Skilled Birth Attendance:
Review of Evidences in Bangladesh

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# Table of Contents

**Acknowledgements** i  
**Foreword** ii  
**Acronyms** iii  
**Defining Skilled Birth Attendant (SBA)** v  

**Chapter 1 : Skilled Birth Attendants: Future of Reduction in Maternal Mortality** 1  
Government Initiatives 2  
Key Success Factors (KSF) 2  

**Chapter 2 : Need assessment study: Identifying Opportunities** 3  
Project Scope, Methodology, Results 3  
Piloting Decision 7  

**Chapter 3 : SBA Training Pilot Programme** 8  
Phase 1: Preparatory 9  
*Stakeholders’ Planning Workshop, Policy Decisions:* 9  
SBA Training Curriculum 9  
Assessment of Training Sites and Institutions 10  
Training of National and District Trainers 11  
Phase 2: Implementation 14  
Training Site Improvement, District Level Training 14  
Selection of Trainees 15  
Implementation of Training 15  
Course Evaluation 18  
Quality Assurance 19  
Advocacy Meetings at District, Upazila and Union levels 20  
Training Follow up: 6 months after Training 22  
Phase 3: Evaluation 23  
Evaluation of the District SBA Training 23  
Assessment of TOT: National and District trainers 24  
Satisfaction on Trainee’s Manual 27  
Assessment of Selection of Trainees 28  
Assessment of District SBA Training 28  
Supervision and Quality Assurance 30  
Level of Trainee’s Satisfaction on the Training 32  
Evaluation of After Training Performances 35  
SBA’s Performances: Self- and Beneficiaries’ assessment 39  
Evaluation of the Curriculum, Training Manuals 55  

**Chapter 4 : SBA Training: Standardization** 60  
Consultation Workshop 60  
Guidelines for Accreditation and Registration, SBA Training 61  
Role of Bangladesh Nursing Council 63  

**Chapter 5 : SBA Training: Scalability** 65  
Phase-wise expansion 65  
Expansion Strategies 67  
GOB actions for the success of the SBA Training Programme 68  

**Chapter 6 : Discussion** 69  
References 72  
Annexes 74
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Maternal mortality ratio in Bangladesh is still high, even though in the last decade substantial progress has been made in improving maternal health situation. The underlying cause is that, at birth, 87 percent of women are not assisted by skilled attendants (doctors, nurse midwives/family welfare visitors) and only less than 10 percent of births occur at health facilities.

Health Population Sector Program (HPSP 1998-2002) had made provision for training of Family Welfare Assistant (FWAs) and Female Health Assistants (FHAs) to provide skilled attendance. The National Maternal Health Strategy approved by the Ministry of Health and Family Welfare (MOHFW) in October 2001 also included the provision of skilled attendants at birth.

Considering the above policy decisions and provision in the GOB (HPSP) programme, WHO Bangladesh initiated and funded a Need Assessment Study (NAS), to ascertain if training of FWAs and FHAs as Skilled Birth Assistants (SBA) would be feasible. Obstetric and Gynaecology Society of Bangladesh (OGSB) was contracted out to conduct the study. The results of the study were presented in a meeting with senior officials, chaired by the Honourable Minister, MOHFW. The results showed that FWAs/ FHAs had adequate educational qualification. They already possessed some knowledge in maternal and newborn care but the skills were lacking. They were willing to undergo intensive training on those skills for six months duration.

Based on those study findings, the MOHFW decided to train the FWAs and FHAs as “SBA” as a high priority under a pilot programme to be implemented in 6 divisional districts. The pilot training programme was completed on September 30, 2003 with the technical assistance from OGSB and the technical and financial support from WHO and UNFPA.

An evaluation of the pilot programme was performed during and 6 months after the training. The results showed that the training was adequate. The competencies were well retained by the SBAs and their performances were good. They covered 33% of home deliveries in the intervention areas. The community acceptance was also high. However, the level of supportive supervision and supply of drugs and logistic for SBA services were found inadequate. The evaluation findings and a proposal on “Scaling up of SBA programme” were presented in a ministerial meeting chaired by the Honourable Minister, MOHFW. The MOHFW decided to scale up and formed a National Steering Committee for policy guidance. Additional Secretary, MOHFW was designated as National Focal Point for scaling up and implementation of all aspect of the programme including logistics and supportive supervision.

The programme has evolved with active participation of stakeholders e.g. GOB, Bangladesh Nursing Council, OGSB, WHO, UNFPA, health worker at various level, and community leaders. It has gone through various steps i.e. pilot phase to scaling up phase. The objective of this publication is to document all the evidences and lessons learnt. We hope that this document will be very useful for Bangladesh as well as other South Asian countries with high maternal mortality ratio.
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADCC</td>
<td>Assistant Director Clinical Contraceptives</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>APW</td>
<td>Agreement for Performance of Work</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>BNC</td>
<td>Bangladesh Nursing Council</td>
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<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<tr>
<td>CME</td>
<td>Continuing Midwifery Education</td>
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<tr>
<td>CM</td>
<td>Community Midwife</td>
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<tr>
<td>CS</td>
<td>Civil Surgeon</td>
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<tr>
<td>CST</td>
<td>Country Support Team</td>
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<tr>
<td>EOC/EmOC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>ESP (RH)</td>
<td>Essential Service Package (Reproductive Health)</td>
</tr>
<tr>
<td>DCS</td>
<td>Deputy Civil Surgeon</td>
</tr>
<tr>
<td>DDFP</td>
<td>Deputy Director Family Planning</td>
</tr>
<tr>
<td>DGHS</td>
<td>Directorate General of Health Services</td>
</tr>
<tr>
<td>DGFP</td>
<td>Directorate General of Family Planning</td>
</tr>
<tr>
<td>DNS</td>
<td>Directorate of Nursing Services</td>
</tr>
<tr>
<td>DPM</td>
<td>Deputy Programme Manager</td>
</tr>
<tr>
<td>DTCC</td>
<td>District Training (SBA) Coordination Committee</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme for Immunization</td>
</tr>
<tr>
<td>FHA</td>
<td>Female Health Assistant</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FI</td>
<td>Field Instructor (trained nurse midwife)</td>
</tr>
<tr>
<td>FIGO</td>
<td>Fedarale Internationalae Gynaecologica and obstetrica</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FWA</td>
<td>Family Welfare Assistant</td>
</tr>
<tr>
<td>H&amp;FWC</td>
<td>Health &amp; Family Welfare centre</td>
</tr>
<tr>
<td>FWV</td>
<td>Family Welfare Visitor</td>
</tr>
<tr>
<td>FWVTI</td>
<td>Family Welfare Visitors Training Institute</td>
</tr>
<tr>
<td>GOB</td>
<td>Government of Bangladesh</td>
</tr>
<tr>
<td>GOVT.</td>
<td>Government</td>
</tr>
<tr>
<td>HSC</td>
<td>Higher Secondary Certificate (Grade XII passed)</td>
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<tr>
<td>HNPSP</td>
<td>Health, Nutrition &amp; Population Sector Program</td>
</tr>
<tr>
<td>ICDDR,B</td>
<td>International Centre for Diarrhoeal Disease Research, Bangladesh</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwife</td>
</tr>
<tr>
<td>ICMH</td>
<td>Institute of Child and Maternal Health</td>
</tr>
<tr>
<td>IMPAC</td>
<td>Integrated Management of Pregnancy And Childbirth</td>
</tr>
</tbody>
</table>
Skilled Birth Attendance: Review of Evidences in Bangladesh

IST In-Service Training
MA Medical Assistant
MBBS Bachelor of Medicine and Bachelor of Surgery
MDG Millennium Development Goals
MCH Maternal and Child Health
MCHTI Maternal and Child Health Training Institute
MCWC Maternal and Child Welfare Centres
MNH Maternal and Newborn Health
MO Medical Officer
MO (CC) Medical Officer (Clinical Contraceptives)
MOHFW Ministry of Health and Family Welfare
MPS Making Pregnancy Safer
NAS Need Assessment Study
NGO Non-governmental Organization
NI Nursing Institute
NIPORT National Institute Population Research and Training
NPPP National Professional Project Person
ObGyn Obstetrics and Gynaecology
OGSB Obstetrical and Gynaecological Society of Bangladesh
PCPNC Pregnancy, Childbirth, Post partum and Newborn Care
PH Nurse Public Health Nurse
PNC Postnatal care
PPH Post Partum Haemorrhage
QA Quality Assurance
RA-NUR Regional Advisor- Nursing (WHO-SEARO)
RMO Resident Medical Officer
SACMO Sub Assistant Community Medical Officer
SBA Skilled Birth Attendant (Acronym)
SSC Secondary School Certificate (grade X)
SMIAG Safe Motherhood Inter Agency Group
SEARO South East Asia Regional Office
TOR Terms of Reference
TBA Traditional Birth Attendant
TTBA Trained Traditional Birth Attendant
TOT Training of Trainers
TTU Technical Training Unit
UHC Upazilla Health Complex
UHFPO Upazilla Health & Family Planning Officer
UFPO Upazilla Family Planning Officer
UNFPA United Nations Population Fund
UNICEF United Nations Children's fund
UP Union Parisad
VAW Violence Against Women
WHO World Health Organization
Definition
Skilled Birth Attendant (SBA)

A "skilled attendant or skilled birth attendant" is an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification, management and referral of complications in women and newborns.

In the context of Bangladesh in addition to above mentioned health workers, the acronym skilled birth attendant (SBA) is defined as the accredited health worker working at community level, such as Family Welfare Assistant (FWA) and Female Health Assistant (FHA), who have been educated and trained to proficiency in all the core midwifery skills and abilities (annex-1) needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in identification and referral of complications after providing first-line management to the mother and newborn(s). They were certified and registered as SBA by Bangladesh Nursing Council (BNC), under BNC Ordinance LXI, 1983, to be a licensed practitioner in the community.

