key informants worried about low retention of CSBAs within health system mainly due to demotivation. This resulted job dissatisfaction and which eventually leading to low productivity.

Low acceptability at the community level: Some of the CSBAs reported that the TBAs are still the first choice of the community. Culturally TBAs are more respected and trusted because they are older and are perceived as more experienced. They also live closer to the community and sometimes even in the presence of a trained CSBA, the community relies on the TBAs' decision.

CSBAs also mentioned that going to the clients' houses during the night and staying there is not culturally acceptable and is considered unsafe. They reported it affects their personal and family lives.

> I have problems going at night. My husband works the whole day and wants me to stay at home with him. He disagrees about letting me go for deliveries at home during the night. He says that you don't have security in your job, how can you travel at night? Sometimes, patients' family members come to pick me but my husband does not allow me to go with them at night. [CSBA]

Discussion

This qualitative study looked at the perceptions of different stakeholders who are involved with the CSBAs program or are beneficiaries of the program. It looked at the program implementation and its challenges in Bangladesh.

Bangladesh is a country with a severe shortage of qualified human resources for health (HRH), and inappropriate skills-mix and inequity in distribution [10,38]. The Government of Bangladesh is trying to address this HRH crisis by training of different cadre of providers. However they still are concerned that they will face serious challenges in achieving the MDG 5 and other targets due to weak governance in the delivery of basic health care services, including maternity care[23].

Addressing inequity in the utilization of maternal health services is essential to expedite the progress towards the MDG 5 target. It is important for such poor countries aiming to achieve the MDG 5 to be focused on interventions that are effective and benefit the poor[39]. Providing skilled care providers for births is one of the key steps towards accelerating progress in achieving MDG5 [17, 19]. The CSBA program is one of the initiatives which has been designed to fulfil that aim but this study in contrast with other studies indicates that low coverage, poor management and lack of a supportive environment and not fit for purpose training lead to poor quality of care and a lack of acceptability and trust by the community[17, 23].

In order to provide quality care an enabling environment is necessary for all maternal health providers. The lack of policies, supplies, inadequate remuneration and professional development opportunities, alongside poor management lead to poor quality of care[40]. Creating a supportive policy and environment is necessary as is allowing all sectors to get involved in the development of CSBAs and to guaranteeing the quality of care [11].

It seems the system is casual in its approach regarding producing CSBAs as it is progressing with program without advanced strategies and interventions related to preparation of infrastructure and environment. Other studies have noted that many factors related to infrastructure and resources will influence the performance of providers and in a situation with lack of access to equipment or supplies, a highly competent provider might perform poorly[41, 42].

Findings suggest that the Bangladesh government needs to establish a strong partnership with the private sector to improve the sustainability of such interventions. The strategy of having a programme seems acceptable as a provisional approach but further improvement is needed to make it more sustainable, attainable, and efficient investment. In a poor settings like Bangladesh it might be necessary to address the issue through a multi sectorial approach in order to achieve more effective results.

This study indicates that the existing referral system is not well set up to respond to the needs of the community. The findings confirmed that due to poor capacity of facilities women were not admitted and returned back to the village and received services from TBAs. This is not only an economic burden but it also delays or denies treatment which may increase risks of morbidity and mortality. So, it is important to prepare the infrastructure in which a skilled attendant can function, without barriers and it meet needs of the community[42, 43].

Different factors influence the motivation of providers, such as remuneration and benefits, community expectations, social value and organizational factors like work environment, resource availability, and efficacy of the management processes [44].

Studies showed that lack of monetary and non-monetary benefits lead to demotivation and lack of accountability which consequently affects the coverage and quality of care. Evidence highlighted that provision of adequate incentives for public workers in order to deliver health services, mainly in the rural areas has a significant effect on the quality of care [45, 46]. It is challenging to be able to retain CSBAs within the health system if they do not receive adequate remuneration and incentives. Added to this the lack of supportive polices and guidelines, supplies, respect from other health professionals and acceptance by the community. Hence there is a need for recognition and advocacy at the policy level to refine the program and to design an incentive system for such multi task health workers, not only for their extra work but also to keep them motivated and functional to serve the community. Maternal health can be improved by posting skilled providers at the community level, if they are given proper training, means, and supervision.[47-49]

Lack of sustainable funding is one of the major causes for lack of supplies and equipment. The SBAs needs to work in an enabling environment which includes the availability of drugs and functioning equipment[4]. So an assured long term funding for this kind of intervention is an absolute requirement. This is more important in view of the poor economy and the unstable political situation.

