

Role of Union Health and Family Welfare Center (UH&FWC) to Promote Maternal Education and Reduce Child Mortality Rate in Bangladesh

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Abstract

Bangladesh has made a remarkable progress in achieving certain goals related to child health, family planning and maternal health indicators in the last three decades. A union-level health and family welfare center is provided the first contact between the people and the maternal health care system and is the nucleus of primary health care delivery. The prime aim of this study is to explore the contribution of union health and family welfare center fostering maternal education and reducing child mortality rate in Bangladesh. It is an exploratory-descriptive research. This study is conducted following both qualitative and quantitative approach based on primary and secondary data. To validate survey data methodological triangulation has been applied in this study. One hundred and ten respondents have been selected from Tukur Bazar union, Sylhet, Bangladesh as sample population of this study employing simple random sampling method. Primary data has been collected from the respondents through face to face interview applying semi-structured (both open and closed ended) questionnaire. Besides interview, observation and case studies have been considered as the most important and befitting data collection tools for this study. Secondary data collected from different published books, journals, reports by academics and regular internet surfing has been done to get update information regarding the purpose of this study. Study findings reveal that in spite of having some limitations union health and family welfare center is contributing a lot regarding maternal and neonatal care in rural Bangladesh. The study brings exclusive importance as it reflects the health seeking behavior of the rural people and institutional weakness to ensure proper health care facilities for rural women and children in Bangladesh. The drawbacks outlined in this research would be the target line and collaborative endeavors eliminating these limitations along with the strategies for promoting this fundamental human right would impact positively on the rural health sector. So, maternal and child mortality rate will be reduced dramatically in Bangladesh; because maternal education leads to better human, social and cultural capital among mothers which is associated with improved child survival. The researchers believed that the study findings would hopefully be guidelines for future researchers who wish to conduct research on this issue from different angles and calling attention to the policy makers regarding this issue.

Keywords: UH&FWC, maternal education, maternal health, maternal mortality, child mortality, neonatal, superstitions, health awareness.

INTRODUCTION

Bangladesh Maternal health challenges cross the entire health system, with deeply rooted issues of human resources, infrastructure, competing priorities and community engagement. Bangladesh is a classic case of a low- and middle-income country achieving the unachievable, which many others failed to. It reduced its maternal mortality by 66 per cent between 1990 and 2010; the reduction was 40 per cent between 2001 and 2010 alone (Prasad, 2014). Bangladesh has made a substantial progress in health and population services, particularly in reducing fertility and child mortality, and in increasing the

coverage of health and family planning services (WHO, 2005). Though there have been substantial reductions in child mortality and improvement in life expectancy, but still maternal mortality ratio in Bangladesh is very high compared to many other developing countries, with persisting socioeconomic differentials. While access to family planning is increasing, access to three other pillars of safe motherhood namely antenatal care, clean and safe delivery, and essential obstetric care, remain largely unfulfilled. Women in Bangladesh have to continue to fight for basic rights and status in terms of political participation, education, healthcare (specially

reproductive and sexual health), labour force participation, mobility, food security, freedom from violence and the recognition and respect for their sexuality. Maternal health status for many Bangladeshi women remains poor. At present about 12,000 women die each year from maternal causes. The estimated lifetime risk of dying from pregnancy and child birth-related causes in Bangladesh is about 100 times higher than that in developed countries. A tragic consequence of these deaths is that about 75% of the babies born to these women are also likely to die within the first week of their life (Nasreen, H. et al., 2007). In this backdrop, the researchers are interested to evaluate the performance of Union Health and Family Welfare Centre promoting health care facilities of the rural poor women and future generations in Bangladesh. Education is the key to reducing maternal and child mortality hence; in turn it has increased women's willingness and ability to seek health care. A big factor is that the government is consistent in encouraging education. Besides the obvious benefits that come with education, like greater employability and more resources in hand, education among girls has led to reduced fertility. This has had a direct impact in reducing both maternal mortality and child mortality. Here the prime role is played by the union health and family welfare center (UH&FWC).

The lowest level of government service center in rural Bangladesh is the family welfare center which serves all the people of a union. Moreover, countrywide at the union level, satellite clinics are organized every month to provide doorstep services. In Bangladesh, maternal mortality declined from 322 to 194, a 40 per cent reduction during the period of 2001 to 2010 (NIPORT, 2010). An increase in deliveries by medically trained healthcare providers was one of the important factors; but deliveries attended by midwifery were low. While there has been an improved access to and use of health facilities, it is the private sector that people most often turn to. Therefore, government should definitely need to provide affordable care to everybody.

STATEMENT OF THE PROBLEM

Bangladesh is one of the densely populated countries of the world. Most of the people of this country live in rural areas, and is inflicted with endemic and chronic poverty. After forty six years of independence, the country is still striving for the mainstream of development for a variety of reasons. Political turmoil, lack of skilled manpower, growing mass poverty, unemployment, rapid population growth, low literacy rate, malnutrition and ill health of the poorer section of the society accompanying with natural calamities are the glaring examples of these problems. Health is a fundamental right of the citizen of Bangladesh as per the section 15(A) and

18(1) of the constitution of People's Republic of Bangladesh.

