2011

# Strengthening union level facility for providing normal delivery and newborn care services: Workshop report

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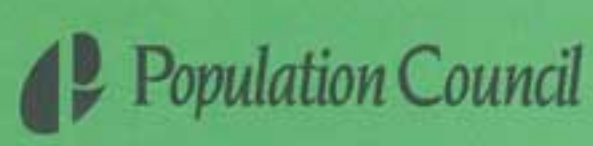
*Workshop Report*

# Strengthening Union Level Facility for Providing Normal Delivery and Newborn Care Services

*Workshop Report*

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*Population Council, Bangladesh*

February 2011

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## *Acknowledgements*

Population Council expresses sincere gratitude to **UK Department for International Development (DFID)** for their interest and financial contribution in organizing the national workshop on Health and Family Welfare Center (HFWC).

The Council is grateful to **Mr. Md. Humayun Kabir**, Secretary, Ministry of Health and Family Welfare (MOHFW), who inaugurated the workshop as the Chief Guest, for providing useful directions towards strengthening HFWCs in providing normal delivery and newborn care services.

We are indebted to former Director General (DG) of Health Services, **Professor Md. Abul Faiz** and **Professor Shah Monir Hossain**, and former DG of Family Planning, **Mr. Mohammad Abdul Qayyum** who shared their experiences and particularly provided a platform for useful discussion.

The Council would like to extend its sincere thanks to **Dr. Makhduma Nargis**, Additional Secretary, MOHFW for expressing her insights on several managerial issues at the community level. We are grateful to **Dr. Shehlina Ahmed** for her presence as a representative of DFID and for delivering a thoughtful speech.

Contribution of designated discussants from government and non-government sectors, who provided thoughtful inputs on the subject, is greatly appreciated. We are thankful to the participants who attended the workshop.

The Council deeply appreciates the technical assistance of **Dr. Jafar Ahmad Hakim**, former Director, Maternal and Child Health Services, Directorate General of Family Planning in organizing the workshop.

Finally, special thanks are due to Population Council staff members for their sincere efforts in organizing the workshop.

## *Abbreviations*

| | |
|---|---|
| ANC | Antenatal Care |
| BCC | Behavior Change Communication |
| DFID | Department for International Development |
| DG | Director General |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| FPI | Family Planning Inspector |
| FWV | Family Welfare Visitor |
| HA | Health Assistant |
| HFWC | Health and Family Welfare Center |
| IMR | Infant Mortality Rate |
| IUD | Intra-uterine Device |
| MA | Medical Assistant |
| MCH | Maternal and Child Health |
| MCH-FP | Maternal and Child Health and Family Planning |
| MDG | Millennium Development Goal |
| MMR | Maternal Mortality Ratio |
| MOHFW | Ministry of Health and Family Welfare |
| MO-MCHFP | Medical Officer-Maternal and Child Health and Family Planning |
| NGO | Non-Governmental Organization |
| PNC | Postnatal Care |
| RD | Rural Dispensary |
| SACMO | Sub-Assistant Community Medical Officer |
| TBA | Traditional Birth Attendant |
| UP | Union Parishad |

## *Executive Summary*

Reaching women and children with essential services has been an important focus of all health sector policies and programs in Bangladesh. A network of government health facilities to provide maternal and child health services from grassroots to higher levels has been established. Despite the sincere efforts of the government, the impact of this comprehensive health services network has been much less than was expected, largely because the services still do not reach the poorest at the community level, who constitute a large segment of the population. Moreover, historically, there exists a significant underutilization of the existing capacity. Home is the site of 85 percent of deliveries, while 15 percent of deliveries take place at facilities. Use of skilled delivery care is low in Bangladesh: only 18 percent of all births are attended by skilled personnel. Nineteen percent of infants receive a check-up from medically trained provider within two days of birth.

In rural areas, first level fixed-facility service is provided at the union level (the lowest administrative unit covering about 30,000 population) through Health and Family Welfare Center (HFWC). These union-level health facilities (HFWC is used interchangeably) are designed to improve maternal and child health by making services available to the people in rural areas. However, a full range of reproductive health services for women is not available in those facilities. In particular, most of the HFWCs do not have the provision for normal delivery services, which is often compounded by the unwillingness of pregnant women to receive maternal health care services from the Upazila Health Complex due to long distance from their home. Transportation is one of the main determinants of low utilization of professional maternity care in Bangladesh. Since Bangladesh is far from achieving the Millennium Development Goal (MDG) of reducing its maternal mortality ratio by 2015, it is critical to ensure access to institutional delivery from the nearest fixed facility. Upgrading the HFWC could help women to receive free normal delivery services within their convenient distance and without difficulties related to transportation.

**Strengthening HFWC is critical**

Traditionally, the union HFWC is the main source for family planning services, maternal health check-ups and child health services. Because of regular household visits by fieldworkers, and HFWC being the nearest health facility in the locality, clients generally go to HFWC to receive services. It is important to note that HFWCs do not have the capacity to provide round-the-clock services. Besides, among six working days a week, the female paramedic posted at HFWC needs to leave the facility for two days to organize satellite clinics in the community.

HFWCs are not utilized optimally, partly due to a shortage of service providers and inadequate availability of some essential services such as delivery, newborn care, and integrated management of childhood illnesses; these services need to be integrated into all the HFWCs. The existing infrastructure would need to be strengthened for providing those services, for which situation analysis is required.

Currently, there is less-coordinated referral system between HFWC and Upazila Health Complex as the paramedics posted at the HFWC prefer to refer clients usually to the Mother and Child Welfare Center (MCWC) that deliver all services for women and children, including assisted delivery, bypassing Upazila Health Complex. It is imperative to develop a functional referral mechanism between HFWC and Upazila Health Complex, so that paramedics could refer clients. At the lower level, functional referral from Community Clinics to the HFWC needs to be ensured.

At the union level, the Family Planning Committee is supposed to act as an oversight body, but these committees are mostly non-functional. Union Family Planning Committees need to be revitalized.

At present, no evidence exists to support whether or not HFWCs can safely and cost-effectively provide normal deliveries. There is a clear need for a policy research initiative that can draw upon concrete evidence to support the necessary policy changes for strengthening the HFWCs to provide normal delivery and newborn care services. To do this, policy advocacy will be critical for sensitizing government policymakers and program managers, development partners, local government representatives and other stakeholders.

With the financial support from DFID, Population Council has undertaken a policy and systems study, aimed at identifying possible mechanism for strengthening the HFWCs to provide normal delivery and newborn care services. As a part of this initiative, a workshop was organized at the onset of this study. Specific objectives of the workshop were to:

- Enhance understanding of programmatic opportunities and challenges to strengthen HFWCs for providing normal delivery and newborn care services.
- Sensitize policymakers, program managers and other concerned stakeholders on the importance of strengthening HFWCs.

**Recommendations**

There are gaps in the existing programs targeted towards reducing maternal mortality. Although initiatives are underway to strengthen Upazila Health Complex to provide emergency obstetric care and Community Clinics being made functional, union-level facilities are in a weak functioning condition. The government is yet to ensure institutional delivery and newborn care services at the union level except a few. It may not be possible to reduce maternal mortality or infant mortality only by strengthening community clinic or upazila hospital while leaving in between weakly functional union health facilities. Without any delay, the union-level facilities need to be strengthened for providing normal delivery and newborn care services.