1 Making Pregnancy safer: the critical role of the skilled attendant, Department of Reproductive Health and Research, World Health Organization, Geneva, 2004. This revised definition has been endorsed by the UNFPA and World Bank
Chapter 1
Skilled Birth Attendants: Future of reduction in Maternal Mortality

Current Scenario
Maternal mortality ratio in Bangladesh is 3.2 per thousand live births (National Maternal Mortality Survey: 2001). 80 percent of such deaths occur at home, where delivery is attempted under unhygienic conditions and assisted by trained or untrained traditional birth attendants (TBAs), close relatives or neighbours. The review of performance of trained TBAs conducted in 1995 by BIRPERHT showed that they continued several harmful birth practices such as performing unhygienic and un-necessary vaginal examination, applying pressure on the abdomen, tying over the abdomen tightly, asking mothers to press prematurely, slapping on the baby’s back and shaking the baby, etc. In spite of such facts, due to existing cultural beliefs and social practices, more than 90 percent of deliveries are still occurring at home, mostly attended by the TBAs.

An important indicator for maternal health status of a country is the number of deliveries assisted by skilled attendants. Evidence shows that countries that have a maternal mortality ratio below 1 per 1000 live births have at least 85 percent of their deliveries conducted by skilled attendants e.g. Thailand (85%), Sri Lanka (95%) and DPR Korea (99%) in the South East Asia Region. In Bangladesh, only 13 percent of deliveries is assisted by individuals with any medical training e.g. doctors, nurses/ midwives/ Female Welfare Visitors (FWV)/ other medical assistants. Most of such ‘professionals’ lack proper midwifery training.

During the 1990s, the Government of Bangladesh (GOB) pursued the strategy of strengthening institutional support for safe motherhood by providing for emergency obstetric care (EmOC) services at the upazila health complexes and district hospitals. However, these services are under-utilised by the community and safety during majority of pregnancies (> 90%) need immediate attention.

Fast Facts
• Maternal mortality ratio 3.2:1000 live births
• 80% of such deaths occur at attempted home deliveries
• More than 90% of deliveries are still occurring at home
• Only 13% of deliveries is assisted by individuals with any medical training
Government Initiatives

Recognizing these factors, GOB has decided to stop investing in further training for TBAs or rely on their current level of expertise. In October 2001, the Bangladesh National Maternal Health Strategy, recommended the provision of SBAs at the grassroots level. Under this plan, GOB is committed to achieving the following goals:

- Increase the rate of deliveries assisted by skilled attendants from 13% to 50% by 2010
- Reduce maternal mortality by 75% between 1990 and 2015, in adherence to the Millennium Development Goals (MDGs) 4 and 5

Key Success Factors in Reduction of MMR

The followings are the key interventions to reduce the incidence and the severity of major complications associated with pregnancy and childbirth:

i. A skilled attendant, i.e. a person with midwifery skills, present at every birth.

ii. Good quality emergency obstetric services at referral centres for complications

iii. Timely referral for each obstetric complication

It is believed that a well-trained SBA would not only fulfill criterion # i, but should also be able to competently perform on # iii. As such, it is important to identify an existing group, which can be trained into the most effective SBAs. The group should have the ability to 1) be trained easily and 2) be accepted into the community seamlessly.

The group that was selected for a pilot SBA training programme leverages the GOB’s unique health infrastructure, which offers at least one basic health worker per 6000 people at community levels. These FWA/ FHAs are primarily responsible for providing preventive health and family planning services at community levels. In the 1998 version of their job description, FWAs/ FHAs were to assist in home deliveries as well. As a result, selecting this group of health workers for the SBA training was one of the key factors of the success of the programme.

The rest of the report give greater details on the road map of the project, methodologies behind selection criteria, implementation results and the success factors of the project that make the SBA training programmes a scalable and sustainable venture.
Chapter 2
Need Assessment Study: Identifying Opportunities

Project Scope
In 2001, WHO Bangladesh initiated and funded a Need Assessment Study (NAS) to assess the feasibility of training FWAs and FHAs to become accredited SBAs. The study also performed an in-depth analysis to establish the requirements of the curriculum and support for such training. The study was designed and conducted by OGSB, with technical and financial support from WHO Bangladesh.

The vision for the proposed training programme was that once they became SBAs, the FWAs and FHAs would be placed at community levels to perform normal deliveries, provide ante-natal care (ANC), post-natal care (PNC), newborn care, identify obstetric complications and do early referrals. With this in mind, the six-month study was conducted between July and December 2001, in two upazilas, Hossainpur (under Kishoregonj district) and Shakipur (under Tangail district).

Methodology
For quantitative data, a total of 108 FWAs (n=72) and FHAs (n=36) were interviewed using a pre-tested questionnaire. Qualitative data was gathered through focus group discussion (FGD) and in-depth interview with different groups. FGDs included FWAs, FHAs, doctors, nurses, FWVs, stakeholders, policy makers, administrators, and women (pregnant or non-pregnant) of reproductive age.

Results
The conclusions from the study were very positive. These are grouped below by relevant sections:

Trainees’ Prior Knowledge
- Many already have basic knowledge on safe delivery, danger signs, obstetric complications and reasons for referral.
  - 61% were able to calculate expected date of delivery (EDD).
  - Respondents were aware of danger signs in pregnancies such as the swelling of feet and hand (91%), headache/fever (74%), bleeding (60%), fits (55%), blurring of vision (49%) and malpresentation (35%). 32-37% stated that they have prior formal training on these areas.
6 Prior Relevant Knowledge contd.

For referrals

- 66% could identify obstetric complications
- 19% could identify complications during delivery
- 16% could identify post-natal complications

For referrals, the FWA/FHAs mentioned the absence of respiration after birth (71%), absence of cry (42%), low birth weight (38%), birth trauma (35%), and blue colour of body (21%) etc. as the signs of complications.

- As reasons for referral, 66% of the respondents could mention obstetric complications like swelling of feet, headache, blurring of vision, eclampsia, short stature, high blood pressure, reduced foetal movement in current pregnancy and history of complications like caesarean section, foetal loss in previous pregnancy or prolonged infertility etc. 19% stated complications during delivery like premature start of labour/rupture of membranes, obstructed labour, prolonged labour etc. 16% could cite complications after delivery such as retained placenta, haemorrhage, and torn-cord etc.

- 70% were in demand by their respective communities to assist in home deliveries. However, only 16% had performed deliveries on their own and another 17% provided assistance to TBAs.

- 80% of FWA/FHAs have a minimum educational level of SSC (grade X), which is a satisfactory threshold. None were below an education level of grade VIII (Figure 1).

- 81% were aged below 40, an appropriate age for the long-term sustainability of the project.

- As per their current job description, both FWA/FHAs stated that they provide services related to maternal and newborn care (Figure 2).

- 96% of respondents wanted training in various maternal and child health care areas (Figure 3). Beside the common desire to be trained on normal/safe delivery, 85% wanted training on ANC and related complications, 61% on newborn care, 54% on PNC and related complications, 15% on referral and record keeping. In addition, 9% asked for training on other agenda unrelated to SBA training.
Trainees’ Readiness

- 93% of respondents expressed their interest to become a SBA at the community level and wanted training to acquire the necessary skills on essential pregnancy, childbirth and neonatal care. (Figure 4) illustrates other factors of readiness and the corresponding responses.

- They were willing to stay for 6 months at the district level for residential training (93% interested to stay in hostels).

- 78% perceived possible resistance from TBAs; 37% perceived possible resistance from community and family.

- 46% did not expect money as incentives or remuneration for the additional services and for conducting deliveries. For the 44% that did, expected payouts were between Taka 200 - 500 (USD 3.5 – 8.5) per delivery.

Maternal and Newborn Health (MNH) as perceived by Community Stakeholders

FGDs and in depth interviews were conducted with stakeholders to understand the community perception regarding MNH situations and needs. Findings show:
Skilled Birth Attendance: Review of Evidences in Bangladesh

- Majority of the people interviewed recognized maternal mortality as an important problem to be addressed.

- Majority of the women stated that they delivered their child at home assisted by TBAs and relatives. They perceived the role of FWA/ FHAs as being able to provide ANC, immunization, distribution of vitamins, contraceptive pills, etc. but not as being qualified to perform deliveries. Most pregnant women did not go for formal ANC and did not recognize it as being important. Hospitals were perceived to be for major complications only whereas it was sufficient to go to village doctors, FWA/FHA or religious leaders for the minor problems. Male guardians also held this perception.

- FWA/ FHAs felt that the community preferred their services for providing ANC to pregnant mothers.

- Doctors, nurses, FWVs and other professionals who have any medical training, believe that home deliveries are not safe, particularly if conducted by TBAs: either trained or untrained.

- Community leaders recognized that ANC, rest, nutrition and avoiding heavy work as important care during pregnancy.

- Several stakeholders thought that it was better to deliver in hospitals, but it was equally acceptable to deliver at home under the supervision of some trained attendant.

- The general consensus on the reasons behind maternal and perinatal mortality is 1) lack of proper care at delivery 2) insufficient number of skilled personnel to attend delivery and 3) faulty manoeuvres/procedures performed by the TBAs.

- Majority agreed with the proposed initiatives from the GOB and felt that training SBAs at the grass root level is a necessary step. All the stakeholders also agreed that the FWAs and FHAs would be suitable candidates to become SBAs. The primary factors affecting this choice were 1) Their level of education; 2) Previous knowledge and experience in MNH care; 3) They are residents of the community and well-accepted; 4) There are a total of 29,250 FWAs/ FHAs available (FWA = 23,500; FHA = 5,750); 5) They are already GOB employees and will not require additional compensation for the MNH services involved and 6) The FWAs/FHAs expressed an interest in receiving SBA training.

- Everybody stressed the need for adequate training, continued supplies of equipment, drugs, logistics and community support and proper accreditation of the SBAs qualifications for the success of such an initiative.

Why FWA/ FHA as SBA?
- Well-educated
- Previous knowledge and experience in MNH care
- Well accepted by the community
- Good availability
- Will not require additional compensation
- Deeply interested in the SBA training
Piloting Decision

On March 17th 2002, WHO Bangladesh organized a presentation on the findings of the NAS7. The meeting was chaired by the Hon’ble Minister of Health & Family Welfare and attended by senior officials from GOB. President - OGSB, presented the study findings and proposed an outline of the curriculum. Based on the findings of the study, GOB decided to pilot the programme in 3 districts, and WHO Bangladesh came forward with technical and financial support.