But most of the people of this country are deprived of proper health care facilities. The poor health conditions in Bangladesh are attributed by the lack of health care and services providing by the government. Health and education levels remain relatively low, although Bangladesh has improved in the sphere of poverty. People in rural areas face some different health issues than the people living in cities. Because they are not getting hospital service on an emergency basis due to long distance and high cost. In rural areas, there have few doctors, and certain specialists are not available due to lack of adequate facilities as they get in urban areas. Even, the doctors, appointed in rural hospitals and clinics, stay with their family members in towns. Because their children go to renowned urban schools, they practice in private hospitals and clinics and response to any emergency calls in any hospitals and getting urban facilities as well. In this way they earn a lot of money and spend few times to provide services for the rural poor for whom they are recruited. Besides, locally appointed doctors make illegal arrangements to transfer them to the city areas. In Bangladesh one in eight women receives delivery care from medically trained health providers and fewer than half of all pregnant women seek antenatal care (Rahman, 2008). Most of the hospitals and clinics are established in towns, so the government cannot ensure equal health care services for the country people. Furthermore, lack of education, lack of awareness, superstitions and religious beliefs among the rural people are some important problems of receiving maternal health care services. As a result, maternal and child mortality rate in our country still now is very high and the rate is vulnerable for rural mothers and children compare to urban areas.

RESEARCH QUESTIONS

The aim of this study is to investigate how union health and family welfare center has been performing its functions to reduce maternal and child mortality rate in Bangladesh. To achieve the prime objective the study attempts to find out the answer of the following research questions:

- ❖ Where UH&FWC performs and what is the existing system of providing services regarding the promotion of maternal and child health care?
- ❖ What are the barriers encountered by union health and family welfare centers in providing maternal education and health services on maternal and child mortality?
- ❖ How union health and family welfare centers would be a successful organ of primary health care services in rural Bangladesh?

REFLECTION FROM RELEVANT LITERATURE

In the study some relevant journals and documents have been reviewed for the purpose of better understanding the term.

Education is the key to reducing child mortality where maternal education is linked between maternal health and child health. The larger lesson is that all the MDGs are interlinked and that success in any one will only be sustainable with success across all of the Goals. Adoption of basic health interventions is possible by community level health care facilities on giving maternal education including early and exclusive breastfeeding, immunization, vitamin A supplementation and the use of insecticide-treated mosquito nets to prevent malaria etc. where economic growth, poverty reduction and access to skilled health workers all contribute to improving child survival and reducing maternal mortality. The education and health levels of communities improve, so, by extension, do their prospects for decreased child and maternal mortality levels (Ann M. Veneman, 2007).

The state of maternal health situation in Bangladesh appears to be poor in terms of some measures like- the levels of antenatal and postnatal care, contraceptive prevalence rate (CPR), coverage of tetanus toxoid (TT) vaccination, proportion of deliveries conducted in health facilities by trained birth attendants, or proportion of unwanted pregnancies, child delivery, EOC services, illegal and unsafe abortion etc.

The outcomes of these indicators are the Maternal Mortality Ratio (MMR), infant mortality rate (IMR), CPR ratio etc. The author also discussed many causes regarding of maternal and child mortality (Rahman, S. A., et al., 2003).

The key elements of improving service provisions relate to primary health care through the Upazila Health System (UHS); Community Clinic (CC) led expansion of primary health care services, making the Union Health and Family Welfare Centers (UHFWC) fully functional as part of the UHS. Selected union facilities and CCs will be strengthened with capacity and readiness to conduct normal delivery and refer complicated cases to higher level facilities to reduce maternal mortality. MNH services have been prioritized to address preconception, pregnancy, childbirth and the immediate postpartum period by increasing number of skilled birth attendants. The UH&FWC as part of the UHS will be the first contact point and entry to the health system (MOH&FW, 2012).

In Bangladesh every four minutes, a child less than 1 month old dies because their mother didn't have access to proper post-natal and ante-natal care. The majority of these deaths can be prevented by

providing children and their mothers with access to proper nutrition and health information. Providing nutritional education and nutritional supplements to pregnant mothers, their newborn babies, and young children; we can drastically reduce child mortality. The study laid emphasis on important household tasks that BRAC educates its existing frontline community health promoters and train new health promoters to provide basic health services to pregnant women and their newborns. The promoters are able to record patient data on a mobile device, like a cell phone, and quickly refer any complications to the nearest clinic or hospital. BRAC's health promoters are also educating and encouraging women to give birth in a hospital or BRAC safe birth hut. This education is also be given to husbands (<http://www.globalgiving.org>).

Study on the maternal health care utilization program components includes media campaigns, educational improvement as well as promoting policies that shape the women livelihoods and implementing maternal health care delivery services especially to make progress towards the MDGs five target in Bangladesh, where the Millennium Development Goals (MDGs) calls for a 75% reduction in maternal mortality between 1990 and 2015. Maternal death is an important public health problem not only because of the large number of women die but also because of a traumatic effect of such an event on the child, the family and the community as a whole. Trained Birth Attendance and Antenatal Care are two of the most important interventions to reduce maternal mortality (Munsur A. M. et al., 2010).