- To begin with, it is necessary to clearly define the problems related to **physical accessibility** in providing delivery and newborn care services from union-level facilities. Technology can be used to conduct mapping of the HFWCs with the purpose to select appropriately located HFWCs for ensuring both cost-effectiveness and accessibility.
- At present, there is no separate cadre of human resource for conducting normal delivery at the union-level facilities. Until now, about 1500 HFWCs have been upgraded to provide delivery services, for which about 1500 Family Welfare Visitors (FWVs), the frontline workforce to provide facility-based MCH services at union level, have been provided midwifery training. The challenge is to deploy these midwifery-trained FWVs in upgraded HFWCs. In future, a new cadre **"midwife"** can be created to address the current and future needs of growing female population. Posting female doctor with required training at the union level will be necessary for supervision of delivery services.
- There is a critical **cultural barrier** that exists in the eastern part of the country. Considering the restricted mobility of village women and cultural conservatism, it will not be a wise decision to post male providers in those regions for conducting or supervising delivery services at HFWCs.

- Shortage and attrition of FWVs is the major challenge to strengthen HFWCs. The long pause in the recruitment of FWVs, gradual phasing out of FWVs, and the paucity of training facilities are three issues which require immediate attention. Priority should be attached to **training** and **recruitment** of **FWVs**, which needs to be appropriately reflected in the next sector program.

- It is important to note that HFWCs do not have the capacity to provide round-the-clock services. Even, among six working days, FWV needs to leave the HFWC for two days to organize satellite clinics in the community. Under this circumstance, it will be a burden for FWVs if they are entrusted with the additional responsibility to conduct normal delivery. Therefore, one **additional FWV** trained in midwifery and newborn care could be posted to provide round-the-clock maternal and child health services from the HFWC.

- The parallel service delivery systems of 'health' and 'family planning' directorates pose particular challenges for establishing an effective referral system. At present, it is difficult to decide where to refer pregnant woman if complications identified at the HFWC. Establishing a **functional referral mechanism** from community to upazila level requires strengthening facilities at the union level in between two levels otherwise there will be referral directly from community to upazila hospital, which may not always be feasible due to distance and lack of attention of service providers at upazila hospital.

- **Functional coordination** between health and family planning directorates is more effective than integration that may create confusions and non-cooperation. Functional coordination will be beneficial when field workforces of both health and family planning directorates work in coordination to track pregnant mothers, and identify mothers at risk and refer them to strengthened union-level facility. However, there should be a separate process of accountability if both health and family planning services are integrated at the upazila level and below.

- There are loopholes in government initiatives to **retain FWVs** at the **well-constructed residence** having modern amenities. The problem is the unwillingness and lack of commitment of FWVs to stay at the facility. Administrative measures should be applied in addition to providing incentive to FWVs as an effective approach to retain them at the residence. It is important to note that some of the residences are not suitable for living, which should be repaired on urgent basis.

- **Absenteeism** is a national problem, which affects all sectors of the government in the periphery. Absenteeism is indicative of poor motivation/commitment as well as poor accountability at the field level. A mix of reward and punishment has been suggested as a way to reduce absenteeism of service providers, i.e., keeping disincentive along with incentive. Moreover, **supervision** and **monitoring** should be properly highlighted in the next sector program as an instrument to ensure accountability of service providers and to maximize efficient use of government resources.

- The number of sanctioned posts for service providers has remained the same for the last three decades while the population doubled over the time. Besides, there is evidence of duplication in service delivery between health and family planning directorates. Policymakers should be watchful of cost effectiveness of programs, which will be possible only if there is **coordination at the managerial level** of two directorates. It is necessary to **geographically reallocate service providers for avoiding duplication** in services.

- Need is not necessarily suggestive of demand. There is a clear need for maternity and newborn health care, but there is no equivalent demand for those services. Most people consider the HFWCs to be for family planning services. **Demand creation** is indispensible; otherwise, people will remain ignorant of maternal and child health services and medicines that are being provided free at the facility. It requires to raise demand or to transform need into demand either through **motivational awareness** or through **incentive**.

- Traditionally, in the rural area deliveries are conducted at home, indicating limited awareness of and demand for facility-based services. Using community resources has the potential to change the attitude and practice of village women. Facility strengthening will not work properly to ensure its optimum utilization unless there is no community mobilization to overcome cultural barrier.

- It is necessary to **revitalize Union Family Planning Committee** with necessary revisions of their Terms of Reference in order to make them function effectively. If revitalized the Committee is likely to improve the physical condition of the HFWC, ensure quality and regularity of services from the HFWC, and enable the facility to mobilize fund locally and use for its maintenance.

- It will be useful if policymakers **devise plans based on** the **importance of** the **issues** because some problems in service delivery can be addressed immediately and some require a long time.

# I. BACKGROUND

Reaching women and children with essential services has been an important focus of all health sector policies and programs in Bangladesh. As such, maternal and child health services have been given highest priority. A network of government health facilities to provide maternal and child health services from grassroots to higher levels has been established. Despite the sincere efforts of the government, the impact of this comprehensive health services network has been much less than was expected, largely because the services still do not reach the poorest at the community level, who constitute a large segment of the population. Moreover, historically, there exists a significant underutilization of the existing capacity. Home is the site of 85 percent of deliveries, while only 15 percent of deliveries take place at facilities. Use of skilled delivery care is low in Bangladesh: only 18 percent of all births are attended by skilled personnel. Nineteen percent of infants receive a check-up from medically trained provider within two days of birth[1].

In rural areas, first level fixed-facility service is provided at the union level (the lowest administrative unit covering about 30,000 population) through Health and Family Welfare Center (HFWC). These union-level health facilities (HFWC is used interchangeably) are designed to improve maternal and child health by making services available to the people in rural areas. However, a full range of reproductive health services for women is not available in those facilities. In particular, most of the HFWCs do not have the provision for normal delivery services, which is often compounded by the unwillingness of pregnant women to receive maternal health services from the Upazila Health Complex due to long distance from their home. Transportation is one of the main determinants of low utilization of professional maternity care in Bangladesh. Since Bangladesh is far from achieving the Millennium Development Goal (MDG) of reducing its maternal mortality ratio by 2015, it is critical to ensure access to institutional delivery from the nearest fixed facility. Strengthening the HFWCs could help women to receive free normal delivery services within their convenient distance and without difficulties related to transportation. However, there are several issues that need to be addressed through policy changes so that HFWCs could provide normal delivery services.

At present, no evidence exists to support whether or not HFWCs can safely and cost-effectively provide normal deliveries. There is a clear need for a policy research initiative that can draw upon concrete evidence to support the necessary policy changes for strengthening the HFWCs to provide normal delivery and newborn care services. To do this, policy advocacy will be critical for sensitizing government policymakers and program managers, development partners, local government representatives and other stakeholders. With the financial support from UK Department for International Development (DFID), Population Council has undertaken a policy and systems study, aimed at identifying possible mechanism for strengthening all HFWCs to provide normal delivery and newborn care services. As a part of this initiative, a workshop was organized at the onset of this study.

[1] National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2008. *Bangladesh Demographic and Health Survey 2007*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and Macro International.

## II. PURPOSE AND ORGANIZATION OF THE WORKSHOP

The goal of the workshop was to identify possible mechanism of strengthening HFWCs for providing normal delivery and newborn care services. Specific objectives of the workshop were to:

- Enhance understanding of programmatic opportunities and challenges to strengthen HFWCs for providing normal delivery and newborn care services.
- Sensitize policymakers, program managers and other concerned stakeholders on the importance of strengthening HFWCs.

