Empowering communities to ensure women's maternal health rights in Netrakona district, Bangladesh

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Introduction

Although the most recent estimates of maternal mortality indicate a reduction in annual maternal deaths from 546,000 to 358,000, the distribution of these deaths has remained unchanged, with 99% occurring in developing countries.[1] This widely cited observation clearly demonstrates the inequities between developed and developing countries, even as it may overshadow the estimated 10 million women annually who suffer from injury or disability related to pregnancy. It is estimated that for every maternal death, 20 women suffer from either chronic or acute illness due to maternal causes.[2] This is especially tragic given the fact that nearly all maternal deaths are avoidable and much of maternal mortality is preventable and/or treatable through medical means that have become routine in developed countries. In response to the social injustice represented by the inequitable burden of maternal death and illness suffered by low- and middle-income countries, the Office of the United Nations High Commissioner on Human Rights issued an historic statement denouncing preventable maternal mortality and morbidity as violations of women's rights to health, life, education, dignity and information.[3] Unfortunately many women, especially in the developing world are not able to exercise their rights regarding maternal health in the same manner as their more advantaged peers. Making motherhood safe for all women is an essential component of achieving women's rights globally.

Bangladesh is among the many countries that has struggled to reduce the risks faced by women during pregnancy and birth. Encouragingly, the recent Bangladesh Maternal Mortality and Healthcare Survey revealed a 40% reduction in maternal mortality from a maternal mortality (MMR) ratio of 322/100,000 in 2001 to 194/100,000 in 2010.[4] These findings uncontrovertibly warrant the encomium received, as they are the result of committed effort by the government of Bangladesh and many international and non-governmental organisations (NGOs); however, the fight to assure safe motherhood needs to be continued with the same intensity and even invigorated in order to ensure that all women in Bangladesh are attaining their rights related to maternal health. Historically, maternal mortality has not been equitably distributed throughout the country and has decreased rapidly in urban areas, even while remaining alarmingly high in rural regions. For example, Ahmed and Hill found a range in maternal mortality ratio from a low of 158 in the capital, Dhaka, to a high of 782 in the northern coastal regions which are

[1]WHO, UNICEF, UNFPA and the World Bank (2010). Trends in maternal mortality: 1990-2008. Geneva: World Health Organization.
[2] Naanda G, Switlick K, Lule E. Accelerating progress towards achieving the MDG to improve maternal health: a collection of promising approaches. Washington, DC: World Bank; 2005.
[3] UN Human Rights Council. Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights. United Nations General Assembly; 2010.
[4] National Institute of Population Research and Training (NIPORT), USAID, AusAid, UNFPA, Evaluation M, ICDDR,B. Bangladesh maternal mortality and health care survey 2010: Summary of key finding and implications. 2011

characterized by low socioeconomic status, poor transportation systems and limited provision of health services, all contributors to maternal mortality.[5] These data underscore the necessity in giving priority to these underserved women to assure their right to health as well as continue the trend of improvement in maternal health nationally.

Addressing the factors that prevent women from assuming their maternal health rights has proven formidable. Research has consistently shown that the risk of mortality for mothers is highest between the third trimester and the first few days of birth, peaking the day of and in the 24 hours immediately following delivery.[6] Based on this observation, providing skilled attendance at birth has become widely regarded as a key component to ensuring women's rights to health and life in childbirth, as most of the problems leading to mortality can be medically treated, though not predicted.[7] However, deliveries attended by a skilled attendant in Bangladesh remain dismally low, with only 26.5% in 2010 of births overall attended by a trained provider, a rate which is much lower in northern regions. [8]

Achieving skilled attendance at birth is especially challenging among underserved populations, with many obstacles preventing women from receiving the care that they are in need of. Increasing women's utilisation of life-saving service requires both supply- and demand-side interventions. While it is crucial that health services be strengthened and both basic and emergency obstetric care services be staffed, well equipped and of high quality, the mere existence of these services will not necessarily result in increased utilisation. Although demand-side barriers are of equal importance in preventing access to health services, interventions addressing these barriers have traditionally been neglected in favour of supply-side action. Demand-side obstacles are often especially burdensome among underserved population and can include physical and financial impediments, knowledge and educational limitations, cultural norms and low status of women.[9] Overcoming demand-side obstacles necessitates a human rights approach to maternal health as it requires communities' participation in creating an environment conducive to assuring women's rights and the empowerment of women to demand these rights.

Netrakona district, located in Bangladesh near the Himalayan border, is comparable to other northern territories in that it is characterized by low socioeconomic status, a paucity of local health services and poor infrastructure to reach health facilities. As a result, delivery with the support of a skilled birth attendant is much lower than the national rate; only 12% of women in the intervention area gave birth with a skilled attendant at baseline.[10] In light of these challenges

[5]Ahmed S, Hill K. Maternal mortality estimation at the subnational level: a model-based method with an application to Bangladesh. Bulletin of the World Health Organization. 2010

[6] Ronsmans C, Graham WJ, others. Maternal mortality: who, when, where, and why. The Lancet. 2006;368(9542):1189–1200

[7] Campbell OM, Graham W. Strategies for reducing maternal mortality: getting on with what works. The Lancet. 2006 Oct;368(9543):1284-1299; WHO. Skilled care at every birth. Geneva: World Health Organization; 2005.