METHODOLOGY AND STRATEGY

It is an exploratory –descriptive research. This study was conducted following both qualitative and quantitative research approach based on both primary and secondary data. To validate survey data methodological triangulation was applied in this study. A quantitative research approach was used to show the significance of data. Qualitative research approach enabled researchers to explore the real picture and situation of the UH&FWC to promote maternal education and to reduce child mortality in Bangladesh. 110 beneficiaries of UH&FWC have been selected as sample population from Takerbazar Union, Sylhet, Bangladesh applying simple random sampling method. Semi-structured questionnaire (both open and closed ended) was applied to collect primary data through face to face interview from the respondents. Besides, some case studies and observation have been considered in this study as the most important and befitting data collection tools. Secondary data means document study like published books, articles, journals by the academics and professionals have been studied deeply to find out the knowledge gap between the existing and completed study in this regard.

Furthermore, the UH&FWC officials, doctors, civil societies have also been sought. Moreover, to get the update data and information regular internet surfing has been maintained to serve the purpose of the study. The collected data has been coded properly then presented and analyzed through graphs and charts. The data has also been discussed and justified employing statistical measurement like Statistical Program on Social Sciences (SPSS), excel-power point etc.

SIGNIFICANCE AND SCOPE OF THE STUDY

Bangladeshi women suffer from chronic energy and iodine deficiency, night blindness during pregnancy. The lifetime risk of dying from pregnancy and childbirth related causes in Bangladesh is also very high compared to any industrialized countries. The main causes of maternal deaths are direct obstetric causes due to injury and violence, indirect causes, common complications like abdominal pain, swelling of the leg or body, anemia, urinary problems, eclampsia and hemorrhage etc. lasting complications such as fistulae, prolepses, inability in controlling urination, or painful intercourses etc. Therefore, the overall maternal health situation is not satisfactory at the rural level. This is because of poor maternal education (on maternal and child health) and service delivery at the UH&FWC due to lack of skilled and trained manpower, technical and logistic support, poor financial allocation, absence of local level planning, lack of accountability and transparency, weak monitoring and supervision etc. But unfortunately, these significant issues got little attention from the policy makers for the betterment of poor mothers and their children. As a result year after year the situation is happening on its own way.

In the same vein, this sector got no considerable amount of attention from academic circle that could contribute to the further development of this maternal health situation by way policy interventions. In other words, true implementation of health policy is yet present.

This study is significant because it has given an opportunity to explore the role of UH&FWC to provide maternal education in order to reduce maternal and child mortality. Though, a very few study was done in small scale and none of them focused on the issue from sociological stand point. Furthermore, considering the proposed issue from development perspective, it has been an academic interest to find out the underlying causes of maternal and child mortality and poor functioning of UH&FWC in Bangladesh. It is expected that the proposed study contributes to the policy implications for further development of proper functioning of UH&FWC focusing on the aspects of maternal and child health from welfare point of view. The study is also believed to draw an academic attention from

scholars and development actors holding that it would be a benchmark study unraveling the mystery that shrouded the truth and painting the real picture of union sub center's function on maternal and child health education in rural Bangladesh.

FINDINGS

It is evident from the study that most of the respondents (47.27%) have primary level of education, where 24.55% of the respondents have secondary and 21.82% have higher secondary level of education respectively. The minority of the respondents (6.36%) is graduated (Table-1).

The study found that among 100 respondents 52.73% of them have awareness about the maternity services given by UH&FWC, where 35.45% of them have no consciousness about the UH&FWC on maternal and child health services. Only 11.82% of the respondents were silence in this regard (Table-2).

40.91% percent of the respondents thought that UH&FWC mainly performed awareness building program to promote maternal education and reduce child mortality in rural Bangladesh.

In other sides, 34.55% of the respondents opined that UH&FWC handled proactive initiatives, where 24.54% of them stated that rural health care center take post birth health care initiatives regarding maternal education to reduce maternal and child mortality (Table-3).

In response to the question of initiatives of UH & FWC regarding maternal education and child health about 32% of the respondents said family planning program, and about 27% respondents opined primary health care services. Another 21% and 20% uttered that child health services and antenatal and postnatal care respectively are the health related measures of union sub center in rural Bangladesh (Table-4).

54.55% of the respondents said that union health care center is not providing delivery services and common sexual and reproductive health care services like white discharge, fistula, menstrual problem, urinary infection etc.; and 23.64% of the respondents opined that they get these services. Only 13.63% and 8.18% of them opined that cervical and breast cancer screening program are sometimes essential but not found from this center (Table-5). In evaluating the performance of rural health care center 46% of the respondents are not satisfied with the present performance of UHFWC for the lack of caesarian section, oxygen facility, normal delivery service etc. where 24% are moderate in response to this question. Another 20% are satisfied and 10% are highly satisfied of the present services given by rural health care center (Table-6).

In response to the question of ways of improving the quality service 29.09% respondents suggest for availability of medical equipment and specialists, 23.64% respondents opined for adequate supply of medicine, and 22.73% uttered on training of service providers. Only 13.64% respondents said for providing incentives and the remaining 10.90% emphasis on monitoring and evaluation for improving the quality services in this regard (Table-7).

From the study it is revealed 40% service provider received Skilled Birth Attendant (SBA) training or training on delivery services to reduce maternal and child mortality in rural Bangladesh; while 30% respondents received training on newborn care. 20% respondents got training on immunization and the remaining 10% received basic training for MR (Table-8).