**Organization**

This report is the outcome of the workshop titled "Strengthening Union Level Facility for Providing Normal Delivery and Newborn Care Services" held on 12 February 2011 in Dhaka. Population Council organized this workshop in collaboration with Directorate General of Family Planning (DGFP) and with the financial support from DFID.

The workshop was designed to produce recommendations that are appropriate and pragmatic. The workshop was half-day long and divided into two sessions. Mr. Md. Humayun Kabir, Secretary, Ministry of Health and Family Welfare (MOHFW), graced the workshop as the Chief Guest. Former Director General (DG) of Health Services, Professor Md. Abul Faiz and Professor Shah Monir Hossain, and former DG of Family Planning, Mr. Mohammad Abdul Qayyum were also present at the workshop. Dr. Ubaidur Rob, Country Director, Population Council chaired the workshop, while Mr. A.K.M. Zafar Ullah Khan, Adviser to Population Council and former Secretary, MOHFW moderated the workshop.

In the first session, Dr. Ubaidur Rob presented the keynote paper. The other session was dedicated to action-oriented discussion, where several designated discussants shared their views on the issue of strengthening HFWCs. Dr. Shehlina Ahmed expressed her views as a representative of DFID. The workshop ended with the forward-looking speech from the Secretary, MOHFW.

The workshop was an apex-level event, which brought together key policymakers, program managers and academicians involved in, and relevant to, the issue of strengthening HFWCs. A total of 69 participants attended the workshop. Participants were mostly from the MOHFW, Directorate General of Family Planning and Directorate General of Health Services. Participants from academic institutions like Dhaka University, Jahangirnagar University, BRAC School of Public Health, and American International University Bangladesh joined the workshop. Among others, representatives from development partners, international organizations and non-governmental organizations (NGOs) were also present at the workshop.

## III. STRENGTHENING UNION LEVEL FACILITY FOR NORMAL DELIVERY AND NEWBORN CARE SERVICES: STRUCTURE, PROSPECTS AND GAPS

The discussion of the inaugural session is summarized in this section. The inaugural session started with the welcome speech of Dr. Ubaidur Rob, Country Director, Population Council. Dr. Rob also presented the keynote paper in the inaugural session.

**Progress towards achieving MDGs 4 and 5**

Dr. Rob started his presentation by mentioning the progress towards achieving MDGs 4 and 5 of reducing infant mortality rate (IMR) and maternal mortality ratio (MMR). He was concerned with the high rate of maternal mortality, which continues to be an important challenge for health systems in Bangladesh. Though MMR declined from 574 in 1990 to 290 in 2009, it is still far away from achieving MDG 5 of reducing MMR to 143 by 2015. On the other hand, over the past two decades Bangladesh has made impressive gain in child health indicators. Encouragingly, Bangladesh is considered to be on track towards achieving MDG 4 of reducing IMR to 31 by 2015 but sustaining this rate will demand cautious and continued effort. A remarkable reduction was observed for IMR, from 94 in 1990 to 52 in 2007 – more than 44 percent reduction was reported between 1990 and 2007. Dr. Rob, however, cautioned that approximately three-quarters of infant deaths occur in the first month of life. Neonatal mortality rate has declined only modestly from 52 to 37 per 1,000 live births within the last decade.

**Government commitments in extending health facilities in rural areas**

Dr. Rob briefly described the evolution of maternal and child health (MCH) programs in Bangladesh. He stated that historically, MCH services have been given highest priority in health and population sector policies and programs. Family Planning program adopted the MCH-based approach in mid-70s. By establishing facilities, maternal and child health and family planning (MCH-FP) services were extended to union level. Besides, there was a strong emphasis on doorstep services to rural women in efforts to ensure universal coverage of services upon considering the restricted mobility of village women. The fieldworkers link clients to receive services from the union level and higher facilities. All these activities were directed towards increasing access to maternal and child health and family planning services for the rural population.

**Utilization of maternal and child health services from facilities**

Historically, there exists a significant underutilization of the existing capacity. Dr. Rob expressed his concern on low utilization of maternal and child health services from facilities. Only 18 percent of all births are attended by skilled personnel. Yet, only 15 percent of deliveries take place at facilities (as women prefer home as the site of their deliveries) with notable disparities between rural and urban area (urban 31% vs. rural 11%).

Dr. Rob mentioned that ensuring access to skilled postnatal care (PNC) among rural women is another area where Bangladesh struggles. Receiving PNC service is critical for prevention of maternal and neonatal mortality and morbidity, but only 21 percent mothers receive PNC from medically trained personnel – 17 percent of the rural versus 39 percent of the urban women receive

PNC services. Utilization of postnatal checkups for infants is nearly similar to that of postnatal care by women. Only 19 percent of infants receive a check-up from medically trained provider within two days of birth with wide disparities between rural and urban children (urban 36% against rural 14%). Dr. Rob also expressed his concern regarding alarmingly low use of infant health care in Bangladesh. Only one in four infants with diarrheal diseases, and one in three infants with symptoms of acute respiratory infections particularly pneumonia, are taken to a health facility or medically trained health provider, respectively. Moreover, many cases of neonatal infection never reach treatment facilities located at the union level and above.

**An overview of Health and Family Welfare Center**

Dr. Rob provided an overview of Health and Family Welfare Center (HFWC), including physical structure, composition of staff strength, and services available. In addition, he highlighted the present status of the HFWCs and delineated the rationale behind strengthening HFWCs to provide normal delivery and newborn care services.

Generally, HFWC is consisted of minimum five staff members. At this facility, services are provided by one female paramedic (Family Welfare Visitor or FWV) having 18 months basic training and one Sub-Assistant Community Medical Officer (SACMO) or Medical Assistant (MA), mostly male, having three years basic training. About one-third FWVs have received six-month midwifery training.

HFWCs are open six days a week and services are provided from 8:00 am to 2:30 pm. Major services provided at the HFWC are: family planning counseling and methods, pregnancy care (antenatal care, TT, referral), postnatal care, child health care (immunization, acute respiratory infection, vitamin-A, malnutrition, diarrhea), adolescent health care, sexually transmitted infections, and general curative services. Normal vaginal delivery services are provided in some upgraded HFWCs which have a FWV trained in midwifery. It is worth noting that most people do not have a clear idea about maternal and child health services provided through HFWCs. Often, they consider the facilities to be for family planning services.

FWV provides family planning counseling and methods, including intra-uterine device, maternal and child health services, menstrual regulation services and organizes satellite clinics two days a week. SACMO/MA treats minor diseases irrespective of age and sex of clients, and provides surgical first aid, and health education. Both FWV and SACMO perform necessary administrative work. FWV prepares monthly report of MCH and family planning activities of HFWC and satellite clinics, and keeps record of contraceptives in the stock register and updates regularly. SACMO/MA records monetary information, sends monthly report of MCH and family planning activities to upazila, and keeps record of medicines in the stock register and updates regularly.

Currently, there are 3,816 HFWCs, which vary in terms of physical infrastructure. The distribution of HFWCs in terms of types is as follows:

- One-storied HFWC: 1511
- Two-storied HFWC: 2206
- Three-storied HFWC: 99.

Within these, about 600 HFWCs were initially Rural Dispensary (RD). All three types of HFWCs have residential facility for service providers. Composition of staff varies across types of facilities.

Staffs working in one- and two-storied HFWC include: SACMO, FWV, pharmacist, aya, and member of lower sub-ordinate services (MLSS)/security guard. For three-storied HFWC, there is a post of Medical Officer in addition to five above-mentioned staff members.