- A small task force, chaired by the Additional Secretary, MOHFW, was formed to formulate the piloting of the SBA training.
- MOHFW garnered wider stakeholders’ participation. The Director General of Health Services (DGHS), through Line Director, In Service Training (IST), will have institutional responsibility for the training, in coordination with the Director General of Family Planning (DGFP),
- Institutional support will be provided by NIPORT and Nursing Institutes (NI)
- Technical assistance will be provided by OSGB
- BNC was proposed to be the certification body and made responsible for developing a proper registration and certification procedure

At a follow-up meeting, MOHFW requested that a SBA training programme to be piloted in 3 additional divisional districts. UNFPA Bangladesh came forward with financial support for these 3 districts. A memorandum of understanding (MOU) was signed among Additional Director General and Line Director IST, DGHS, WHO Representative and UNFPA Representative (August 2002).

The chosen districts were Tangail, Comilla, Barishal Jessore, Joypurhut and Hobigonj, and the pilot program went into effect from March 1st, 2003.
Chapter 3
SBA Training Pilot Programme

In 2002, GOB approved the piloting of SBA training in six districts. The objective of the project is to train selected professionals who will help reduce the high rates of maternal and newborn mortality in Bangladesh.

FWAs and FHAs were chosen through a rigorous and selective process and trained for 6 months at district facilities and within the selected communities. The training was conducted from March 1st 2003 and ended on 30th September 2003.8-16

Ninety trainees successfully completed the training regime and were certified by BNC as SBAs. This certification allows the SBAs to receive a registered license to start practicing in the community.

The pilot was an innovative and well-designed programme consisting of three distinct phases: Preparatory, Implementation and Evaluation. The following framework summarises this approach and the subsequent sections provide additional details.

Framework for SBA Training Pilot Programme
Phase 1: Preparatory

Stakeholders’ Planning Workshop

The one-day workshop was held with active participation from MOHFW, DGHS, DGFP, NIPORT, ICMH, MCHTI, OGSB, BNC, DNS, WHO, UNFPA, UNICEF at the national level. District participants included Civil Surgeon, Deputy Civil Surgeon, DDFP, ADCC, Principal FWVTI/Instructor NI, RMO, UHFPO, MO-MCH, PH nurse, NGO from 6 piloting districts. The outcomes of the workshop affected different phases of the project, including preparatory and implementation.

All participants were strongly committed to the success of the pilot program. They developed proposals on selection criteria of trainees, the sites for training and accommodation, the composition of district trainers, and the composition of District SBA Training Coordination Committee (DTCC).

With regard to operational issues, it was decided that the financial support, supply and equipment would be provided through the Civil Surgeon. Guidelines were also set for the Advocacy workshop at the district and upazila levels, with primary responsibility assigned to DTCC.

Policy Decisions: National Coordination Committee

In October 2002, under the Chairmanship of the DGHS, a National SBA Training Coordination Committee was formed. The objective of this committee was to design and develop the SBA training programme, to ensure coordination between directorates, institutes, organizations and development partners and to provide policy guidance for implementation and management of the project.

The committee comprised of members from DGHS, DGFP, NIPORT, DNS, ICMH, MCHTI, BNC, WHO, UNFPA, UNICEF, ICDDR,B and OGSB.

Throughout the programme, this committee provided continuous support to the implementation partners from national to field level.

SBA Training Curriculum

Based on the NAS findings, a SBA curriculum was developed by OGSB, with technical support from WHO Headquarters, Regional and country experts. 74 essential skills (annex-2) were included in the SBA curriculum from the skills recommended by the Safe Motherhood
Interagency Group (SMIAG 2001). The curriculum provides theoretical and practical knowledge on essential midwifery skills for ANC, childbirth, and PNC for the woman and her newborn, including training on performing normal deliveries. In addition, the selection of skills also include 1) the capacity to identify illness and conditions detrimental to the health of the woman and/or her newborn, 2) carry out the first line management in emergency situations and 3) arrange for timely referral as needed.

The contents were mostly adapted from the WHO Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC: draft-10) guide for essential practice.

In September 2001, reviews were conducted on the appropriateness of the curriculum, the trainee's and the trainer's manuals through two workshops. The review was led by OGSB and supported by WHO and UNFPA. The National Curriculum Committee approved the curriculum October 21st 2002.

Assessment of Training Sites and Institutions

The purpose of the training site assessment was to determine the adequacy of the district level training sites and institutes required for the SBA training. The Assessment Team comprised of representatives from OGSB, GOB, WHO, UNFPA and the Quality Assurance Team. The team visited District hospitals, Maternal and Child Welfare Centre (MCWC), NIs, Family Welfare Visitor’s Training Institute (FWVTI) at the 6 districts chosen for the pilot project.

The assessment was based on six factors, which are analyzed by number of facilities fulfilling the set criteria. Figure 5 illustrates adequacy of facilities assessed.

All Institutes
- Organizational and management capacity
- Identification of potential trainers for the SBA training

Figure-5
Adequacy of the district clinical facilities (n=12)
Skilled Birth Attendance: Review of Evidences in Bangladesh

District Hospitals and MCWCs
- Technical and clinical decision making skills of the providers
- Mother and baby friendly practices in clinical care areas
- Infection prevention practices in clinical care areas
- Availability of equipment and other supplies
- Documentation practices

FWVTI and Nursing Institutes
- Training facilities
- Accommodation facilities

After analysis it was decided that FWVTIs or Nursing Institutes would be used for the classroom training and the practical training would be provided at the District Hospitals and MCWCs.

Training of National and District Trainers

Orientation of National Trainers
A group of 22 professionals comprised of Obstetricians, Pediatricians, Medical officers working in Obstetrics, Senior Nurses, FWVs and GOB programme managers were oriented for 2 weeks at Maternal and Child Health Training Institute (MCHTI). The orientation was designed to make these selected individuals into National Trainers, who in turn would train the District Trainers. Table 1 illustrates the key achievements of this orientation:

<table>
<thead>
<tr>
<th>Composition of the National Trainers</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Numbers</td>
</tr>
<tr>
<td>Obstetricians/ Medical officers</td>
<td>13</td>
</tr>
<tr>
<td>working in Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Paediatrician</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Midwives</td>
<td>2</td>
</tr>
<tr>
<td>Sister Tutors</td>
<td>2</td>
</tr>
<tr>
<td>FWVs</td>
<td>1</td>
</tr>
<tr>
<td>Programme Managers</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

Recommendation from Sites assessment

Classroom
- FWVTI: Barisal, Comilla and Tangail
- Nursing Institute: Jessore, Joypurhat
- District Hospital: Habigonj

Clinical Practice
- District Hospital & MCWC: 6 districts

Accommodation
- FWVTI: Barisal, Comilla, Tangail
- Nursing Institute: Jessore, Joypurhat
- Private Accommodation at Habigonj

Resource Persons in National Traineers Orientation
Training of Trainers (TOT)\textsuperscript{10}

Ninety District Trainers, 15 from each of the six pilot districts were selected and trained through a two week long TOT course. The training was provided in 6 separate batches at MCHTI and Institute of Child and Mother Health (ICMH). Starting on 15\textsuperscript{th} December 2002, it ended on 30\textsuperscript{th} January 2003.

The participants included consultants (Ob-Gyn), Assistant registrar (Obs-Gyn), Medical officers from District hospital, Medical officers (Clinic), ADCC, Principal FWVTI, FWVs, Senior Nurses, Nursing instructors, Trainers from FWVTI\textsuperscript{8, 10}.

The district trainers were orientated on the SBA Training pilot programme, familiarised with the course schedule and contents, lesson plans and different training methodologies. They defined their roles and responsibilities for the Implementation Phase and formulated action plans.

There were a total of 72 sessions over 12 working days. The first three days were dedicated to orient the District Trainers on the programme, different training methodologies and assessment tools. Then the participants were asked to do role-plays, clinical session demonstrations on dummies and patients, which were evaluated by National Trainers, National Consultants and the Quality Assurance Team. Immediate feedback was provided to improve the participants’ skills in the session.

As part of their practical training, for one day the trainees were given the opportunity to practice ANC, PNC and counselling under the supervision of National Consultants, and National Trainers. The participants were taken to a community site at the Sonargaon Upazila near Dhaka. The trainees perceived this exercise to be a very effective learning experience. The inputs from the participants were useful for planning the action plan of “Community clinical practice” for the SBA trainees i.e. FWAs and FHAs during District SBA Training”.

\textbf{National Traineers in Clinical Demonstration}

\textbf{Antenatal counselling by Participants at community}
Repeated evaluations before, during and after the course, and skill improvement with repeated practice under the supervision of National Trainers were the strengths of the TOT course.

Thirty-five district trainers were evaluated during the TOT course. The data shows that the majority fulfilled the criteria for a good trainer. The average score across categories was 82% (range 62 to 94%). The majority (80-95%) effectively used the most important skills set for an ideal trainer/presenter (Figure 6). 48% used positive humour during sessions; 28% could provide an effective summary at the end of session, and only 14% could cite lesson materials in clinical or practical applications.

**Figure-6**
*Class room presentation skills by District trainers (n=45)*

**Key events in preparatory phase**
- SBA Curriculum was approved on the 21st October 2002, Training manuals were developed.
- 22 National Trainers were orientated at MCHTI at Dhaka
- 90 district Trainers from Comilla, Tangail, Barisal, Joypurhat, Jessore and Hobigonj were trained at ICMH & MCHTI, Dhaka
- Implementation of SBA Training from 1st March 2004
Phase 2: Implementation

The process of implementation for the SBA Training included selection of trainees, actual training and evaluation, final examination for certification and registration. The 6 month long training started on 1st March 2003 and ended on 30th September 2003.

The pilot programme was formally inaugurated by DR. Khandaker Mosharraf Hossain, Hon’ble Minister, MOHFW at a ceremonial event at Comilla district. The event was attended by Secretary, MOHFW, DGHS, DGFP, President – OGSB, WHO Representative, Deputy Representative of UNFPA and by other national and district level stakeholders, trainees and trainers.

Training Site Improvement

After the Training Site Assessment (see details under Preparatory Phase), and by analysing the reports, specific recommendations and suggestions for modifications prepared through discussion at the Stakeholders Planning Workshop.

A plan for modifications was prepared according to the specific needs of the individual district. Improvements to the training sites were designed so that sufficient logistic, medical supplies, including partographs and training materials, would be available for conducting a quality SBA Training Programme. Improvements were supported by WHO and UNFPA.

SBA Training was piloted in 6 districts with 90 trainees (15 per district). The team comprised of 74 FWAs and 16 FHAs. Training was held at sites that were improved according to the recommendations from the site assessment.