30% of the respondent opined that coordination systems with the local level health care centers are performed largely through monthly and periodical meeting at upazila and district level, and 30% uttered the monitoring systems are mainly handled by direct visits of upazila health and family planning officer to union sub center. 20% respondents said that monitoring and coordination systems are carried out through time to time submitting report to upper level committees and the remaining 20% stated committees on different levels and disseminating information to different health care center stairs (Table-9).

50% respondents are agreed that political influences in case of providing maternal health services are held where the relatives of union chairman, member get better and quick services, better medicine and extra benefits. Again 36.36% respondents said that no political influence occurred at the service center, while 13.64% of respondents were silence about that issue (Table-10).

In response to the question regarding the challenges of UH &FWC to provide better services for the clients 22.73% respondents stated financial crisis, 20.91% of respondents stated shortage of medical equipment, medicine and technology, and 18.18% opined shortage of training and skilled manpower. 11.82% of respondents stated lack of transportation, 10% claimed weak monitoring and supervision, and 9.09% said scarcity of power and water. The remaining 7.27% opined superstitions as the challenges of UH&FWC (Table-11).

CASE STUDY 1

In this study Rumana (pseudonym), another service recipient woman of 37 years old was taken as a case. She is higher secondary certificate pass, and living in the study area with her husband. She has been receiving maternal and child health care facilities from union sub center from more than seven years.

She said that UH&FWC is the great achievement of Bangladesh government for providing health care facilities for the rural poor community. She told "It is somehow effective, but cannot rich the desired ends due to lack of effective officials, doctors, nurses, delivery services, medicine and technological capacities as well as regular monitoring by the higher authority". She also said that "when I was pregnant, I was taking check-up and antenatal service from UH&FWC though they have no good doctors and good service provisions. I had some complicacy and FWV (people treat her as a doctor, because the absence of doctor in union sub center) said my baby was dead and I needed Caesar. That's why my family decided to go Sylhet government hospital for delivery. But after testing my body and baby, doctors at Osmani Medical College said my baby was alive, but she was very weak and thin. Finally I received services from Osmani medical college." Therefore, FWV has lack of skills to give antenatal care, but year after year she provided services as a doctor, where many women suffer a lot similar to me. There should be taken immediate action from higher authority. Because proper monitoring would reduce unexpected harassment of local people." She also requested the authors to attract the government attention eliminating the problems and corruption at union health and family welfare center

DISCUSSION

Bangladesh, a South Asian small country with a large number of populations is inflicted with poverty, malnutrition, ill-health, and political turmoil accompanying with natural calamities and disasters. Especially in rural areas where 75-80% people living Bangladesh, have no easy access to any health care facilities provided by the government. In former periods, more than 6 lack children were died in six diseases and government of Bangladesh had no capacity or power to control these diseases (Seddiky, 2013).

So, the rural people had to suffer a lot in case of proper and modern treatment and technological support to diagnosis any type of diseases. In this regard they had to go to town or cities taking proper treatment, which requires a large amount of money. But the rural people are very poor and they cannot get proper treatment in urban hospitals or other health care centers. In the age of globalization, with the origin of welfare state, the government has to emphasis on the decentralization of health care facilities from urban to rural areas and for this government has established union health and family welfare center in every union of Bangladesh. A union-level health and family welfare center provides the first contact between the people and the maternal health care system, and it is the nucleus of primary health care delivery.

The center is staffed by a male paramedic (known as Medical Assistant), who provides basic health services, and a female paramedic (known as Family Welfare Visitor). This woman who provides family planning, maternal and child health services, typically have a higher secondary level of education and eighteen months of technical training. They are supposed to conduct satellite clinics eight times monthly at various sites in each union to give contraceptive, injections, ANC and PNC care etc. As a matter of fact FWAs are the lifeline of the family planning program in Bangladesh. However, the acute shortage of doctors, nurses and the technicians in rural health care centers has forced many patients to resort to traditional healers.

Therefore immediate recruitment in the vacant positions is needed to boost-up the maternity services. They are not only giving the treatment but also arranging different types of awareness building program in rural communities. So that child mortality in Bangladesh can be reduced.

In Every 1000 babies born alive, 12 die within hours of birth, eight of them due to injury during deliveries. In a recent study it was found that of the 695 admitted neonates 231 were due to birth asphyxia. One hundred and sixty-five 165 neonates died in the hospital, and 93 of them due to birth asphyxia and its complications. More than one-third of the asphyxiated cases reach hospital 24 hours after the difficult delivery they usually die. This death including neonatal can be prevented if more centers for safe delivery and proper neo-natal treatment are made available in the country(Kabir, SM.H, 2012).Therefore, the government is continuously increased the number of union health and family welfare center in Bangladesh.

Chart-1

Name of facility	Existing June-2011	To be constructed by June 2016
Union Health & Family Welfare Centre (UH&FWC)	3,860	254

Source: Kabir, SM. H. (2012). Reproductive healthcare services. National Encyclopedia of Bangladesh. Bangladesh Asiatic Society, Dhaka, Bangladesh.