People living in a union (30,000) are supposed to seek general health care, maternal and child health, and family planning services from the HFWC. Particularly, 5,000-6,000 women of reproductive age are key target population for a HFWC. Each year, 600-700 married women get pregnant in a union, who may seek pregnancy care from the HFWC. In addition, 3,000-3,500 under-five children can be given health care at each HFWC every year.

**Strengthening HFWC is critical**

Traditionally, the union HFWC is the main source for maternal health check-ups and child health services. Because of regular household visits by fieldworkers, and HFWC being the nearest health facility in the locality, clients generally go to HFWC to receive services. Fieldworkers act as a bridge between the facility and the community by guiding clients to receive services from the HFWC. Nevertheless, the union-level facilities are not utilized optimally, partly due to a shortage of service providers and inadequate availability of some essential services such as delivery, newborn care and integrated management of childhood illnesses; these services need to be integrated into the HFWCs.

It is important to note that HFWCs do not have the capacity to provide round-the-clock services. Even, among six working days, FWV needs to leave the HFWC for two days to organize satellite clinics in the community. In this situation, one additional FWV trained in midwifery and newborn care could be posted to provide maternal and child health services from the HFWC. Large number of medical graduates is produced each year, but it is not easy to retain these new doctors in rural areas. HFWCs could be upgraded as the first-level care facility in rural areas, with a Medical Officer for supervision of MCH services and management of complications.

Dr. Rob highlighted several human resources issues at the workshop, which are considered as barriers to providing MCH and family planning services in rural areas. The key problem is the inadequate number of FWVs. Large number of vacant posts has been identified as the major weakness in the service delivery. Dr. Rob compared between sanctioned posts and available positions for services providers at HFWC. He informed that 5705 FWVs were recruited until 1998, of them 1441 FWVs have retired. Most of the remaining FWVs are aged and will be gradually retiring. Discontinuation in the training and attrition of FWVs are likely to jointly pose a formidable challenge for the health system at the union level in the coming years. Sufficient number of posts was not created as "pharmacist". Currently, there are 801 sanctioned posts of pharmacists while 458 are available in position. The government has made half of sanctioned posts of Medical Officer-Family Welfare available at the HFWCs. In reality, all 125 doctors are posted at the upzila level against the post of Medical Officer-Maternal and Child Health and Family Planning (MO-MCHFP).

Currently, there is less-coordinated referral system between HFWC and Upazila Health Complex as the paramedics posted at the HFWC refer clients usually to the Mother and Child Welfare Center (MCWC) that provides all services for women and children, including assisted delivery, bypassing Upazila Health Complex. It is imperative to develop a functional referral mechanism between HFWC and Upazila Health Complex, so that paramedics could refer clients. At the lower level, functional referral from Community Clinics to the HFWC needs to be ensured.

**Ensuring accountability of HFWCs**

At the union level, the Family Planning Committee is supposed to act as an oversight body, but these committees are mostly non-functional. The committee consists of: Union Parishad (UP) Chairman; all UP Members (male and female); government officials at Union level; Headmaster from one Primary School, Boy's High School, Girl's High School, and Madrasha, and Principal from a College, if any (to be selected by UP); Ansar Commander; President, Union Imam Association; President, Union Kazi Association; Representative, non-governmental/voluntary family planning organization (to be selected by UP); President of Mother's Club/Mohila Somiti; SACMO; FWV; and Family Planning Inspector (FPI). UP Chairman is the President of the Union Family Planning Committee and FPI is the Member-Secretary. Dr. Rob identified reluctance of the members to meet routinely as the key challenge. Moreover, these committees lack a specific plan of action. They require financial resources for carrying out monitoring activities. Dr. Rob urged the government to revitalize Union Family Planning Committees with necessary revisions of their Terms of Reference in order to make them function effectively. He was optimistic that if revitalized the Committee is likely to improve the physical condition of the HFWC, ensure quality and regularity of services from the HFWC, and enable the facility to mobilize fund locally and use for its maintenance.

**Revisiting the policies and programs on HFWC**

Dr. Rob stated that although the government has well-devised policies and programs to ensure the availability of MCH services, it is yet to ensure institutional delivery and newborn care services at the union level. There are some structural problems that the government needs to overcome to strengthen HFWCs to provide normal delivery and newborn care services. Dr. Rob identified human resources issues as a matter of immediate concern to strengthen HFWCs. Utilization of normal delivery and newborn care from HFWCs can be ensured if there is equivalent increase in staffing and medicines. However, Dr. Rob identified several opportunities to strengthen HFWCs:

- MOHFW's sincere intention towards achieving MDGs 4 and 5.
- Physical infrastructure.
- Staff-mix.
- Provider's accommodation.
- Free-of-cost services and medicines.
- Systematic record keeping system.

Dr. Rob suggested revisiting MCH-FP strategies and programs to make it consistent with the current and future priorities of increasing institutional delivery while the existing HFWC structure needs to be fully utilized.

## IV. OPPORTUNITIES AND CHALLENGES TO STRENGTHEN UNION LEVEL FACILITY: STAKEHOLDERS' VIEWS

In the action-oriented discussion session, former DGs of Family Planning and Health Services shared their experiences and particularly provided a platform for useful discussion. Several designated discussants, from government and non-government sectors, provided thoughtful inputs on the subject. Finally, the Secretary, MOHFW provided useful directions towards strengthening HFWCs for providing normal delivery and newborn care services.

**Addressing barriers to accessibility**

**Mr. Mohammad Abdul Qayyum,** Former DG of Family Planning identified several key barriers to access facility-based maternal and child health services. Mr. Qayyum stated that public sector is the only option for the people seeking health care in rural areas. At the union level and below, there is no market because of lack of demand and limited purchasing power of the poor people. In towns and cities, market forces determine the demand and accessibility despite there is no government primary health care structure. Mr. Qayyum advised to consider the absence of market at the union level before designing any interventions in the public sector.

Broadly, Mr. Qayyum shared his opinion regarding the challenges to strengthen HFWCs for providing maternal and newborn care services from two perspectives: (i) accessibility, and (ii) demand-supply interaction. He also sketched out potential solutions to those problems.

On **accessibility** criteria, Mr. Qayyum centered his discussion on three generic problems: physical barrier, financial barrier, and cultural barrier. He stressed to identify the accessibility barriers to receive delivery and newborn care services from union-level facilities. He suggested using technology to conduct mapping of the HFWCs with the purpose to select appropriately located HFWCs for ensuring both cost-effectiveness and accessibility. It is necessary to conduct research to clearly define the problem related to physical accessibility.

Regarding **financial** accessibility, Mr. Qayyum drew the attention of the workshop participants to facility-based "hidden" cost, which is also a major barrier in receiving services from the facilities. Hidden cost increases people's out-of-pocket costs and creates financial burden for poor families. Providers at the public facility often charge informal fees despite the services are supposed to be free. Mr. Qayyum felt the need to investigate how much people are paying as hidden cost and for what, to find out whether hidden cost is a barrier or not, and subsequently to implement interventions to remove those hidden costs.

Mr. Qayyum pointed out a critical **cultural** barrier that exists in the eastern part of the country. He was not optimistic with the idea of posting male doctors to solve the accessibility problem related to maternity services. Considering the restricted mobility of village women and cultural conservatism, it will not be a wise decision to post male doctors in those regions for conducting caesarian and normal vaginal delivery.