District Level Training

The DTCC, with support from Focal Point, National consultants (3) and Quality Assurance Team members (3), organized the implementation at the district level. During implementation, local authority took initiatives for each step in implementation as per the national guidelines. The key events in implementation are as follows:
Selection of Trainees

A SBA Selection Committee selected a total of 90 trainees, 15 from each pilot upazila. 25-30 FWAs/ FHAs were called for interviews and finally 15 were selected based on the section criteria, including written and oral tests. 5 additional participants were put on a waiting list in the event of dropouts.

Mean age of the trainees was 36.2 years (range 28 – 47 years); Mean duration of services was 15 years (range 10 – 30 years); 98% were married. 61% SSC (X grade) while rest are above i.e. 17%) at HSC, 4% at Bachelor degree and 2% with Masters qualified (Figure 7). There were two areas of discrepancy between the proposed selection criteria (Page-63) and what was eventually implemented i.e. 1. Age: even though the threshold had been set at 40 years, there were a few trainees above that age and 2. Residence: the status of permanent residence was difficult to judge as some of the trainees lived in other communities that were adjacent to the ones they served.

Implementation of Training

The following steps were applied at the district levels before starting the training sessions:

- A DTCC, headed by a civil surgeon, was formed in each district for implementation and supervision of the programme.
- Training sites were prepared and upgraded according to the recommendations of site assessment.
- The required training materials, developed during the training at the national level, were acquired.
- District trainers, along with DTCC, took initiatives for proper conduction of training.
- Focal Point, National consultants and QA team members continuously provided technical support throughout the implementation.
Implementation of SBA training in the six pilot districts was started simultaneously. The training is a 26 weeks competency based programme, conducted in phases: classroom sessions (4 weeks), clinical practice (13 weeks) in District Hospitals and MCWCs and then community clinical practice (8 weeks) in the community where they are posted. At the end there was a final examination on the last week of the course.

Table 2: Time Schedule of Phases of the District SBA Training

<table>
<thead>
<tr>
<th>Phases of Training</th>
<th>Classroom Sessions</th>
<th>Clinical Practice</th>
<th>Community Practice</th>
<th>Final Examination</th>
<th>Total Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>FWVTI, NI or DH</td>
<td>District Hospital &amp; MCWC</td>
<td>At the place of work</td>
<td>At district level</td>
<td>26 weeks</td>
</tr>
<tr>
<td>Duration</td>
<td>4 weeks</td>
<td>13 weeks</td>
<td>8 weeks</td>
<td>1 week</td>
<td></td>
</tr>
</tbody>
</table>

**Classroom Sessions**

Classroom sessions were conducted at FWVTI in 3 districts, Nursing Institutes in 2 districts and in a District Hospital in one district. Facilities were modified at each of the centres and equipped with all essential training aids.

The 15 trained district trainers conducted or facilitated the sessions according to the schedule of the Implementation Phase and training manuals. Each trainer conducted an average of six sessions.

There were a total of 90 sessions, consisting of various learning methodologies and approaches such as theoretical classes, practical demonstrations on models through role plays and case studies. Repeat classes were offered on important topics.

Overhead projectors and transparencies, flipcharts and markers, board and marker, VIPP card with display board, poster, pictorial with display apron, obstetric phantom with fetal head, articulated pelvis, section through female pelvis, fetal head, models of placenta with cord, breast, uterus, cervix, fetus and other related instruments for obstetric care and infection prevention were used as visual aid for the training.

**Clinical Practice**

The clinical practice was conducted under supervision of District Trainers at district hospitals and MCWCs. Half of the trainees were placed at the District hospitals, where most of the complicated cases are referred, while the rest were placed at the MCWCs, where mostly normal cases are handled. A rotational program was established so that all the trainees received comparable opportunities.
All trainees attended the morning shifts to practice ANC, PNC, Newborn care, FP services and performing deliveries. At times, they were also placed in the delivery room of both the institutes during the evening and night-shift duty.

The clinical training was successfully completed by 30th June 2003. During the 13 weeks worth of clinical practice, there were several review classes, monitoring and supervisory visits. Throughout the course, District Trainers conducted continuous evaluation on the trainees.

**Community Practice**

After completion of clinical practice, each trainee was placed with the selected community to acquire practical experience. The decision to place them was made after a “mid term training review” i.e. a team of National Trainers, QA team members and national consultants performed a thorough assessment of each of the trainees before they were placed. The objective of this mid term review was to assess the level of knowledge and competencies acquired by each trainee. It was assumed that this judgment, followed by additional tutoring, would help the trainees to be a more effective performer in their intended activities.

At the end of the review and the additional training, the trainees were placed in their respective communities for 8 weeks from July 1st 2003. Trained senior nurse midwives were placed as Field Instructors (FIs) alongside the trainees to provide supportive supervision.

One of the first tasks performed by the trainees was to register the pregnant women in their locality and conducted at least 3-6 health education or advocacy sessions for community awareness regarding their services. Each SBA trainee conducted those meetings with community leaders, village elite, local GOB people, pregnant and lactating mothers. They provided services such as ANC, PNC, Newborn care, FP and home deliveries under FI.
supervision and some on their own. They achieved their targets (annex-3) and performed adequate number of home deliveries and referrals. The supervision of the community practice was done by national and district level supervisors, national consultants, and QA team members.

**Course Evaluation**

Systematic evaluations were conducted throughout the training program in order to assess the knowledge, skills and attitude of a trainee.

**In course evaluations**

Periodic evaluations of the theoretical classroom sessions were done through questions & answers, use of checklists and models. Repeat classes, as part of the classroom sessions, served as reflective assessment on whether the trainees acquired the proper knowledge.

Evaluations of the practical aspect of the project, including Skill practice for care management, was documented through the use of logbooks and assessed by the district clinical trainers/ instructors and field instructors using the skills checklist. Each skill was assessed at least four times or until performed satisfactory in the health facility as well as the community.

In addition, before the trainees were allowed into community practice, a *Midterm Evaluation* was carried out. All district trainers, trainees and FIs were evaluated through this review process. Trainers were evaluated through written test, skill test, and classroom presentation skills. Their logbooks and records were reviewed. One resulting suggestion was that more active participation from the district trainers was required.

Nearly all trainees achieved their performance targets. Ones who fell short were given additional attention and support by the district trainers, until the performance targets were met. In some centres, National Trainers conducted a complete session on newborn resuscitation because the performance of the trainees was found deficient.

The participants of the review shared their experiences, views and constraints encountered during the training. One general suggestion was that more attention should be given to the supplies of teaching/ training materials.

Most of the FIs were deficient in some areas of skill and hence further coaching and training of FIs were suggested.

Most of the district trainers and trainees noted that the review was useful and satisfactory. Based on the results of the review, the National team provided feedback and took appropriate actions to ensure that the District...
Trainer and the trainees met the performance targets. Subsequently, with support from National Trainers and National Consultants, detailed action plan and guidelines, for community practice and community awareness, were developed by the trainees and trainers.

**Final Examination**

A Final Examination was conducted by the BNC on the 26th week of the training programme after participants returned to the training centres from their respective communities. For this examination, there were written, oral and practical tests, conducted by a panel of examiners from BNC, OGSB and district clinical trainers.

The results of the final examination and the trainees’ records from during the course created the basis for certification and registration by BNC. All 90 trainees successfully completed the course and achieved the certificates by BNC.

**Quality Assurance**

Quality assurance (QA) teams, consisting of 4 members (two doctors, two nurse midwives), were created for thorough and constant supervision of the programme. These team members were given an orientation on SBA Training and equipped with benchmarks and other tools for quality assurance, which were developed through meetings and workshops by experts. Observations from these QA exercises were analysed and discussed at the national level at the monthly and quarterly QA meetings. Feedback was prepared and sent to the appropriate sites for incorporation. The feedback was also compiled at the national level in order to improve the overall quality of the training.

Supervisory Teams were also created, for monitoring the progress and quality of the training, at national, district and union levels. The national team consisted of representatives from DHS, DFP, OGSB, MCHTI, ICMH, BNC, DNS, NIPORT and National Trainers. District level teams comprised of members of DTCC and District Trainers were responsible for monitoring the SBA Community Practice at the union level. Periodic visits were conducted using pre-determined supervisory tools and benchmarks (supervisory and technical checklist).

To provide encouragement and peruse progress of the project, senior officials from the Ministry and Directorates of Health and Family Planning visited the training sites on different occasions and provided encouragement to the trainees and trainers. Support to the programme was also strengthened through a number of national, district, and upazila level workshops which were participated by various categories of participants: GOB, NGO, Political Leaders, Community leaders, Religious leaders and other stakeholders.
Advocacy Meetings at District, Upazila and Union levels⁸,⁹,¹⁵

Advocacy within the communities was recognized as an important part of promoting the objectives of the SBA training programme and MNH services. The success of the advocacy hinges on the involvement from stakeholders and leaders, either political or non-political, govt. or non-governmental.

During the pilot, Stakeholders Planning Workshops (refer to the Preparatory Phase) raised awareness and commitment of the stakeholders regarding the implementation of the programme. At these workshops, the roles and responsibilities of the stakeholders were identified at the national, district and upazila levels, and compliance guidelines developed. Activities were planned and implemented accordingly.

One advocacy workshop per district and one per upazila were organized. At or below the union level, the SBA promotion and advocacy meetings were organized and conducted by the Trainees during their community practice. The Trainees were set a target of conducting 3 health education sessions with pregnant women and their relatives and 3 advocacy sessions with community leaders/decision makers/TBAs at or below the union level (approximately 540 meetings were conducted over a 8 week period: August 2003-September 2003, at the rate of 6 meetings per trainee, from a set of 90 trainees).

Some of the other discussions and outcomes of the workshops were:

- Issues on Management and Coordination of SBA Training at Upazila level, Community support for the acceptance of SBAs in the community; referral mechanism for SBAs was discussed.
- Proposals for expansion of the SBA Training to cover all FWA/ FHAs at the upazila level.
- For referrals to be timely, they suggested that
  - A Van could be provided per union for referral transport
  - The rich should help the poor for transport
- Referred cases should be entertained at UHC.
Skilled Birth Attendance: Review of Evidences in Bangladesh

- It was also suggested by many that one doctor should be assigned 24 hours at UHCs, who will provide technical support to SBAs facing problems in field.
- Supplies such as drugs (iron, folic acid, vitamins, oxytocin,) gloves and other necessary items must be ensured.
- Provision of mobile phones for each SBA was requested by the SBAs to enable easy contact with the referral centres.
- The Police, Administration, UP chairmen and all community members, should strengthen social security and support for the programme. Moreover, the SBAs should be careful and be accompanied by acquaintances, to avoid Violence against women (VAW)/assault.
- Community Support and Advocacy need to be raised through union and village level advocacy campaign.