The government of Bangladesh has invested in maternal health programs with support from a number of development partners. In the present time UNESCO, UNICEF, UNDP, JAICA and other international agencies are helping Bangladesh government in national immunization program with a view to reducing the six diseases and infant mortality. Within first ten years child mortality rate has been reduced more than half, really has been created a landmark in the history of health sector of Bangladesh. In order to sustain these programs the

government has been arranged different educational programs among the rural poor people, so that they can be aware about the maternal health related diseases and can take proper treatment to reduce the risk of maternal and child mortality in Bangladesh. UH&FWC is the prime unit trying with their best to reduce maternal and child mortality in time of prenatal and postnatal period. Before pregnancy and delivery they provide immunization and treatment along with some health trips so that they can give birth quite and well babies without any types of difficulties. The awareness raising programs in rural areas creates positive impact among them who are illiterate about the risk of the diseases and proper care of children. In this regard UH&FWC also provides different types of information and consultancy freely among the rural community. So, the rural poor communities are able to get the desirable services. UH&FWC also acts as the bridge between the Upazila health complex and rural people.

One of the underlying factors leading to poor maternal situation in Bangladesh is that a very low percentage of women actually seek professional medical assistance for pregnancy related care, deliveries and complications. Mothers prefer to receive antenatal services from a government facility and to use the services of an untrained provider at home. A wide range of factors have been identified as influencing these decisions, including: lack of information and education about services, superstitions, fear of losing family prestige, financial crisis, negligence of service providers, insufficient supplies (lack of adequate drugs or medicine), shortages of skilled doctors, and predominance of male doctors in the government hospitals. Many of these barriers will lead to delays in seeking all forms of maternal care; even when life-threatening emergencies arise, which may be a major factor behind the high level of maternal mortality. In Bangladesh, a 2011 survey found only 61% of women who sought medical care decided to do so within six hours of recognizing the need, with delays of three days or more in some cases (NIPORT-2012).

According to the official estimates the current level is 4.7 maternal deaths per 1000 live births- or about 28,000 maternal deaths nationally each year- which is about 100 times higher than the level in the Northern Europe, and one of the highest in Asia. The main causes of maternal mortality are: postpartum haemorrhage, abortion, obstructed labor, eclampsia, puerperal sepsis, and other obstetric causes.

However, UH&FWC is the result of decentralized health system of Bangladesh that is the demand of the time. The rural people at the present time can talk with the civil surgeon, MBBS doctors, other family planning officers easily. They are providing different types of oral training which educate them about the

secure and risk free child birth. The officials working in local areas of Bangladesh are facing other types of problems to provide better services to rural mother, because most of them living in rural areas are believed in superstition, jhar-fuk and kabiraz. The rural mother and family members are very conservative and they have no openness and they will be silence rather than die. It has been a great challenges for the officials of UH&FWC to make them aware and to break the silence. Besides, the propaganda or projected medicine and technologies as well as facilities that UH&FWC can provide is absent in some cases like- Caesar facilities, small surgical activities, small operation theater, free cost of treatment etc. The doctors are not available everyday according to their needs and demands.

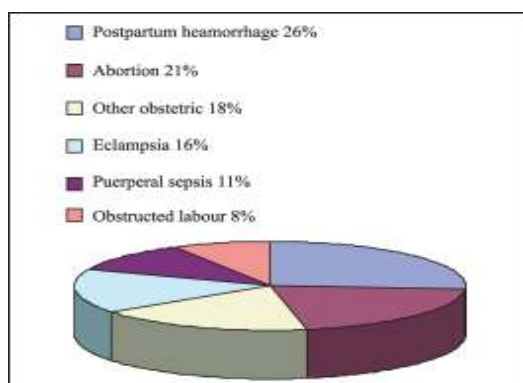


Figure-1 Causes of maternal Death in Bangladesh
Source: National Encyclopedia in Bangladesh, 2012

In a month one or two days they came to visit the health condition of rural mother. It is not sufficient and training program of officials is not much more effective due to lack of application.

In 2006, The Ministry of Health and family Welfare (MOHFW) took an initiative for ‘Accelerating Progress towards Maternal and Neonatal mortality and Morbidity Reduction (MNHI). Its overall goal is to reduce maternal and neonatal mortality in Bangladesh with an emphasis on equity issues in order to achieve MDGs 4 and 5. Committed to achieving the Millennium Development Goal (MDG) 5, Bangladesh’s targets are to reduce the maternal mortality ratio (MMR) to 143 per 100000 live births by 2015, and to increase skilled attendance at birth to 50 percent by 2016(NIPORT, 2010). In the last decade the health, nutrition and population sector program of Bangladesh has adopted a national strategy for maternal health focusing on Emergency Obstetric Care (EmOC) for reducing maternal mortality, focusing on early detection and appropriate referral complications and improvement of quality of care. The government also embarked a program to retrain existing government community health care workers as Community Skilled Birth Attendants (CSBA). Maternal and child mortality declined in

Bangladesh as a consequence of improved access to care, substantially better education among women, improved awareness etc. The present status, targets meet, attention to be given etc. are showing below in two separate tables-

Chart-2: Millennium development goals -4 for child health

Indicators	Base Year	Current Status	Target 2015	Status of Progress
Under-five (6-59months) mortality rate (per 1000 live births)	146	44 (2011)	48	=
Infant (0-1 year) mortality rate (per 1000 live births)	92	35 (2011)	31	→
Proportion of 1 year-old children immunized against measles (%)	54	85.5 (2011)	100	→

Here, →On track, =Goal met, ↓ Need attention.
Source: General Economic Division (GED), Bangladesh Planning Commission. Divisional Workshop on Post -2015 Development Agenda, held at Sylhet DC office in 4th April 2013.