Mr. Qayyum strongly suggested designing program on the basis of local context. For example, interventions related to physical barrier may be needed in some places, and other areas may require interventions for removing cultural barriers. Financial interventions will be required for marginalized

population groups in rural areas across the country. In addition to these three generic accessibility barriers, there are other barriers accompanied with those generic ones. It is necessary to find out what are the additional barriers that exist in the service delivery in rural area. Key problem lies with human resources, which encompass availability, motivation and commitment.

Mr. Qayyum differentiated between demand and need for services. Need is not necessarily suggestive of demand. There is a clear need for maternity and newborn health care, but there is no equivalent demand for those services. It requires to raise demand or to transform need into demand either through motivational awareness or through incentives.

On the supply side, several human resources issues were mentioned by Mr. Qayyum. Large number of vacant posts at the field level has been identified as the major weakness in the service delivery. There is also the problem of absenteeism, indicative of poor motivation/commitment as well as poor accountability at the field level. Discontinuation in the training of government field-level functionaries and gradual phasing out of field-level staff is another problem. Mr. Qayyum questioned the policy issue related to long pause in the recruitment of FWVs, the first frontline workforce to provide facility-based MCH services. He also highlighted the paucity of training facilities.

Mr. Qayyum also discussed on the loopholes in the government policies to retain FWVs at the well-constructed residence. He strongly recommended deduction of house rent of FWVs irrespective of their occupation as a way to keep those providers at the residence attached to HFWC.

To overcome generic barriers, it is necessary to hold all satellite clinics regularly in a way to address the physical and cultural barriers. Mr. Qayyum expressed his concerns regarding mismanagement or pilferage of drugs, which are supposed to be given free to the service recipients. He asked for the collaboration of the development partners to equip facilities for providing delivery services at the union level.

Mr. Qayyum concluded his speech by highlighting five factors:

- Provide a total package of obstetric care, which includes antenatal care (ANC), delivery by skilled attendant, and postnatal care (PNC).
- Identify complicated cases. About 20 percent of pregnancies develop complications who need to be referred to higher facilities.
- Ensure four ANC check-ups for pregnant women.
- Create a cadre of nurses trained in midwifery to provide delivery service from union-level facilities.
- Strengthen collaboration between public and private sector.

**Creating a cadre of midwives**

**Professor Dr. Shah Monir Hossain**, Former DG, Health Services appreciated the HFWC strengthening initiative with high importance. To begin with, he pointed out the conflict of management between health and family planning directorates. By elaborating on bifurcation of services, particularly the facilities governed separately by directorates of 'health' and 'family planning', Professor Hossain stated the adequacy of HFWCs (union level facilities of DGFP), which can be upgraded to conduct delivery and to provide indoor services. Meanwhile, he identified two problems for providing delivery services from the HFWCs.

In Professor Hossain's opinion, the most important challenge is human resources and its management. At present, there is no appropriate human resource for conducting normal vaginal delivery at the union-level facilities. It will be burden for FWVs if they are entrusted with the additional responsibility to conduct normal delivery. Even if a medical doctor is appointed at the union facility for conducting normal delivery, it will not work because this doctor, particularly a newly recruited one, does not know how to conduct normal delivery efficiently. Moreover, most of them are male doctors, who do not usually have the training on essential obstetric care. Professor Hossain was not in favor of posting doctors, primarily male, at the HFWC, which may be counterproductive. Rather he strongly recommended creating a new cadre "midwife".

Another problem identified by Professor Hossain is the less coordinated referral system in rural areas. The parallel service delivery systems of 'health' and 'family planning' directorates pose particular challenges for establishing an effective referral system. He wanted to know where to refer pregnant woman if complications identified at the HFWC. Specifically, who will be the staff at the Upazila Health Complex to whom FWV can refer complicated cases, provided the dual management at the Upazila Health Complex. FWV can refer the complicated cases to MO-MCHFP, but this medical officer is not capable of attending those patients.

Professor Hossain is a strong proponent for integrating health and family planning services in rural areas to ensure optimum utilization of HFWCs for delivery services. Functional integration at the upazila level and below is necessary to better coordinate the referral in rural areas.

Professor Hossain reiterated to develop a cadre of midwives who can provide services at the union level facilities as a part of long-term planning. He was of the opinion that it is not possible for skilled birth attendants to provide the same services like trained FWVs from HFWC. He concluded his speech by suggesting to conduct a thorough survey to know whether normal delivery services can be provided at the HFWC.

**Capitalizing on existing programs and resources**

**Professor Dr. M. A. Faiz**, Former DG, Health Services highlighted the government's commitment to extend facilities despite having limited resources. Professor Faiz, however, was concerned with the low utilization of facilities. He compared the situation between government facilities in rural areas and identified gaps in the programs targeted towards reducing maternal mortality. Although initiatives are underway to strengthen Upazilla Health Complex to provide emergency obstetric care and Community Clinics being made functional, HFWCs are in a weak functioning condition. He suspected that it may not be possible to reduce the maternal mortality or infant mortality only by

strengthening Community Clinic or upazila hospital while leaving aside weakly functional union health facilities.

It is important to ensure availability of human resources at the facilities. Besides, Professor Faiz emphasized enabling environment for the service providers by reasoning that only mere structure and deployment will not be enough. He was skeptic to undergo a comprehensive research, by stating that health system components and inputs are in place, services are well designed and all other necessary things are in place. He suggested utilizing the private and non-government sectors in addition to the public sector. In this regard, he advised to have mapping of health facilities to maximize the optimum use of existing resources.

Professor Faiz was in favor of functional coordination between health and family planning directorates rather than integration of both the directorates, which may create confusions and non-cooperation. It is necessary to provide health, family planning and nutrition services from every facility at the union level. He strongly believed that normal delivery, antenatal check up, post natal check up is part of total system and only providing normal delivery in an isolated way may not be effective.

**Views of government stakeholders**

**Mr. Abdul Mannan,** Joint Chief, MOHFW was optimistic in terms of providing round-the-clock services from HFWCs. To do that, three sets of FWVs/midwives will be required as informed by the Joint Chief. For upgrading all 4,000 HFWCs, 8,000 additional FWVs/midwives need to be recruited and trained. At present, the government does not have the capacity to create such amount of service providers within a short time. The Joint Chief noted that there are 12 training institutes for developing FWVs, which remained closed for the last 12 years. However, at the community level, manpower is not a problem as justified by the Joint Chief. Currently, there are 44,416 Family Welfare Assistants and Health Assistants. In addition, the government is to develop 13,500 "community health care providers" for the community clinics. Thus a total of about 60,000 fieldworkers will be available against about 40,000 wards, indicating more than one worker in a ward. The Joint Chief strongly believed that if these fieldworkers are given the same task, health workforce will not be problem in rural areas. He heightened the importance on the management of existing human resources and on strengthening the referral system.

**Dr. A.K.M. Mahbubur Rahman**, Line Director, Clinical Contraception Service Delivery Program, DGFP highlighted several government initiatives to ensure the optimum utilization of local level facilities. Until now, about 1500 HFWCs have been upgraded to provide delivery services. A total of about 1500 FWVs received midwifery training. The challenge is that not all midwifery-trained FWVs are in the upgraded centers. Dr. Rahman also mentioned of holding 30,000 satellite clinics per month across the country for providing maternal health check-ups. He warranted the attention of policymakers to two issues: shortage and attrition of FWVs, and retention of medical officers. Dr. Rahman echoed the same tone as Professor Hossain in terms of using field-level functionaries in a coordinated way. It will function effectively when field workforce of both health and family planning directorates work in coordination to track pregnant mothers, and identify risk mothers and refer them to strengthened union-level facility. Traditionally, the culture in the rural area is that deliveries are conducted at home. Dr. Rahman suggested using community resources in changing the attitude and practice of village women. Facility strengthening will not work properly to ensure its optimum utilization unless there is no community mobilization to overcome cultural barrier.