[8] National Institute of Population Research and Training (NIPORT), USAID, AusAid, UNFPA, Evaluation M, ICDDR,B. Bangladesh maternal mortality and health care survey 2010: Summary of key finding and implications; 2011.

[9] Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. Health Policy and Planning. 2004 Mar 1;19(2):69 -79.

[10] Rahman A, Miah H, Rahman F. Enabling individual, family and community to improve maternal and neonatakl health in Netrakona district: baseline survey. Unpublished internal document: PARI Development Trust; 2009.

and with the objective to help women located in rural Bangladesh attain their right the safe motherhood, PARI Development Trust, a locally based NGO, supported by Enfants du Monde, implemented a programme based on the World Health Organisation's framework for working with Individuals, Families and Communities (IFC) to improve maternal and newborn health in this district.

IFC programme organisation in Netrakona district

The overarching objectives of the IFC framework are to empower women, men, families and communities to increase their capacities to improve maternal and newborn health and to increase access to quality maternal and newborn health services. This is achieved through a combination of community level and health services level interventions. The following four priority areas form the basis of interventions within the IFC framework: (1) developing capacities to stay healthy, make healthy decisions, and respond to obstetric and neonatal emergencies; (2) increasing awareness of the rights, needs and potential problems related to maternal and newborn health; (3) strengthening the linkages for social support between women, men, families and communities and with the health delivery system; and (4) improving quality of care, health services and interactions with women and communities.[11] Critical to the framework is the mobilisation of communities in favour of women's rights to health and life throughout pregnancy, childbirth and postpartum. Within the programme, the collective community, men as well as women, take ownership of maternal and newborn health, an area which has traditionally been considered to be women's private matters in Bangladesh.

In line with the IFC frameworks' emphasis on active community participation and intersectoral collaboration, a bottom-up community organisation structure developed by a partner NGO ensures that maternal and newborn health rights are included in the broader strategy of community development. At the village level, two Primary Groups, one for women and one for men to facilitate ease in discussing issues, are composed of 20-25 community members each. These individuals form subgroups in thematic areas, including health, education, gender, and leadership. A representative from each village Primary Group is selected to participate in the Community Central Committee at the union level. Finally, one member from each Community Central Committee is selected to participate in the People's Institution of the upazila (sub-district). The People's Institution holds the legal status of a charitable organisation, giving it the recognition necessary to work with the government and the opportunity to represent the community in the decision making process at higher levels.

This structure allows for a particularly effective means of community penetration and ensures that women's rights to maternal health are included as a fundamental component of development strategies. The members of the Primary Groups are acutely aware of the needs of the community. Within maternal and newborn health, they are aware of each pregnant woman and their specific needs and conversely they know the health workers and therefore serve as a critical link between women and health services. In addition they have been sensitised on MNH rights. Within the Primary Group, members overseeing maternal and newborn health work collaboratively with other subgroups to reach collective solutions and express their community's needs at higher levels having direct contact with the health workers.

[11] WHO. Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2010.

In addition to active community participation, the IFC framework advocates for extensive interagency collaboration. Historically, the cooperation of partners in development programmes in Bangladesh has been extremely limited, but following a bottom-up approach to building coalitions, various partner organisations have come together to work toward common goals within the context of the IFC programme. Programme coordinating committees form the basis of partnership and have been created at the union and upazila levels. These committees include the district level Ministry of Health, various NGOs and representatives of the Community Central Committees. Through these meetings, the partners implementing the IFC programme, including the Ministry of Health, become accountable to the community for their actions. A collaborative partnership of this calibre with government institutions, NGOs and communities working side-by-side in a common project is unique for Bangladesh. This coalition is considered one of the consequential advantages of the IFC programme in empowering communities and increasing their participation in maternal health.

Programme implementation

The IFC programme was initiated in 2008 by PARI Development Trust with the financial and technical support of Enfants du Monde, a Swiss NGO, following several years of programme planning. Based on the input of community members and government planning, birth and emergency preparedness became an important focus of the IFC programme in Netrakona district. Partner organisations worked with community representatives to elaborate a community awareness strategy, including education activities and tools. In order to implement the programme, partners also developed a health workers training strategy to instruct all community and healthcare personnel working within maternal and newborn health in the intervention area. Following the training, the health workers are prepared to educate women and families and assist them to create a birth and emergency plan as well as work in groups with community representatives, including Primary Groups, to develop community awareness of the importance of birth and emergency preparedness.