Chart-3 Millennium development goals for maternal health

Indicators	Base Year	Current Status	Target 2015	Status of Progress
Maternal Mortality Ratio (per 100,000 live births)	574	194 (2011)	143	→
Proportion of birth attended by skill health personnel (%)	5.0	31.7 (2011)	50	↓
Contraceptive prevalence rate (%)	39.7	61.2 (2011)	72	→
Antenatal care coverage (at least 1 visit) %	27.5	67.7	100	↓
Antenatal care coverage (at least 4 visits) %	5.5	25.5	50	↓
Unmet need for family planning (%)	21.6	13.5	7.6	↓

Here, →On track, =Goal met, ↓ Need attention.
Source: General Economic Division (GED), Bangladesh Planning Commission. Divisional Workshop on Post -2015 Development Agenda, held at Sylhet DC office in 4th April 2013.

The educational attainment of household members or mother is an important determinant of their opportunities and behavior. The study found that most of the rural mothers have primary level of education that is one of the causes of unawareness about their and their baby’s health as educational attainment affects reproductive behavior, contraceptive use, fertility, infant and child mortality and morbidity and issues related to family health and hygiene etc. We know that as more educated women as more likely to take ANC, PNC, neonatal care from medically trained providers etc.

Up to 2000, there was a major effort to upgrade comprehensive emergency obstetric care. By 2010, the number of Upazila Health Complexes offering comprehensive emergency obstetric care had increased to 132. MOH&FW was recently upgrading 1,500 Union Health and Family Welfare Centers at rural areas in Bangladesh (NIPORT, 2010). This definitely a blessing for poor villagers, which improved availability of health facilities outside the district headquarters, where Union Health and Family Welfare Centers were concentrated. It is explored that, people have much knowledge about the union health and family welfare center and the services that is given for maternal and child health care. The UH&FWC officials also visits like- FWV, Family Welfare Assistants (FWA) and distributes the family planning materials and other services of maternal education at that areas that is under of their services. Moreover, in the meantime of their visiting the villages, local people also known about the activities regarding maternity care of UH&FWC.

UH&FWC definitely has a major role and some education related functions to promote maternal education. They have awareness building program through seminar, symposium, uthan baithak (informal gathering), showing mina cartoon and other health related awareness building programs through power point presentation etc. for the rural community. Some proactive initiatives are also taken for rural mother. The basic emergency preparedness that health workers suggest are making arrangements for money, transportation, danger signs of maternal complications, night blindness during pregnancy, iodine deficiency, energy deficiency etc. Health workers also make awareness about the superstition regarding food habits to pregnant mother. Superstitions like- not to take eggs, different types of fishes, twine bananas, coconut that would make the baby large in size and make difficult to delivery. Currently, pregnant women received maternal education from a health worker during ANC visits about arranging money in case of emergency during pregnancy. Pregnant mother also discussed about the preparedness of delivery with the family members, that she learned from UH&FWC health workers. Post birth related health care educations also given to promote maternal education and reduce infant as well as child mortality in Bangladesh like health and hygiene of mother and their newborn babies, encouraging only breast feeding up to 6 months of baby which would help quick involution of uterus, lactation and also protect her baby by providing immunity from the attacks of infection and communicable diseases, give confidence to eat all types of foods for mother specially taking nutritious food, keeping baby always in clean environment, having baby some sort of sun light at the morning to make their bones strong etc. Therefore, by the union

level health staffs mothers are always be advised for regular breast feeding.

To minimize the risk of maternal deaths normally it requires management at facility by a medically trained provider, as most of the cases mother and their babies are died due to pregnancy complications. In this case UH&FWC are provided the direct health measures like family planning program to avoid unwanted pregnancy, ANC, PNC, TT vaccination, child health care, primary health care services etc. It is found from observation that union health and family welfare centers are only good at family planning services, because supplies of family planning materials are available and good from the government side.

However, some service consumers argued that union health providers claimed money for family planning (FP) materials. Moreover, Family Welfare Visitor (FWV) monthly visits 4 times in 4 villages for giving ANC and PNC services names satellite clinic. FWA, health assistants are also serving Family planning and Extended Program on Immunization (EPI) services to rural mother and their children.

Emergency Obstetric Care (EOC) services, common sexual and reproductive health services, cervical and breast cancer screening program, menstrual regulation (MR) services, post abortion care, malaria of child, severe diarrhoea etc. are very essential at rural area; but maximum time this services are referral system; even it is not available at upazila level due to lack of financial, technical capacity as well as shortage of trained manpower. Though, the government EOC project has been proven as an effective way of maternal care, but UHFWC is not able to provide it. Due to lack of delivery service, maximum of the time the rural mother handled delivery at home without any trained personnel that cause a great life risk both for mother and their children.

The quality of care has many dimensions, all of which are important. Most of the people are dissatisfied due to lack of oxygen facility in any emergency situation, caesarian section, normal delivery services, absence of diagnosing and testing facilities like blood test, urine test for urinary infection, diabetics, blood pressure etc. Moreover, ambulance services are completely absent here that is vital for pregnant mother in any emergency situation to reduce the maternal and infant mortality. Due to shortage of skilled or trained doctors and nurses they frequently move to NGOs clinic or districts hospitals.