**Dr. Mohammed Sharif,** Director, MCH, DGFP highlighted on the weaknesses and gaps in the existing service delivery. He informed of the discontinuity of FWV training for the last 12 years. Unavailability and absenteeism of FWVs and SACMOs are two areas that need attention of policymakers. He suggested to strengthen monitoring and supervision as part of ensuring accountability of service providers. Dr. Sharif felt that there should be a separate process of accountability if both health and family planning services are integrated at the upazila level and below. At the same time, referral linkages between Community Clinics, HFWCs and Upazila Health Complex need to be established.

**Dr. Faikuzzaman Chowdhury**, Director, Field Services, DGFP emphasized to create demand among the people, otherwise they will remain ignorant of the services and medicines that are being provided free at the facilities.

**Mr. Ganesh C. Sarker**, Director, Information Education and Motivation, DGFP was not supportive of the functional integration of health and family planning services. Rather, he recommended having functional coordination of health and family planning services with particular emphasis on referral. Mr. Sarker advised to increase number of service providers proportionate to the size of the population. He noted that number of sanctioned posts for service providers remained the same for the last 30 years while population doubled over the time. Finally, Mr. Sarker referred to the incentives DGFP is providing for accepting long-acting and permanent family planning methods and suggested to provide an attractive compensation package to both service providers and clients in case of facility-based delivery.

**Dr. Jahir Uddin Ahmed**, former Director, MCH, DGFP was worried with problems at the supply side, particularly unwillingness and lack of commitment of FWVs and SACMOs to stay at facility, which has modern residential structure and amenities. Dr. Ahmed was not complaisant with the idea of only upgrading HFWCs with necessary infrastructure and equipments for providing normal delivery services, which might not necessarily ensure activation of those services. According to Dr. Ahmed, key input that is missing is the delegation of authority to local level. Moreover, supervision, monitoring and accountability are issues to be considered with high importance.

**Mr. Md. Helal Uddin**, Deputy Chief, MOHFW was not poised with the idea of over burdening existing FWV with maternity-service responsibility. Instead, Mr. Uddin suggested to have trained midwives or nurses for performing those services. He also suggested increasing the service hours at the HFWCs provided midwives would stay at the facility. It is a matter of serious concern that most of the home deliveries are conducted by traditional birth attendants (TBAs). Mr. Uddin advised to deploy midwives at the community level who will replace the TBAs. He differed from other discussants as he was supportive of strengthening community-level interventions (including targeted behavior change communication activities) along with strengthening HFWCs at the same time.

**Views of non-government stakeholders**

**Dr. Barkat E Khuda**, Professor of Economics, Dhaka University advised to utilize lessons learned from the upgraded HFWCs where deliveries are conducted. Professor Khuda underlined that it is important to know what has worked there and what has not worked. Lessons from those upgraded HFWCs can be utilized to scale up interventions in other HFWCs in terms of both manpower and infrastructure along with the management issues. Professor Khuda urged the government to invest

its own money to upgrade HFWCs while technical assistance can be sought from research organization.

**Dr. Selina Amin,** Health Adviser, Plan International advised to reactivate the Union Family Planning Committee. It is also necessary to assess how many service providers are actually needed at the union level facilities and when needed.

**Dr. Reena Yasmin**, Director-Program, Marie Stopes Clinic Society was interested to know why service providers do not want to stay at facilities in the rural area. Dr. Yasmin opined that it would be useful if service providers can be involved to discuss those issues and express their views and needs. Providing incentive to field-level functionaries may be an effective approach to keep them at the facility as surmised by Dr. Yasmin. Incentives may be either monetary or professional. Dr. Yasmin provided some evidence on the effectiveness of cash incentives in improving availability of service providers at the facility. Examples also include rewarding promotion upon the commitment and regularity of service providers at the rural setting. At the same time, it is necessary to create demand among the community people in a way to guide them to seek services from the facility.

**Key observations**

After an interactive discussion, **Professor Sushil Ranjan Howlader**, Institute of Health Economics, Dhaka University suggested some future strategies by compiling the key points identified in the action-oriented discussion.

- Fill in vacant posts immediately.
- Increase the number of sanctioned posts by adjusting with current population size.
- Strengthen monitoring system.
- Introduce conditional incentives along with disincentives.
- Post female doctors at the union level.
- Reduce existing distance between 'health' and 'family planning' directorates through functional coordination.
- Undertake special program to create awareness at the demand side.

There are many structural inputs into the health system service delivery. Inputs, however, alone cannot ensure production. It is the process that transforms the inputs into output. Professor Howlader mentioned two types of inputs for the service delivery: large and small. Human resources is the large input while physical infrastructure, medicines are the small inputs. Professor Howlader urged the program managers to focus on the functioning and managing such inputs. He advised to have a comprehensive assessment of HFWCs in terms of providing normal delivery services before embarking upon new program for union level facilities.

**Speech of the Additional Secretary, MOHFW**

**Dr. Makhduma Nargis**, Additional Secretary, MOHFW centered her discussion on several managerial issues.

Despite sincere intention of the government, absenteeism remains. Dr. Nargis suggested a mix of reward and punishment in a way to reduce absenteeism of service providers. She was not convinced with the idea of giving only incentives to the service providers. If service providers get used to

receiving incentives routinely without any penalties, it might increase providers' tendency towards absenteeism again. Dr. Nargis strongly recommended disincentives along with incentives.

There is evidence of duplication in service delivery between health and family planning directorates. Dr. Nargis stated that cost effectiveness of programs will be possible only if there is coordination at the managerial level of two directorates.

Dr. Nargis advised to devise plans based on the importance of the issue as she substantiated that some problems in service delivery can be addressed immediately and some require a long time. She urged the policymakers to attach priority to on-the-job training of service providers, which needs to be reflected in next sector program. Similarly, supervision and monitoring should be duly highlighted as an instrument to ensure accountability of service providers and to maximize efficient use of government resources. It is also necessary to create a cadre of midwives to address the future needs of growing female population.

Dr. Nargis was of the opinion that establishing a functional referral mechanism from community to upazila level requires strengthening facilities at the union level otherwise there will be referral directly from community clinic to upazila hospital, which may not always be feasible due to distance and lack of attention of service providers. She was particularly concerned with the possibility that if referrals made by Community Clinics are not given priority at the health facilities it will in turn diminish the credibility of Community Clinics among the rural population.

**Speech of the Special Guest**

**Dr. Shehlina Ahmed,** Health Adviser, DFID requested the policymakers to pay immediate attention to strengthening the union level facilities for providing normal delivery and newborn care services. She stressed the need to address the issue of human resources management and retention on a priority basis. Dr. Ahmed appreciated the idea of recruiting a new cadre, i.e. midwives; she, however, cautioned that this process would warrant a prolonged period. Dr. Ahmed referred to the effectiveness of government's incentive program in keeping providers' interests and suggested the same for strengthening HFWC services. She was also supportive of functional coordination of health and family planning services, which has the potential to ensure efficient use of resources. Equally important is to clearly articulate scope of functional coordination at different tiers of management, from union to central level. Monitoring is critical to yield optimum output against inputs or resources invested by the government. Dr. Ahmed appreciated the recent government initiatives that use technology to improve the accountability of service providers working at the rural setting.