A Birth and Emergency Preparedness Plan card which has been produced by local partners and endorsed by the District Ministry of Health is a fundamental tool in this effort. It is intended that all pregnant women in the intervention area receive a card and create a plan based on it. This card illustrates through pictograms the choices and preparations that need to be made for birth including choosing a birth place and transportation to reach the birthplace, choosing a birth attendant, choosing a birth companion, the identification of a possible blood donor, creating a strategy to save money for costs related to pregnancy and identifying where to seek care in the case of complications. The Birth and Emergency Preparedness Plan card also contains pictographs of the most common danger signs to help women and families identify complications and seek care in a timely manner. Women discuss their birth plan with community healthcare workers and with health care providers at the time of antenatal check up and at any further encounter with a health worker during pregnancy. Once they have developed the plan, they share it with their husbands and other influential family members, such as mothers and mothers-in-law. Through interactions with health workers and through developing a birth and emergency plan, women are empowered to make health promoting choices before, during and after birth and demand their maternal health rights.

Additionally, communities are mobilised through meetings and awareness campaigns in favour of maternal and newborn health held by Primary Groups and health workers. . Communities

come to see the process of ensuring women's right to maternal health as belonging to the entire community, and as such, they work collectively to identify key barriers to health care seeking for pregnant women and explore solutions. Once solutions are agreed upon, the community takes concrete action to implement these solutions.

Programme results

Through mobilisation activities, communities have successfully come together in Netrakona district to address transportation and financial barriers to care seeking. Three out of the four intervention unions have purchased with funds collected at the local level and are effectively managing transportation for pregnant women to reach health facilities. The Kharnoi union purchased a rickshaw van in 2009, which 13 women utilised to reach health care facilities in 2010. Inspired by their example, Nazirpur union mobilised political will and through community members' contributions also purchased a rickshaw van to transport pregnant women to services. The Rangchati union has also taken steps to overcome transportation barriers for women reaching health services and repaired an abandoned rickshaw ambulance donated by the government. In each case, the transportation is managed by van committees within the Community Central Committee.

The Barkhapon union has created an emergency monetary fund to support women and newborns in case of emergency. A separate bank account was opened specifically for the emergency fund and a steering committee was organised to oversee its smooth operation. The fund has received a high level of community support, as Barkhapon is a particularly remote area that is waterlogged for up to nine months out of the year. The people are poor, and before the creation of the fund, they had no means to access health facilities in case of emergency. Between January and August 2010, seven pregnant women took advantage of the fund to cover expenses related to obstetric needs.

In addition to this emergency monetary fund at the union level, ten additional emergency funds have been created at the village level directed by Primary Groups. These funds are accessible for emergency care, to pay for hospital services, medications and transport according to specific criteria varying by the Primary Group. The funds are collected from community members and borrowers return the funds at a 0%-interest rate.

As haemorrhage is one of the two leading causes of death in Bangladesh, identifying a potential blood donor in case of the need of a blood transfusion is an important component of planning for birth and emergencies. In response to this, a blood group screening campaign has been organised within the context of the programme to identify potential blood donors for pregnant women. In 2010, a total of 876 individuals had their blood screened throughout the course of the campaign (411 pregnant women and 465 relatives or possible donors).

These preliminary results are very encouraging in favour of community empowerment interventions to assure women's rights to maternal health. It is especially promising to note that since the inception of the programme all four intervention unions have taken concrete steps to overcome transportation and financial barriers to health services for pregnant women. These decisions were made at the community level with the suggestions of partner NGOs and governmental organisations and the steps to realise these actions were taken almost exclusively by the community. For example, in Nazirpur union, when the Community Central Committee

determined that providing transportation was a crucial component of linking pregnant women with health services, they organized meetings with community leaders, union council chairmen, community members, teachers and farmers to mobilise them in this initiative. Through these efforts they were rapidly able to collect the entire sum necessary to purchase a rickshaw van.

The results of the programme suggest that community empowerment is an effective practice in the effort to ensure women's reproductive rights during pregnancy and childbirth. The communities in question have started to take control of maternal and newborn health as the community has come to see assuring women's and newborn's rights to health and life as a concern belonging to the entire community. This collective thinking has been exhibited in donations received to purchase rickshaw and to create the emergency monetary funds that are loaned to women specifically for costs incurred in paying for maternal and newborn health services. These united actions guarantee community ownership of interventions and bode well for sustainability. Women are enthusiastic about using these services once they know that they are available and communities have consistently expressed their support in favour of these services.

Conclusion

Ensuring access to the resources, including knowledge and health services, that make motherhood safe to all women is essential to ensuring women's basic human rights, as reproduction should be an experience not only survivable but satisfying to women regardless of residence or socioeconomic status. Empowering individuals, families and communities is a vital component in this effort. The early results of the IFC programme implemented in Netrakona district Bangladesh are very promising in favour of community participatory approaches to improving maternal health and suggest that community empowerment is an effective practice in ensuring women's rights to maternal health services and information.