The advocacy initiatives and the Health Education meetings created a favourable environment for the SBA trainees.

- The trainees were able to perform a high number of home deliveries while achieving consumer satisfaction.
- SBA Trainees and TBAs became more collaborative.
- SBA Trainees made a significant number of referrals during their community practice, with increasing support for the decisions from the patient’s family and the community.
- Union Parisad Chairmen and members, particularly females, who participated in the workshops were found to be actively involved in promoting SBA services in their locality.
In retrospect, the promotion of the SBA training played a significant role in implementation of the SBA Pilot programme and ensuring sustainability. At the end of the 6-month SBA Training the FWA/ FHAs would go back to the communities where they are posted, and start practicing as a SBA. Raised community awareness and acceptance of the SBA's practices become necessary for realizing the full potential of the SBAs, in their ability to reduce maternal and neonatal mortality. As such, continued Advocacy and Birth planning meetings were suggested, especially at or below the union levels where the community can participate to develop their own support system.

**Training Follow up: 6 months after Training**

A follow-up on the trainees was planned as a part of pilot programme, to be conducted once at 3rd month and a second follow up after 6 month of the training. A team comprised of National Consultant, QA officers and GOB members, followed structured checklists for the two evaluations. Assessments were done on a random pick of 5 trainees, out of a group of 15 per district. Findings showed that SBAs were continuing with their assigned tasks even though they felt they did not have proper supervision or logistic support. Beyond this, the findings were not well documented and reported.
Phase 3: Evaluation

This integral phase of the SBA Training Pilot Programme included the following components:

- Evaluation of the SBA training at the district levels
- Evaluation of the curriculum, training manuals/ assessment tools.
- Evaluation of the SBA’s after training performance

Evaluations of the district level SBA Training and after training performances, conducted from the 20th January 2004 to 31st March 2004, were performed by Research Evaluation Associates for Development (READ)20, Bangladesh. WHO and UNFPA supported this activity. An external team comprising of experts from WHO Bangladesh, WHO SEARO and UNFPA evaluated the curriculum.

The purposes of the evaluations were:

- Ascertaining how the SBA training was conducted, including a review of all the steps followed in the project, training methodology, and trainees’ performance during training and six months after the training.
- Assess the quality of SBA’s services and performance, compared to other birth attendants in the community (FWVs and others)
- Ascertained the community’s acceptance of the SBA’s services
- Provide recommendations for, if any, modifications, further expansion and sustainable scalability of the programme.

Evaluation of the District SBA Training

Performances during implementation of the training were evaluated through review of the available documents, records, progress reports, WHO-activity (APW: Agreement for Performance of Work) wise reports, the training manuals & tools. Trainees, trainers, and administrators’ opinions, regarding the adequacy of the training manuals, were assessed through interviews/ questionnaires.

Reviewing records and conducting interviews with trainers, trainees and administrators also assessed the adequacy of the Training of Trainers and Trainees, Supervision and Quality Assurance of the training programme. The findings are presented in the following sections:

- Assessment of TOT
- Assessment of Training Site and Institutions
- Assessment of District SBA Training (limited to selection process, implementation of SBA training, evaluation of trainees)
Supervision and quality assurance and SBA’s level of satisfaction on training

Assessment of TOT: National and District trainers

The adequacy of the orientation course, TOT course and client satisfaction were assessed by interviewing the trainers and reviewing records and reports. Nine National trainers, 24 District trainers and 86 trainees, selected at random, were interviewed for the assessment.

Adequacy of the Orientation of National Trainers

The national trainer’s orientation course was assessed through a self-assessment and the district trainers evaluated the performance of the national trainers. The performance of the national trainers who facilitated the TOT was also assessed.

The findings from the national trainers’ interviews on the orientation course are highlighted below:

- Almost all the national trainers stated that the training environment was excellent and the orientation course was very useful and enjoyable to them.
- A combination of participants, from highly qualified specialist to lower level health service providers like FWVs, made the environment conducive for an enriching training experience.
- Use of practical materials was identified as an attractive teaching/learning method.
- Most of them suggested inclusion of more practice sessions, to use more visual aids and models during the sessions, to spend more time on the important topics. Trainers felt that the lesson plans should be refined before the SBA training and the trainers should practice training methods repeatedly.

District trainers’ assessment of the National Trainers is highlighted below:

- The number of National Trainers was adequate for the TOT sessions.
- They rated the quality of the training (in terms of knowledge, attitude and skills). 75% of national trainers were ranked as ‘Excellent’, 17% as ‘Very Good’ and rest were ‘Satisfactory’ or below (Figure 8).

Figure-8
Evaluation of National Trainers by District Trainers
Adequacy of the Training of District Trainers (TOT)

In addition to interviews on the satisfaction and adequacy of the TOT course, relevant documents were reviewed as part of the assessment.

- Most of the trainers found the TOT course to be adequate, appreciating the training environment and its management.
- The trainers were perceived to be very competent, who ranged from doctors, to non-clinical instructors.
- The sessions on training methods illustrating the use of transparencies, flipchart, conducting case studies and role-play, and demonstrations on models were new to most of the participants.
- Pairing/ grouping of the trainers and trainees in preparation and conduction of class room sessions, clinical demonstration or demonstration on model was excellent and interesting.
- The training methods such as role play, case study, group work, presentation, practicing skills, observing infection prevention practices, supporting care during labour and delivery in squatting position, and partograph plotting were deemed to be effective.
- All of the nine national trainers expressed satisfaction about conducting the TOT sessions. The important reasons for their satisfaction were that the TOT was well organized, used set guidelines, benchmarks, trainers manual, every body was strongly motivated and there was active participation from the district trainers.
- Most of the 24 district trainers expressed satisfaction on the TOT course. The main reasons they mentioned were the duration, content, and methods of the training.
  - Half of them thought that the duration was sufficient while the rest suggested a longer duration to make it a less stressful experience. For some sessions such as partograph, more time was deemed necessary.
  - All of them mentioned that the content of TOT course was sufficient and was conducted as per schedule. According to them, the TOT had plenty scope for developing trainer’s skills such as skills for clinical demonstration, use of partograph, infection prevention practices and communication skills.
  - Due to the use of participatory methods the training was entertaining. Role play made the training more attractive. The models, flip charts, posters, and VIPP card etc. were identified by most of the trainers to be useful for such training.
**Trainer’s satisfaction on Trainer’s manual**

All national trainers expressed satisfaction with the training manuals. According to them, it was comprehensive and systematically organized. However, most of them suggested reallocation of the duration of some theoretical and practical sessions based on the importance of the topics; to update, correct and modify some of the evaluation questionnaires and their answer-keys. They also suggested correction of spelling and grammatical mistakes, including repetition of words, and inclusion of an index in the manuals.

All district trainers expressed full satisfaction on the use of the Trainer’s manual as it was easy to follow and the training methods/processes were adequate and user friendly. However, they wanted to include characteristics of good trainers and an index of the materials in the manual. They also suggested correction of spelling and grammatical mistakes, including repetitions.

**Satisfaction on “Assessment Tools”**

The district trainers and trainees were interviewed on assessment tools such as checklists and logbook.

**Checklists**

Overwhelming majority (92%) of the District trainers expressed their satisfaction with the use of assessment tools. However, most of them suggested modifications to some of the checklists such as “measurement of height and weight” and “newborn resuscitation”.

Most of the trainees (93%) interviewed were satisfied with the checklists. They found the tools to be user friendly and suggested that the checklists should be used more frequently with adequate allocation of time during classroom and practical sessions. This will allow them better learning and practices of skills.

**Logbook**

91% of the trainees were satisfied with the logbook. All trainees stated that they maintained the logbook regularly. According to them the advantages of the logbook were:

- Regular recording of cases in logbook gave them a clear understanding of the cases
- It facilitated review and discussion of the cases with the trainer and other trainees at a later date, and the mistakes could be identified and corrected through feedback from trainers or peers.
- By reviewing the records, they could easily remember the case history and its management long after the training session during which it was created
Suggestions for changes include improvement of the format for ANC, by inclusion of counselling and management components, usage of better quality cover page, papers and binding. They also felt the need for a better structured register for registration of their clients including pregnancy registration.

**Satisfaction on Trainee’s Manual**

**National Trainers**
- All of them expressed satisfaction with the Trainee’s manual.
- According to them, the manual was thoroughly reviewed several times by experts; pre-tested and modified.
- The manual provided adequate information and met the objectives for each lesson included in the training.
- It was systematically organized, illustrated and easy to understand.

Suggestions for improvements include elaboration on the lessons on Breast Feeding and Essential drugs, reallocation of time per topic/sessions based on relative importance. They also wanted the health statistics to be updated with the most recent data, felt the document needed better grammatical editing and required an index on the topics discussed.

**District Trainers**
- All of them expressed satisfaction with the Trainee’s manual.
- Majority stated that the topics included in the manual were easy to understand, clear and specific.
- All felt the manual was easy to because it is well illustrated and written in Bangla.

50% of the respondents suggested inclusion of information on topics like anatomy of the vagina, episiotomy, repair of perineal tear and STD/HIV/AIDS. A few of the trainers were sceptical about the ability of SBAs in treating difficult cases of PPH that requires compression of the abdominal aorta and management of eclampsia with magnesium sulphate, and suggested omission of those skills.

**Trainees**
- Majority (93%) were satisfied with manual.
- The manual was easy to read and understand and the contents fit will with the work assignment.

The trainees felt that, considering the importance of topics dealt in the training manual, the duration of training should be extended in order to
cover all topics adequately. The trainees also recommended inclusion of skills such as Episiotomy and repair of perineal tear. They also demanded more elaboration of the lesson on Essential Drugs.

Assessment of Selection of Trainees

The process for selection of trainees was assessed by reviewing set criteria and analysing the data collected after the selection was made (refer to the section on NAS).