**Speech of the Chief Guest**

**Mr. Md. Humayun Kabir**, Secretary, MOHFW began his speech by pointing out the extensive network of physical infrastructure in the health and family planning sectors. The Secretary, however, underlined the inadequacy of non-physical inputs, which include skills or training of service providers, regularity and accountability of service providers, and quality of services.

The Secretary trusts that the government will be able to achieve MDG goal of reducing MMR. He mentioned two recent initiatives of the Ministry in this regard: posting ad-hoc doctors at the union level; and commencing the training to create midwives. Around 3,500 doctors have been posted at

the union level who will work for both the directorates. Moreover, there is plan to recruit and train 3,500 midwives by 2015.

Absenteeism is a national problem, which affects all sectors of the government in the periphery. The Secretary regarded the primacy of towns and cities responsible for discouraging field-level functionaries to stay at the rural setting. He also identified the absence of regional development as a key factor contributing to absenteeism nationally. Nevertheless, the MOHFW has undertaken punitive measures to reduce absenteeism of doctors as informed by the Secretary. As a result of strengthened monitoring, the availability of doctors in rural areas has increased remarkably. At the same time, it is also necessary to ensure career path of doctors who are posted at the rural setting as the Secretary reasoned that doctors generally have the logical expectation to get specialized training, which bears more value to them than cash incentive.

The Secretary is not hopeful of the functional integration if done hastily through the decision made at the central level. Functional integration of two directorates requires reforms in administration of those directorates that are historically working with separate structure, culture, chain of command and career path. Such decision or change in policy will be difficult to implement, as it will be incumbent upon both the directorates to adjust their orientation and service delivery as well as to address issues of human resources management.

The Secretary informed that the Ministry usually undertakes medium-term sector-wide program covering three sectors, namely health, population and nutrition, while there is also scope to incorporate national issues into the sector program. He highly appreciated the appropriateness of holding such a workshop on union level facilities and encouraged to embark on a pilot project if situation demanded.

## V. WAY FORWARD

There are gaps in the existing programs targeted towards reducing maternal mortality. Although initiatives are underway to strengthen Upazila Health Complex to provide emergency obstetric care and Community Clinics being made functional, union-level facilities (HFWCs) are in a weak functioning condition. The government is yet to ensure institutional delivery and newborn care services at the union level except a few. HFWCs are not utilized optimally, partly due to a shortage of service providers, limited service hours, and inadequate availability of some essential services such as delivery, newborn care, and integrated management of childhood illnesses. It may not be possible to reduce maternal mortality or infant mortality only by strengthening community clinic or upazila hospital while leaving in between weakly functional union health facilities. Without any delay, the union-level facilities need to be strengthened for providing normal delivery and newborn care services.

- It is necessary to conduct research to clearly define the problems related to **physical accessibility** in providing delivery and newborn care services from union-level facilities. Technology can be used to conduct mapping of the HFWCs with the purpose to select appropriately located HFWCs for ensuring both cost-effectiveness and accessibility.

- On supply side, several human resources issues were identified at the workshop. Large number of **vacant posts** at the field level has been identified as the major weakness in the service delivery. There is also the problem of **absenteeism**, indicative of poor motivation/commitment as well as poor accountability at the field level.

- At present, there is no separate cadre of human resource for conducting normal delivery at the union-level facilities. Until now, about 1500 HFWCs have been upgraded to provide delivery services, for which about 1500 FWVs (the frontline workforce to provide facility-based MCH services at union level) have been provided midwifery training. The challenge is to deploy these midwifery-trained FWVs in upgraded HFWCs. In future, a new cadre **"midwife"** can be created to address the current and future needs of growing female population. Posting female doctor with required training at the union level will be necessary for supervision of delivery services.

- There is a critical **cultural barrier** that exists in the eastern part of the country. Considering the restricted mobility of village women and cultural conservatism, it will not be a wise decision to post male providers in those regions for conducting or supervising delivery services at HFWCs.

- Shortage and attrition of FWVs is the major challenge to strengthen HFWCs. The long pause in the recruitment of FWVs, gradual phasing out of FWVs, and the paucity of training facilities are three issues which require immediate attention. Priority should be attached to **training and recruitment of FWVs**, which needs to be appropriately reflected in the next sector program.

- It is important to note that HFWCs do not have the capacity to provide round-the-clock services. Even, among six working days, FWV needs to leave the HFWC for two days to organize satellite clinics in the community. Under this circumstance, it will be a burden for

FWVs if they are entrusted with the additional responsibility to conduct normal delivery. Therefore, one **additional FWV** trained in midwifery and newborn care could be posted to provide round-the-clock maternal and child health services from the HFWC.

- The parallel service delivery systems of 'health' and 'family planning' directorates pose particular challenges for establishing an effective referral system. At present, it is difficult to decide where to refer pregnant woman if complications identified at the HFWC. Establishing a **functional referral mechanism** from community to upazila level requires strengthening facilities at the union level in between two levels otherwise there will be referral directly from community to upazila hospital, which may not always be feasible due to distance and lack of attention of service providers at upazila hospital.

- **Functional coordination** between health and family planning directorates with particular emphasis on referral is more effective than integration that may create confusions and non-cooperation. Functional coordination will be beneficial when field workforces of both health and family planning directorates work in coordination to track pregnant mothers, and identify mothers at risk and refer them to strengthened union-level facility. However, there should be a separate process of accountability if both health and family planning services are integrated at the upazila level and below.

- There are loopholes in government initiatives to **retain FWVs** at the **well-constructed residence** having modern amenities. The problem is the unwillingness and lack of commitment of FWVs to stay at the facility. Administrative measures should be applied in addition to providing incentive to FWVs as an effective approach to retain them at the residence. It is important to note that some of the residences are not suitable for living, which should be repaired on urgent basis.

- **Absenteeism** is a national problem, which affects all sectors of the government in the periphery. Despite sincere intention of the government, absenteeism remains in the health sector. A mix of reward and punishment has been suggested as a way to reduce absenteeism of service providers, i.e., keeping disincentive along with incentive. Moreover, **supervision and monitoring** should be properly highlighted in the next sector program as an instrument to ensure accountability of service providers and to maximize efficient use of government resources.

- The number of sanctioned posts for service providers has remained the same for the last three decades while the population doubled over the time. Besides, there is evidence of duplication in service delivery between health and family planning directorates. Policymakers should be watchful of cost effectiveness of programs, which will be possible only if there is **coordination at the managerial level** of two directorates. It is necessary to **geographically reallocate service providers for avoiding duplication** in services.

- Need is not necessarily suggestive of demand. There is a clear need for maternity and newborn health care, but there is no equivalent demand for those services. Most people consider HFWCs to be for family planning services. **Demand creation** is indispensible; otherwise people will remain ignorant of MCH services and medicines that are being

provided free at the facility. It requires to raise demand or to transform need into demand either through **motivational awareness** or through **incentives**.

- Traditionally, in the rural area deliveries are conducted at home, indicating limited awareness of and demand for facility-based services. Using community resources has the potential to change the attitude and practice of village women. Facility strengthening will not work properly to ensure its optimum utilization unless there is no community mobilization to overcome cultural barrier.

- It is necessary to **revitalize Union Family Planning Committee** with necessary revisions of their Terms of Reference in order to make them function effectively. If revitalized, the Committee is likely to improve the physical condition of the HFWC, ensure quality and regularity of services from the HFWC, and enable the facility to mobilize fund locally and use for its maintenance.

- It will be useful if policymakers **devise plans based on the importance of the issues** because some problems in service delivery can be addressed immediately and some require a long time.