The programme is under the management of two General Directorates (Director General Health Services & Director General Family Planning) and this managerial hierarchy has resulted in chaos within the programme and caused overlapping or lack of accountability. An ongoing evaluation of interventions during the implementation phase is essential to measure the efficiency of the program and to ensure the quality[4, 17] .

The general perception in this study was that CSBAs need to be able to deal with complicated cases as they are supposed to conduct home deliveries. With the insufficient level of knowledge and skills of this group, it would be impractical to expect them to work effectively. So, it is critical to build the capacity of skilled birth attendants to provide safe care even after their basic training[42]. Furthermore, the community expects CSBAs to provide services for which they do not have the required skills or knowledge which could lead to malpractice and placing the community at risk. Literatures highlighted that most of these type of community health workers just have the basic health care knowledge and they did not have the required skills for saving lives [50]. As community birth attendants are required to deal with unexpected and unplanned home births which by definition are more risky and difficult they need to have the necessary support, skills, and

knowledge to perform these effectively [51]. Lack of literacy and adequate basic education was additional causes for students for not being able to learn the advance subjects in a short period. Lessons from similar setting like Afghanistan showed that as a short term solution, adding a vocational bridging course simultaneously to upgrade all students to the same level of understanding for basic concepts, would be helpful[47-50].

Providing in-service training and technical updates to help health providers retain skills and knowledge and to ensure public safety is crucial. It was projected that the 6- month CSBA training would be followed by nine months' field experience and three months' additional training would be provided in the form of in-service. However, data from earlier studies indicates that only the 6-month basic training has been implemented, which is insufficient to provide the skills expected from the CSBA[24].

The Study findings suggest that there is needs for integration of community based orientation and continuum of care. The training of CSBAs is more focused on facility based services rather than home based services, being trained in a clinical based environment might, thus, detach them from the home setting and make them less confident to provide home based services. Findings indicate that, during the six months training, none of the interviewed CSBAs had been exposed to home delivery during their training. Consequently, the past experience and current working practices of many community birth attendants may make them identify with the hospital culture and results in lack of experience of home births[51]. So adding a component of home setting practice needs to be considered in the future training of such providers.

Advocacy to increase community awareness and involvement are key factors for the sustainability of the program. Though the role of the government and other stakeholders for advocacy cannot be ignored but the community health providers like the CSBAs also must have knowledge about how to engage with the community to obtain their support on both training and health service delivery [52]. The programme evaluation in 2005 also highlighted the need for advocacy, interpersonal communication, mass media and indigenous communication intervention programmes to bring about the positive support of the community leaders and to promote the CSBAs' image [28].

The community still prefers to receive services from TBAs, as they have the same culture are long-serving members of the community. One of the reasons for low interest on seeking health care from the CSBAs services is that the women are not treated with respect and dignity which include privacy and culturally appropriate care. Similar studies also showed that disrespect and lack of cultural sensitive care by health system forced women to seek care from informal community providers like TBAs[22]. The TBAs are more accessible, available and cheaper as compared to the CSBAs who are less in number and often living out of their catchment areas[53].

The availability and accessibility of services alone cannot ensure effective coverage if the services are not acceptable to the women and community. Evidences from other poor settings show that cultural and social norms have a critical impact on the level of acceptability by the underserved populations [34]. The study on the CSBA program also illustrated that there is a need to strengthen CSBAs' services in the community by upgrading their knowledge and skills which will help to improve their credibility[28]. Given the reality of shortfalls in training of this cadre the results of this study can assist policy makers and programme managers to refine and modify the programme towards more comprehensive and integrated maternal health care in Bangladesh. Gaps in training and incompetent healthcare providers have been identified by other studies and it has also been suggested that Bangladesh needs to revise its strategy for training of CSBAs [24, 28].

Conclusion

Despite the training of various types of skilled birth attendants in Bangladesh, none of them meet the international standards based on ICM and WHO definitions. To achieve MDGs for maternal and child health targets the health system cannot deny the necessity of competent community based birth attendants who can provide quality services. The CSBA program may not be the best solution in the long term and should only be an interim measure. It could be a transitional model, which changes behaviour resulting in more women seeking care from professionally trained providers [23].

There is a pressing need to ensure sustainable funding along with advance strategies and interventions to prepare adequate infrastructure and an environment, which will lead to effective practice, motivation of the providers, and improved quality of care.

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