Although it has been assumed that the set criteria for trainee selection was followed, it was difficult for the selection committee to verify the status of residence during the selection. Surveys revealed that about one third of the trainees were not residing in their selected community of service. For instance, in one district about 50% of the trainees were found residing outside their unit of posting. Moreover, two trainees had been selected at random but they were related and residing in the same house. Therefore, it was suggested that the local community leaders/ Union Parisod members could be invited to certify the residency of the trainee in the community.

Other constraints for this process were identified as 1) lack of separate fund/ budget for SBA Selection, and 2) it was difficult to get 15 participants per district (across 4-5 unions) within the proposed age limit of 40. As such, the age limit was later extended to 45 years.

20% of those qualified in the selection process for the SBA Training refused to stay up to 6 months at their chosen district(s).

Assessment of District SBA Training

The SBA Training at the district levels were assessed by reviewing the available reports/ documents and also by interviewing the trainers, trainees and administrators. The findings are presented here below under following headings:

- Classroom session
- Clinical Practice
- Community Practice

Classroom session

The classroom sessions were evaluated by reviewing the records and interviewing the trainees.

- All of trainees completed the classroom session successfully (pretest and 3 weekly tests).
- The lectures, discussions, group work, role-play, case studies and use of anatomical models at all the centres, and other learning methods used in the training were found satisfactory.
In addition to classroom activities, they also practiced skills on models/dummies. Attendance of the trainees in classroom session was almost 100%. Trainers followed the class schedule regularly without any interruption. 92% SBAs expressed their satisfaction with classroom sessions because the trainers were friendly, there was enough scope for practice using models & checklists, and there was an evaluation at the end of each week with provision of regular feedback. 8% SBAs were not satisfied because 1) the necessary equipment and supplies were not arranged in a timely manner and 2) management of deliveries was shown on video, which could not equal practical training and 3) practical training was limited at some centres due to inadequate number cases.

Clinical Practice
The clinical practice component of the training, which was for 13 weeks, required the trainees to observe, then assist and eventually perform deliveries. The session was assessed by reviewing programme reports.

Findings show that the trainees received adequate knowledge and clinical skills as reflected from the midterm training review conducted by National Trainers before the trainees were placed in the community to practice supervised ANC, deliveries, PNC, Newborn care and referrals.

92% trainees commented that they got adequate opportunity for clinical practice in different areas. Their performances in ANC, deliveries, PNC and newborn care were satisfactory. All trainees fulfilled their minimum performance targets (annex-3) for clinical practice as stated in the curriculum.

All 90 trainees combined, 1800 normal deliveries were performed, 4500 received ANC, 2000 received PNC and 2000 received newborn care during the clinical training period (Figure 9).
Community Practice

The community practice component was assessed by reviewing documents/records and interviews.

The community practice proved to be very effective in raising the confidence of the trainees by working in a home setting. The community became well aware of the trainees’ abilities to perform ANC, deliveries, PNC and newborn care. During the community practice, the minimum performance targets and requirements of health education sessions were fulfilled according to the curriculum.

During the community practice (8 weeks) the trainees performed a satisfactory number of ANC, deliveries, PNC and newborn care (Figure 10). All 90 trainees performed approximately 709 normal deliveries, 3600 ANC, 500 PNC and 350 Newborn care during the clinical training at community level.

85% of the trainees were satisfied because they achieved their minimum performance targets. Working in the community helped them build confidence and gain the acceptance from the community. They appreciated the full time supportive presence of FIs (trained senior nurses) and also acknowledged that they got plenty opportunity or clients to perform their practices.

However, they suggested that it could be better if they could get more support from the Field Instructors with increased duration of community practice and supply of some drug like Iron, folic acid. They also stated that the cooperation and support from the community needed to be raised for improvement of their services.

Supervision and Quality Assurance

The coordination and supervision of the training was done by DTCC. The activities of the district level administrators during the SBA training were to coordinate, supervise, monitor the training including guiding and observing training sessions, clinical practice and the community practice. As a member of DTCC, they were also responsible for in course and end of course evaluations, accommodation of the trainees, procurement and supply of logistics, organization of various meetings like stakeholder/
advocacy workshops material and to keep liaison with national level for proper implementation of the programme.

Quality Assurance on the training was done through review of records, reports and interviewing relevant personnel i.e. administrators and trainers. Perception of the trainees regarding the supervisors and their support was assessed through interviews of the trainees (n=86).

**Results**

- Records on performance of SBAs were well maintained in all 6 centres, except Comilla.
- Meeting records/minutes were maintained in all the centres except in Comilla and Hobigonj. Attendance registers were maintained at all 6 centres.
- Coordination of SBA training was good in 5 centres and fair in Jessore.
- According to the trainees, accommodation was insufficient in Jessore and Hobigonj. Transportation was insufficient Tangail, Jessore and Hobigonj.
- Weekly performance evaluations were done at all the centres and reported during the DTCC meeting.
- An average of 8 (range 6-12) coordination meetings were held during SBA training. Almost all members of DTCC attended the coordination meetings.
- 79% of administrators claimed that the minutes of the meeting were well kept.
- DTCC interviewees claimed an average of 19 (range 2-88) supervisory visits during the training. Two of the 14 administrators said that they visited daily. 79% of the respondents said that they preserved the reports of supervisory visits.
- Constant supervision from DTCC improved the quality of the programme through record keeping, immediate resolutions of problems and helping to ensure better participation of trainers and trainees in the programme.
- DTCC took initiatives to solve problems regarding accommodation and food, transport, logistic supply and scheduling, as these were brought to attention.
Level of supervision as perceived by the SBAs

Classroom sessions, clinical practice and community practice were regularly visited/ supervised by members of QA team and from national and district supervisory team. They also mentioned that visits by high-ranking GOB officials encouraged them very much.

However, their observations on the quality of the supervision were not encouraging.

- Supervision during classroom sessions was adequate in all the centres, but there were very few visits during community practice.
- The supervisors at the upazila or community seldom asked for reports on their performances regarding ANC, deliveries and PNC.
- Supervisors did not ask them whether they were facing problems in their SBA work.
- Majority reported that they did not meet any supervisors in the field.
- According to them the supervisors gave less importance to SBA services and rather gave preference to other areas EPI and Family planning.

It was assumed that FWVs working at union level would be the most appropriate technical supervisors for SBA activity in the field. Therefore, clinical orientation of FWVs from pilot upazilas was conducted at district level by the district trainers as a part of the pilot project. However, according to the trainees' statements FWVs working in the local Female Welfare Centres (FWC) and upazila health complexes provided minimal support to the SBA's activities.

Level of Trainee’s Satisfaction on the Training

86 trainees were interviewed based on a structured questionnaire to assess their level of satisfaction on the training programme. They were asked to rank, from a scale of 1 to 4, the importance of the various training methods such as use of checklists, demonstrations/ practice on models, bed-side clinical coaching on patients and role plays in the development of their clinical skills. They were also asked to rank the effectiveness of different phases of training i.e. classroom sessions, clinical practice, and community practice in the development of their knowledge and skills.

Training Methods

The trainees were asked to rank various methods of classroom learning on the basis of perceived importance. Most of the trainees ranked “Bed side clinical coaching on patients” as the most important one (rank 1). This was followed by “demonstration on models”, “use of checklist” as third and role-play, respectively (table 3).
The use of role play and practice on models during training was found very important.

They suggested use of video for demonstrating live delivery and its management.

**Training Phases**

92% expressed satisfaction with classroom sessions. There was plenty scope to fill the gaps identified during periodic evaluations with appropriate feedback from the trainers. Only 8% of the trainees showed dissatisfaction.

Almost all the trainees were satisfied with the clinical practice and thought they had adequate opportunity for practical application.

85% (n=78) of the trainees were satisfied with the community practice.

The trainees (n=86) were asked to rank various sections of SBA Training on the basis of their effectiveness in their learning process. The ranking was from a scale of 1 to 4, with 1 being the most effective and 4 being the least.

According to the responses, the clinical practice was most effective (71% rated as rank-1). Community practice was rated as 2nd by 51% of the trainees and classroom sessions were ranked 3rd by 63% of trainees (Table 4).
General Issues

- They did not like the delayed supply of necessary equipment and other necessities.
- All the trainees said that classes were held regularly according to the schedule. The proposed schedule was followed perfectly with plenty scope of repetition of the theoretical or practical sessions.
- Trainers were friendly, sincere and conducted the sessions in an easy way.
- All the trainees stated that the acquired skills were adequate for their assigned SBA services/activities at the community levels. Majority acquired skills such as performing normal deliveries, identifying high risk pregnancies, performing ANC, PNC, new born care, physical examinations, measurement of BP, manage and refer PPH, resuscitate newborns and timely referrals of complicated cases.
- They felt that they now have the tools to make the life of the mother and the newborn safer than what they were able to do before. They were excited about being able to use oxytocin, to deliver placenta, and clamps, to separate the baby from the mother.
- They now had the confidence to deal with high risk and complicated cases, provide first aid treatment, counselling and timely and proper referral.
- Regarding the duration of training, only 28% of the trainees agreed with 6 months being adequate. 72% was in favour of increasing the duration of training. 76% of this group suggested that the training should be of 12 months duration instead of 6 months. They found the contents to be too intensive to learn within 6 months. It was difficult for them to fulfil the performance targets of clinical practice in 3 months.
24 district trainers and 14 administrators were also interviewed for general comments on the training programme. All of the district trainers were satisfied with the training programme. However, they made additional suggestions to ensure supply of training materials at the beginning of the training, to arrange structured video sessions as indicated in the curriculum, and to increase the duration of the training if possible.

The administrators were mostly satisfied with the implementation of the programme. However, they suggested more coordination between the directorates, national and district level authorities. Supervisory roles of the supervisors at all levels need to be better defined and prioritised. Timely release of funds, availability of required logistics, delivery kits and medical supplies were some of their main concerns.

**Evaluation of After Training Performances**

After completion of the SBA Training, 90 trainees returned to their respective places of posting and were assigned to provide ANC, home deliveries, PNC, newborn care and referral services, in addition to their regular assignments under their job description. Their regular job descriptions include services like EPI, ARI, Family Planning.

As a part of the evaluation study, the after training performances were evaluated by READ, a reputed independent organization. The evaluation was conducted in the 6th month after the training. The retention of knowledge, skills, quality of relevant services offered, level of client satisfaction, community support to and community acceptance of the SBA’s services were thoroughly assessed.