## *Annexure 1:* Program of the Workshop

**Strengthening Union Level Facility for**
**Providing Normal delivery and Newborn Care services**

Date: 12 February 2011
Venue: Spectra Convention Center, Dhaka

| | |
|---|---|
| 9:30 am – 10:00 am | **REGISTRATION** |
| Chief Guest: | **Md. Humayun Kabir,** Secretary, Ministry of Health and Family Welfare |
| Chair: | **Ubaidur Rob,** Country Director, Population Council |
| Moderator: | **A.K.M. Zafar Ullah Khan,** Advisor to Population Council & Former Secretary, Ministry of Health and Family Welfare |
| 10:00 am – 10:05 am | Recitation from Holy Quran |
| 10:05 am – 10:40 am | Welcome Address & Keynote Presentation<br>**Ubaidur Rob,** Country Director, Population Council |
| 10:40 am – 11:00 am | **TEA** |
| 11:00 am –12:15 pm | Action-orientated Discussion<br>**A.K.M. Zafar Ullah Khan,** Advisor to Population Council & Former Secretary, Ministry of Health and Family Welfare |
| 12:15 pm – 12:50 pm | Open Discussion |
| 12:50 pm – 1:10 pm | Speech by the Special Guest |
| 1:10 pm – 1:25 pm | Speech by the Chief Guest |
| 1:25 pm | Closing by the Chair |
| **LUNCH** | |

## *Annexure 2:* List of Workshop Participants

*(Not according to seniority)*

1. Mr. Md. Humayun Kabir, Secretary, Ministry of Health and Family Welfare (MOHFW)
2. Dr. Makhduma Nargis, Additional Secretary & Project Director-CCHCP, MOHFW
3. Mr. Md. Abdul Qayyum, Additional Secretary & National Project Director-CDMP & former Director General, DGFP
4. Mr. Zakir Hossain, Joint Secretary, Family Welfare, MOHFW
5. Mr. Abdul Mannan, Joint Chief, Planning, MOHFW
6. Mr. Helal Uddin, Deputy Chief, Family Welfare, MOHFW
7. Mr. Abdul Hamid Moral, Assistant Chief, Health Economics Unit, MOHFW
8. Dr. M.A. Sabur, Team Leader, Program Support Office, MOHFW
9. Dr. Tofayel Ahmed, DTC, DMIS, MOHFW
10. Dr. Md. Saikhul Islam Helal, Program Preparation Cell , MOHFW
11. Dr. Rezaul Karim, Member (DGFP Representative), Program Preparation Cell, MOHFW
12. Brigadier General Muhammed Masud Hossain, Director, Store & Supply, DGHS
13. Dr. Mohammed Sharif, Director, MCH Services, DGHP
14. Dr. A.K.M. Mahababur Rahman, Line Director, CCSD, DGFP
15. Mr. Ganesh Chandra Sarker, Director, IEM & Line Director, IEC, DGFP
16. Mr. Faikuzzaman Chowdhury, Director, Finance & Line Director, Field Services, DGFP
17. Ms. Rina Parveen, Line Director, Planning, DGFP
18. Mr. Kafil Uddin, Director, Logistic & Supply, DGFP
19. Dr. Bishnupada Dhar, Program Manager, CA & SS & Deputy Director, MCH Services, DGFP
20. Mr. Mohammad Zearul Islam, Deputy Director, IEM, DGFP
21. Dr. Tapash Ranjan Das, Deputy Director, MCH, DGFP
22. Mr. Rezaul Islam, Deputy Director, MIS, DGFP
23. Ms. Ratna Talukder, Deputy Director, IEM, DGFP
24. Dr. Shamsul Karim, Deputy Program Manager, MCH, DGFP
25. Mr. Pijush Kanti Datta, Research Officer, Planning Unit, DGFP
26. Ms. Selina Choudhury, Gender and Social Development Specialist, Swiss contact, Directorate of Technical Education, Ministry of Education
27. Dr. Shehlina Ahmed, Health and Population Adviser, DFID
28. Dr. Jahir Uddin Ahmed, USAID Division, Team Consultant, USAID
29. Dr. Sukumar Sarker, Senior Clinical Officer, PHN Office, USAID-Bangladesh
30. Dr. Sharmina Sultana, Project Management Specialist, SSFP, USAID-Bangladesh
31. Brig. Gen. (Retd.) Dr. Shahid Khan, Managing Director, SSFP, USAID-Bangladesh
32. Ms. Yukie Yoshimura, Chief Advisor, Safe Motherhood Promotion Project, JICA
33. Dr. Ahmed Al Sabir, MEASURE Evaluation
34. Dr. Sayed Rubayet, Manager-SNL, Save the Children
35. Dr. M.H. Chowdhury, General Manager, Marie Stopes Clinic Society
36. Dr. Reena Yeasmin, Director Program, Marie Stopes Clinic Society
37. Dr. Pronab Chaudhury, Monitoring & Evaluation Specialist, Marie Stopes Clinic Society
38. Mr. Mahbub E Alam, Team Leader, Monitoring, Evaluation & Research, Engender Health
39. Dr. S.M. Shahidullah, Program Manager, Community Managed Health Care, Plan International

40. Dr. Rezzaqul Alam, Plan International
41. Mr. Jamil Hossain Chowdhury, Director (Research), RTM International
42. Dr. A.Z.M. Zahidur Rahman, Head, Disease Prevention, SMC
43. Mr. Md. Masudul Haque, Chief Executive, BWHC
44. Ms. Nargis Sultana, Project Director, CWFD
45. Mr. M.A. Hossain, CTL, Deliver
46. Mr. Tarik Hasan Shahriar, News Reporter, Daily Sun
47. Professor Barkat-E-Khuda, Department of Economics, University of Dhaka
48. Professor M. Kabir, Department of Statistics, Jahangirnagar University
49. Professor K. Saleh Ahmed, Former Vice-Chancellor, Jahangirnagar University
50. Professor Sushil Ranjan Howlader, Institute of Health Economics, University of Dhaka
51. Dr. Ahmed Neaz, Professor, American International University Bangladesh
52. Dr. Farah Mahjabeen, Senior Lecturer & Coordinator CEP, JPGSPH, BRAC University
53. Prof. Dr. Shah Monir Hossain, Former Director General, DGHS
54. Prof. Dr. M.A. Faiz, Former Director General, DGHS
55. Mr. Md. Abdullah, Former Joint Chief, MOHFW
56. Dr. Jafar Ahmad Hakim, Former Director, MCH, DGFP
57. Ms. Nargis Sultana, Research Officer, Population Council
58. Ms. Nondini Lopa, Research Officer, Population Council
59. Ms. Eshita Jahan, Senior Research Officer, Population Council
60. Ms. Kaji Tamanna Keya, Senior Research Officer, Population Council
61. Mr. Mostafizur Rahman Khan, Senior Research Officer, Population Council
62. Mr. Amar Krishan Baidya, Assistant Program Officer, Population Council
63. Mr. Md. Noorunnabi Talukder, Program Officer, Population Council
64. Mr. Md. Moshiur Rahman, Program Officer, Population Council
65. Dr. Ismat Ara Hena, Program Officer, Population Council
66. Ms. Laila Rahman, Senior Program Officer, Population Council
67. Mr. A.K.M. Zafar Ullah Khan, Advisor, Population Council
68. Dr. Sharif Mohammed Ismail Hossain, Associate, Population Council
69. Dr. Ubaidur Rob, Country Director, Population Council

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