Justifying the opinion of the mass people, the study also suggests for the mechanisms in ensuring quality service where availability of medical equipment and availability of specialists and adequate supply of medicine, training, incentives, promotions and

motivation of service providers are the most prioritized. Motivation policy for service provider are also necessary like allowance for servicing in remote rural area, extra remuneration, praise, award and prize for better performance etc. It is well known that performance of health service mostly depends on the capacities of health center. So, improvement of these capacities is needed as a safeguard for quality management like financial capacity, and technical capacity, administrative and managerial capacity. Above all, monitoring and supervision from higher authority is needed to boost up the quality services.

Skilled Birth Attendant Training Program of Director General of Health Services and Obstetrical and Gynecological Society of Bangladesh (OGSB) from 2001 provided training of existing Family Welfare Assistants (FWAs), Family Welfare Visitors (FWVs), Female Health Assistants (FeHA) in basic midwifery skills in order to provide home based maternal health services in addition to their regular assignments. A recent UNFPA supported program review showed that the contribution of health staffs who were taking training was very minimal in increasing the proportion of skilled birth attendants at birth as they get little support and guidance from the health system after initial training (UNFPA 2010). Training as a means for capacity building and as a tool for upgrading the present service delivery is vital for ensuring quality aspects. Skilled Birth Attendant (SBA) training, basic training for MR, training on delivery services, training on anesthesiology, training on newborn care, training on vaccination etc. are the prime requirements for better service (Begum and Rahman, 2013).

Proper monitoring and supervision is one of the mechanism for maintaining accountability and transparency. Monitoring systems are mainly performed through visiting by the Upazila health and family planning officers and coordination systems are mainly handled by Monthly and periodical meeting at Upazila and District level.

Besides these, through reporting, disseminating information monitoring and coordination systems are performed. But from observation it is found that in most cases of monitoring and supervision system there exists severe corruption, biasness and irregularities. At the UH&FWC higher authority rarely monitor the activities of local health providers as there is no transportation facilities for monitoring the activities of union health staff. Due to absence of doctors FWW played the role as doctors and often doing malpractices like taking service charge, prescribing unnecessary testing or diagnosis and vitamin, high-power antibiotic to children which affects their Kidneys etc. But there is no good monitoring system in reducing such type of corruption.

Political influence in case of providing services are also exists in union sub center. Sometimes equality and priority based services are not given to the rural poor mother. Local political influence is seen here. As a result, the relatives of union chairman, member get better and quick service. They get better medicine than general people. They also get quicker service as they need no serial to go to the chambers of health officials. Therefore, there are some challenges of union health care center to provide a better service that is needed to minimize for effective results in this sector.

LIMITATIONS OF THE STUDY

We have faced greater problems due to shortage of information and relevant literatures like books, articles and writings by academics about the research topic. It is harder for the study to conduct a worthy research work due to inadequate information and it is caused a major problem that is limiting the scope of the analysis of data.

Most of the respondents were unaware and illiterate. So, the idea of maternal health and maternal education was obscure to the investigated people that take a long time discussion with them about this matter. Rural mother are also ambiguous about that issue.

The respondents were so busy in their own working hour, and some of them were not interested to talk with unknown people. So collecting data from respondent has been somehow difficult.

It takes long time to get permission for data collection from the concerned authority.

Health is a sensitive issue. Most of the women were doubtful and ashamed to provide real information on this issue.

Wider concept made it difficult to cover the whole area.

CONCLUDING REMARKS WITH POLICY IMPLICATIONS

Maternal and child mortality is a serious public health concern and a great contemporary challenge for Bangladesh. Besides mortality, there are numerous other factors responsible for maternal morbidities. These include malnutrition and anemia, infections, fistula, uterine prolapse, diabetes, and morbidity resulting from unsafe delivery and abortions done by the traditional practitioners. Progress in reducing maternal mortality and morbidity is possible—but not happening quickly in Bangladesh to reach global goals. Although there are some direct causes of maternal mortality, but three delays in addressing complications are major like delay in deciding to seek care, delay in reaching service delivery point, and

delay in care that is provided by the health staffs. Maternal health care utilization behavior is actually influenced by a number of interlinking forces that include individual and familial influences as well as more other forces such as health services availability and access. The findings demonstrate that maternal education plays a dominant role in accelerating the use of maternal health care in Bangladesh.

Maternal health care utilization program components could include media campaigns, educational improvement as well as promoting policies that shape the women livelihoods and implementing maternal health care delivery services especially to make progress towards the MDGs five target in Bangladesh. To deliver an effective and efficient maternal education as well as service provisions following recommendations should be considered:

Strengthening institutional issues like UH&FWC should be strengthened with appropriate technical and logistic support, drugs and medicine, 24 hour presence of doctors for ensuring emergency obstetric care.

Effective training for the medical personnel (Doctors, Gynecologists, TBA) and their responsible performance is essential for quality service.

To foster better understanding and bring attitudinal changes, Behavior Change Communication (BCC) activities will also be strengthened. Increasing awareness and encouraging higher educational levels among rural mother are also important.

To prevent maternal mortality and improve the maternal health in the country, it is prerequisite for fundamental improvement of all maternal healthcare services and a change in attitudes of individuals, families and communities about pregnancy and childbirth care.