Evaluation of the After Training Performances of the SBAs, conducted on trainees from all 6 centres, was done to assess the following:

- Retention of knowledge and skills by the SBAs 6 months after the training;
- SBAs performances on ANC, conduction of Deliveries, PNC and Referral
- Beneficiaries’ satisfaction with SBA services and market demand for maternal care services; and
- Support and level of acceptance of the community

Study methodologies included qualitative investigations, such as review and analysis of relevant documents and reports, intensive interviews and FGDs. The sampling design for the representative respondents was based on multi stage stratified random sampling method. Under each of the six pilot Upazilas, 2 work areas (Mouzas) served by an equal number
of SBAs (2) were selected at random. List of randomly selected SBAs and their units are in annex-4.

Further quantitative surveys were carried out through one-on-one interviews with representative respondents i.e. currently pregnant women and women who had delivered a child within the last 3 months. The sample of ‘currently pregnant women’ and the ‘women delivered child in last three months’ were identified in the selected Mouzas through a quick house to house census (using a short checklist). 469 currently pregnant women were identified, out of which 366 i.e. 78% were interviewed. Similarly, 355 women who delivered within the last 3 months were identified and 288 i.e. 81% were interviewed.

The focus of the evaluation was on midwifery clinical care (including counselling) and services provided by the SBAs to women during antenatal, delivery and postnatal periods. The performances of the SBAs were evaluated both in terms of coverage of services (number and proportion of targets covered) and quality of services (efficiencies and effectiveness) rendered, and measured in terms of client satisfaction. In addition, the SBAs’ performances were compared with those of five other categories of providers (non-SBA) serving in those selected areas. These other categories were i) Doctors or Medical Officers, Obstetricians/Gynaecologists; ii) Medical assistants or SACMO, iii) Nurses, FWVs; iv) FWA, FHA/HA, TTBA, NGO worker, CNP; v) TBA, Neighbours/Relatives. The key findings of this study were also compared with those in the SBA NAS 2002. Furthermore, level of community support and acceptance of the SBAs and their services was assessed in order to determine the demand for the SBAs’ services in the community and sustainability of the programme.

The findings of the evaluation are presented in the following sections:

**Knowledge retained by the trainees**

The SBA’s level of knowledge retention was assessed by asking 86 SBAs to mention 10 major topics/lessons included in the Trainee’s manual/curriculum.

The level of retention of knowledge was evaluated through the following categories:

1) **Correct**: If the SBA could mention ten topics correctly as stated in curriculum or training
manuals i.e. ANC, PNC, Newborn care, Communication and Counselling etc. They were graded as being “Correct”.

2) Partially correct: If SBA mentioned a part of the 10 topics but could recollect fully on assistance from the interviewers.

3) Incorrect: If they could not mention 10 topics or mentioned any topic not included in the curriculum or manuals, they were graded as being “Incorrect”.

55% of the set of 86 SBAs interviewed could correctly mention the topics included in the curriculum, about one third of them (31%) responded partially correct and about one sixth (14%) were wrong (Figure 11).

Skills retained by the trainees

The trainees’ retention of skills was evaluated by directly observing their performance on 10 selected skills out of the 74 included in the curriculum (Figure 12). Trained nurses/ FWVs (n=3), who were familiar with the SBA programme, directly observed performance of the 12 SBAs as they applied those skills either on a patient, model or dummy.

Core skills related to ANC, making deliveries, PNC and newborn care were chosen for the assessment. These were

i. BP Measurement
ii. Measurement of Height & Weight,
iii. Antenatal Physical examination
iv. Counting Foetal heart rate
v. Washing Hands,
vi. Wearing gloves,
vii. Conduct delivery (2nd and 3rd stage)
viii. Use of partograph
ix. Postnatal Counselling
x. Care of Newborn and
xi. Newborn Resuscitation

To assess the skills for assisting deliveries, it was originally decided to observe 12 SBAs on
Skilled Birth Attendance: Review of Evidences in Bangladesh

site (4 cases per SBA). However, due to time and geographical constraints, the target could not be met. Eight SBAs were observed during conducting a total of 22 deliveries. The SBA’s performance on a skill was weighted according to the importance of the components used in the checklist17.

**Antenatal Skills**

Required during antenatal examination, 75% recorded the height and weight, 81% recorded the Blood pressure, 70% were able to auscultate sound of the foetal heart, 70% correlated the height of the uterus with the EDD, only 60% told the mother about the examination findings and none washed their hands after antenatal examination.

**Performing Deliveries**

Over 85% of the SBAs performed as per the standard checklist. 94% washed their hands and 93% wore gloves. However, none of the participants documented their activities and their skills in preventing infection were lacking. In some centres, it was found that the delivery kits did not contain BP instrument, clamps and measuring tape. Nevertheless, general level of skills retention for conducting a normal delivery (2nd and 3rd stage) was satisfactory.

Overall, the level of skills retention by the SBAs was quite satisfactory. Scores ranged from 68% to 94% across various skills. 92% of those evaluated were correct in calculating the EDD from the stated LMP (First day of Last Menstruation).

**Filling in Partograph**

The twelve already selected and 12 more SBAs (total 24) were assessed on their ability to fill up a partographc from a given case scenario, to interpret the data and to make decisions based on the interpretation.

The ability to fill-up a new partograph and interpretation of the data was excellent. The average score was over 80%. The decision-making ability, based on the data interpretation, was also very good in all SBAs assessed.

Some minor deficiencies were observed in only one out of the 24 SBAs. This person was not able to take a decision regarding referral of a case with prolonged labour and foetal distress. Also most of the SBAs were not utilizing the partograph tool and mentioned the lack of supply of partographs from the authorities as the major constraint.

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17 Modified WHO Partograph


**Newborn Care**

- 78% of the trainees could provide newborn care properly
- Only 68% could correctly demonstrate the resuscitation steps of a newborn.
- 79% could perform postnatal counselling.

It became obvious from the current evaluation study that the majority of the trainees retained important midwifery skills learned during the training. Still a significant number of SBAs needed refresher training for update and improvement of skills. Also, issues related to delays in supplies should be addressed.

**SBA’s Performances: Self-assessment and Beneficiaries’ assessment**

Performance assessment was based on the self-statement of SBAs (n=86) and by interviewing the beneficiaries of services from 12 SBAs. The beneficiaries were the currently pregnant (n=366) and women who delivered within the last 3 months (n=288).

**Self-Assessment**

58% of the SBAs stated that they were facing some form of problem(s) in discharging their services. 12 out of 14 SBAs interviewed in Joypurhat and 11 of 13 interviewed in Hobiganj stated that they faced problems when providing SBA services in the community. Table 5 illustrates a comparative analysis of the SBAs’ performance on ANC, Delivery and PNC.

**Table 5: Comparison of SBAs having problems vs. those who did not in discharging services**

<table>
<thead>
<tr>
<th>Districts</th>
<th>No. of SBAs facing No problem</th>
<th>No. of SBAs facing Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangail</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Barisal</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Comilla</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Jessore</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Joypurhat</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Hobiganj</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37 (42%)</strong></td>
<td><strong>49 (58%)</strong></td>
</tr>
</tbody>
</table>
The following were some of the reasons for the SBAs problems:

- There was interference in their work due to programmes such as EPI and other national programmes
- Sometimes, more than one delivery occurred at the same time, creating bottlenecks
- Emergency calls for performing deliveries, particularly at night, often became difficult to attend because of family and community restrictions.
- The additional assignment became too stressful, affecting the SBAs’ health

**Self-assessment benchmarks by SBAs**

- The average number of ANC performed per month by the SBAs, irrespective of problems they might have faced, was 9-10 women. However, the care provided by SBAs superseded in quality to all other types of attendants except that provided by doctors/ medical assistants/ nurses.

- SBAs who did not face problems, performed double the monthly average number of deliveries conducted by SBAs facing problems. 35% of the SBAs facing no problems could perform, on average, 4 or more deliveries per month, while only 12% of SBAs facing problems performed 4 or more per month.

- SBAs with problems performed an average of 3 and the group without problems performed an average of 5 PNC. Though the number is low in absolute numbers, the service was significant for the communities being served.

<table>
<thead>
<tr>
<th>Districts</th>
<th>No. of SBAs facing No problem</th>
<th>No. of SBAs facing Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangail</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Barisal</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Comilla</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Jessore</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Joypurhat</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Hobiganj</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>10</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Table 6. Average ANCs performed per SBA per month in-groups having ‘no problem’ (n=37) compared to those having ‘problems’ (n=49).
Beneficiaries’ Assessment of SBA Performance

Currently pregnant women (n=366) and women who delivered within the last 3 months (n=288) were interviewed regarding 1) the number of care/services they received during antenatal, delivery and postnatal period and 2) who their providers were. The performances of SBAs were assessed based on the beneficiaries’ statements.

Within a short period of time, the newly placed SBAs provided a major share of the total maternal and child health care services to the clients in their working areas. The contribution of the newly placed SBAs in various areas of maternal and newborn care in the community are reflected in the following statements from the beneficiaries:
ANC

According to the clients’ responses, currently pregnant women received ANC 154 times and women who had already delivered received ANC 148 times, for a total of 302 ANC services (Table 9) from SBAs. In the survey area, an average of 25 ANCs were performed per SBA.

Table 9: Average number of ANC by SBAs, as stated by Currently pregnant women (n=366) and Women who had delivered within the last 3 months (n=288)

<table>
<thead>
<tr>
<th>Districts</th>
<th>No. of SBAs</th>
<th>Pregnant women</th>
<th>Women delivered</th>
<th>Combined (n=654)</th>
<th>Average ANCs per SBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangail</td>
<td>2</td>
<td>15</td>
<td>18</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>Comilla</td>
<td>2</td>
<td>40</td>
<td>33</td>
<td>73</td>
<td>36</td>
</tr>
<tr>
<td>Joypurhat</td>
<td>2</td>
<td>19</td>
<td>18</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>Jessore</td>
<td>2</td>
<td>5</td>
<td>15</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Barisal</td>
<td>2</td>
<td>26</td>
<td>20</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td>Hobiganj</td>
<td>2</td>
<td>49</td>
<td>44</td>
<td>93</td>
<td>46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>154</strong></td>
<td><strong>148</strong></td>
<td><strong>302</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

In the survey area, a total of 580 ANCs were provided to both groups of women. Out of the total, 52% was performed by the SBAs. Within the breakdown at the next level, 55% of the ANC offered to currently pregnant women was performed by SBAs whereas they provided ANC services to only 49% of the women who had already delivered.