At the Union Health and Family Welfare Centers the Sub Assistant Community Medical Officer (SACMO) and Family Welfare Visitors (FWV) should provide safe delivery care.

The trend of raising the education levels among young women should be increased that can be expected to bring awareness about their and their babies health which favor more use of skilled birth attendants, from facility deliveries, more and quicker treatment seeking for complications.

Emphasis should be given upon community skilled birth attendant training that needed to be further expanded.

Regular and effective monitoring and supervision from higher authority should be taken to ensure the

accountability and transparency of health service providers at the rural community.

To upgrade the combination of 3Fs like functions, functionaries and funds should be considered as the vital elements for effective functioning of maternity service provisions.

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APPENDIX

Table-1: Distribution of Respondents According to Educational Level

		No. of Respondents	Percentage	Valid Percentage	Cumulative Percentage
Educational Status	Primary	52	47.27	47.27	47.27
	Secondary	27	24.55	24.55	71.82
	Higher Secondary	24	21.82	21.82	93.64
	Graduation	7	6.36	6.36	100.0
	Total	110	100.0	100.0	

Field Data Collected from Sylhet; August 14, –September 20, 2014.

Table-2: Opinion Regarding the Awareness of Respondents about UH&FWC on Maternal Health

Awareness of respondents	No. of respondents	Percentage	Valid Percentage	Cumulative percentage
Yes	58	52.73	52.73	52.73
No	39	35.45	35.45	88.18
Silence	13	11.82	11.82	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August 14–September 20, 2014.

Table-3: Education related Functions of UH&FWC to promote maternal Education and Reduce Child Mortality

Opinion	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Education and Awareness building program	45	40.91	40.91	52.73
Proactive initiatives	38	34.55	34.55	75.46
Post-natal health care	27	24.54	24.54	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August 14–September 20, 2014

Table-4: Health Related Measures of UH&FWC regarding Maternal Education and Reduce Child Mortality

Health related measures	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Family planning	35	31.82	31.82	31.82
Antenatal and postnatal	22	20.0	20.0	51.82
Child health care	24	21.82	21.82	73.64
Primary Health care	29	26.36	26.36	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August 14- September20, 2014.

Table-5: Types of Services not Accessed by Rural Mother

Types of Services	No. of Respondents	Percentage	Valid Percentage	Cumulative Percentage
Delivery services	60	54.55	54.55	54.55
Common sexual and reproductive health services	26	23.64	23.64	78.19
Cervical and breast cancer screening program	15	13.63	13.63	91.82
HIV/ AIDS related services	9	8.18	8.18	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August14–September20, 2014.

Table- 6: Satisfaction Rate of Beneficiaries Group Regarding the Maternal Health Services

Satisfaction rate of beneficiaries	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Highly Satisfied	10	10	10	10.0
Satisfied	20	20	20	30.0
Moderate	24	24	24	54.0
Dissatisfied	46	46	46	100.0

Field Data Collected from Sylhet; August14–September20, 2014.

Table- 7: Measures to Improve the Quality of Services of UH&FWC

Measures	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Availability of specialists & medical equipment	32	29.09	29.09	29.09
Adequate supply of medicine	26	23.64	23.64	52.73
Training of service providers	25	22.73	22.73	75.46
Incentives and promotion	15	13.64	13.64	89.1
Monitoring & supervision	12	10.90	10.90	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August14–September20, 2014.

Table- 8: Training Program for the UH&FWC Officials

Types of Training	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Training on Immunization	2	20.00	20.00	20.00
Skilled Birth Attendant (SBA) Training	4	40.00	40.00	60.00
Basic Training for MR	1	10.00	10.00	70.00
Training on Newborn Care	3	30.00	30.00	100.00
Total	10	100.0	100.0	

Field Data Collected from Sylhet; August14–September20, 2014.

Table-9: Monitoring and Coordination System of UH&FWC

Monitoring and Coordination System	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Direct visits of UH&FPO	3	30.00	30.00	30.00
Monthly and periodical meeting at Upazila and District level	3	30.00	30.00	60.00
Reporting	2	20.00	20.00	80.00
Committees on various levels and Disseminating information	2	20.00	20.00	100.0
Total	10	100.0	100.0	

Field Data Collected from Sylhet; August14–September20, 2014.

Table-10: Political Influence in Case of Providing Services

Political Influence	No. of respondents	Percentage	Valid Percentage	Cumulative percentage
Yes	55	50.00	50.00	50.00
No	40	36.36	36.36	86.36
Silence	15	13.64	13.64	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; August14–September20, 2014

Table- 11: Challenges of UH&FWC to Provide Maternity Education and Health Care Services

Challenges	No. of respondents	Percentage	Valid Percentage	Cumulative Percentage
Financial Crisis	25	22.73	22.73	22.73
Shortage of Trained/Skilled Manpower	20	18.18	18.18	40.91
Shortage of medical equipments ,medicine and Technology	23	20.91	20.91	61.82
Superstition	8	7.27	7.27	69.09
Weak Monitoring and Supervision	11	10.00	10.00	79.09
Lack of Transportation in any crisis situation	13	11.82	11.82	90.91
Scarcity of power and water	10	9.09	9.09	100.0
Total	110	100.0	100.0	

Field Data Collected from Sylhet; Augus