Table 10: Performances in ANC by various service providers to the currently pregnant women (n=366), women delivered in last 3 months (n=288) as reported by the beneficiaries.

<table>
<thead>
<tr>
<th>Categories of service providers</th>
<th>Currently pregnant women</th>
<th>Women delivered within last 3 months</th>
<th>Combined pregnant &amp; women delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Center</td>
<td>Home</td>
<td>Total</td>
</tr>
<tr>
<td>SBA</td>
<td>49</td>
<td>105</td>
<td>154</td>
</tr>
<tr>
<td>Doctors</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>MA/Nurse/FWV</td>
<td>34</td>
<td>1</td>
<td>35</td>
</tr>
<tr>
<td>FWA/FHA/TTBA</td>
<td>48</td>
<td>18</td>
<td>66</td>
</tr>
<tr>
<td>TBA/relatives</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>153</strong></td>
<td><strong>128</strong></td>
<td><strong>281</strong></td>
</tr>
</tbody>
</table>
A large number of ANC services rendered to the women who had delivered within the last 3 months (i.e. became pregnant 12 months before) could have been performed by other service providers before SBAs were in place. Some of the ANCs (in 24 cases) performed by SBAs have overlapped with those performed by non-SBA FWAs/ FHAs.

Out of a total of 580 ANC services, 252 ANCs were offered at home to the two groups of women combined. SBAs performed 80% of total domiciliary ANC services, making them the single highest provider of ANC services at the client’s home (figure 13).

Deliveries

The women who had delivered within the last 3 months (n=288) were asked about their providers. According to their statements:

TBAs/ neighbours/ relatives performed 47% of the deliveries while SBAs performed about a third (29%).

SBAs performed 33% of home deliveries (n =255) whereas majority (67%) were conducted by unskilled attendants i.e. FWA/ FHA / TBA /or relatives (Figure 14).

Doctors, medical assistants, nurses and FWVs performed 11% of the total deliveries but almost none at home (only one home delivery).

Findings of this survey suggested that SBAs performed 3 deliveries per month on average, which also matches the number stated by the SBAs in their self-assessment (range 2-4).

The coverage of 33% of the home deliveries by SBAs in the intervention area reflected a significant success of the programme.
Skilled Birth Attendance: Review of Evidences in Bangladesh

PNC
Note: In response to queries regarding PNC and its providers, women who had delivered within the last 3 months (n=275) stated that, they received a total of 76 postnatal services within 6 hours of delivery and another 69 within 6 weeks of delivery, for a total of 145 PNC from SBAs (Table 11).

Table 11: Performances on PNC by various providers as specified by women delivered in last three months (n=288)

<table>
<thead>
<tr>
<th>Categories of service providers</th>
<th>Number of PNCs received within 6 hours of Delivery</th>
<th>Number of PNCs received within 6 weeks of delivery</th>
<th>Total number of PNCs received by delivered women</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBA</td>
<td>6 70 76</td>
<td>3 66 69</td>
<td>145 44</td>
</tr>
<tr>
<td>Doctors/Mos</td>
<td>16 2 18</td>
<td>16 7 23</td>
<td>41 13</td>
</tr>
<tr>
<td>MA/Nurse/FWV</td>
<td>15 2 17</td>
<td>11 1 12</td>
<td>29 9</td>
</tr>
<tr>
<td>FWA/HA/TTBA</td>
<td>1 24 25</td>
<td>5 19 24</td>
<td>49 15</td>
</tr>
<tr>
<td>TBA/Neighbors/Relatives</td>
<td>0 38 38</td>
<td>0 24 24</td>
<td>62 19</td>
</tr>
<tr>
<td>Total</td>
<td>38 136 174</td>
<td>35 117 152</td>
<td>326 100%</td>
</tr>
</tbody>
</table>

Of the total PNCs, 44% were performed by the SBAs; 13% by Doctors, 9% by the nurses and 15% by the FWAs/ HAs/ TTBAs. The rest were performed by untrained people i.e. TBAs/neighbors/relatives (table 11).

Referrals
To assess the contribution of the SBAs in the referral services in their respective working areas, 86 trainees and the beneficiaries (currently pregnant and women who had delivered in last 3 months) were interviewed during the survey period.

According to the statements of trainees (n=86), SBAs had made 824 referrals. Monthly referrals for complications related to antenatal issues were 70, for complications/ problems faced during conducting delivery was 33, complications arising during delivery was 27 and complications during the postnatal period was 8. The average number of monthly referrals made by 86 SBAs was 137, which is very significant.
According to the beneficiaries, 42 cases were referred out of which 22 (55%) was done by the SBAs (Figure. 15).

The referrals by SBAs were deemed to be of higher quality and the urgency in proportion to the importance of identified indications such as prolonged/obstructed labour, malpresentations, ruptured uterus, high blood pressure, twin pregnancy, eclampsia, post caesarean pregnancy and retained placenta.

### Maternal and Neonatal Deaths as stated by SBAs and Beneficiaries

In the survey area, 12 SBAs and 25 other providers were interviewed on issues related to maternal and neonatal deaths. All the 37 respondents reported that even though there had been 11 neonatal deaths, they were not aware of any maternal deaths in their areas within the last six months.

The respondents stated multiple causes for neonatal deaths. From all those statements, 24 reasons were listed as the most recurring causes of the deaths within the study area. Obstructed labour or prolonged labour
ranked highest, followed by premature rupture of membranes and malpresentation (Figure 16). Some of the other causes were deaths jaundice, premature delivery, pneumonia and tetanus.

**Figure 16**
Causes of Neonatal Deaths (Frequencies)

**Comparative Study**

Women delivered within last 3 months (n=288) were asked whether they faced problem or complications during their ANC, delivery and PNC, irrespective of provider. 15% of 275 women reported some form of complications or problems The complications mentioned by the respondents were high BP, swelling of the legs, short stature of the mothers, premature rupture of the membrane, convulsion, weak foetal movement, bleeding during pregnancies and anaemia.

The women were cross-categorized in terms of type of providers and type of complication suffered (Table 12). Results show that women served by TBAs/Neighbours (34%) experienced highest number of problems/complications. Only 14% of the women served by the SBAs experienced complications.

Table 12: Distribution of women delivered in last 3 months (n=275) who experienced problems/complications during last pregnancy or delivery by categories of service providers.

<table>
<thead>
<tr>
<th>Category of Service provider</th>
<th>Women served</th>
<th>Women experienced problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>SBA</td>
<td>140</td>
<td>19</td>
</tr>
<tr>
<td>Doctor/medical Officer</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>MA/SACMO/Nurse/ FWVs</td>
<td>37</td>
<td>5</td>
</tr>
<tr>
<td>FWA/HA/ TTBA</td>
<td>59</td>
<td>7</td>
</tr>
<tr>
<td>TBA/Neighbours</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>41</td>
</tr>
</tbody>
</table>
**Performance benchmark: SBA Area vs. non-SBA Area**

The assessment also included non-SBA areas (Bogra, Sunamgonj and Jessore districts) served by untrained FWAs and FHAs, in order to compare their performances on ANC, Deliveries, PNC and Referral services with the SBA served areas. Samples covered 100 currently pregnant women and 100 women who had delivered within the last 3 months. High-level results are presented in (Table-13)

In Non SBA areas 61 percent deliveries are performed by TBAs and 39 percent by Doctors, Nurses, FWVS and TTBAs). The untrained FWA/FHAs in those areas conducted no deliveries. On the contrary, in the SBA areas, the trained FWA/ FHAs performed about 29% of the total deliveries, the TBAs covered 47% and others (Doctors, Nurses, FWVS and TTBAs) covered the remaining 24%. Therefore, a shift of caseload from the TBAs to SBAs is the desired and important impact on MNH services (Figure 17).

**Beneficiaries’ Satisfaction on SBA services**

Women who had delivered in the last 3 months (n=288) were interviewed to assess their level of satisfaction (well satisfied, fairly satisfied or unsatisfied) with the services provided by SBAs (n=12) and other providers. They were also asked about their desire to receive services from SBAs over the other providers, to assess the level of acceptance and effectiveness of SBA services in the community.

**Satisfaction Benchmark**

Overwhelming majority of the beneficiaries expressed full satisfaction of the services delivered by the SBAs (84% of women had received ANC, 92% had deliveries by SBAs and 90% received PNC). 10 to 16% expressed some level of dissatisfaction with the SBA services (Table 14).
Figure 21 shows a comparison between levels of beneficiaries’ satisfaction with the services rendered by SBAs and other providers, on completion of PNC and newborn care received. Among all the providers, SBAs have achieved greater degree of client satisfaction compared to all other providers.

51% of the clients served by SBAs were well satisfied and 61% were satisfied and none was unsatisfied. On the contrary, the TBAs/neighbours/relatives have been identified as the group achieving greater degree of dissatisfaction (‘unsatisfied’ - 50%).

### Future demand of SBA Services

Women who had delivered within the last 3 months were asked about their choice of service provider during their next delivery. Among the respondents, 45% of the respondents either said they did not plan to have any more children or were unsure if they would have more children. About half of the respondents (49%) desired a child and wanted help from a service provider during the delivery. Of this group, 60% expressed a preference for SBAs’ services, followed by a preference for the services of TBAs/Neighbours/quacks/relatives (18%). Another 13% preferred the services of FWAs.
Table 15: Percent distribution of women delivered child in last 3 months by choice of providers for future delivery (n=141)

<table>
<thead>
<tr>
<th>Categories of Service providers</th>
<th>Tangail</th>
<th>Comilla</th>
<th>Joypurhat</th>
<th>Jessore</th>
<th>Barisal</th>
<th>Hobigonj</th>
<th>Total 6 districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBA</td>
<td>32</td>
<td>60</td>
<td>65</td>
<td>14</td>
<td>88</td>
<td>78</td>
<td>60</td>
</tr>
<tr>
<td>Doctors</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>FWA</td>
<td>8</td>
<td>26</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>TTBA</td>
<td>16</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>TBA/relatives</td>
<td>36</td>
<td>12</td>
<td>23</td>
<td>57</td>
<td>0</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Of those who preferred the services of SBAs in future for delivery of their child, 88% of the respondents were from Barisal, followed by 78% from Hobigonj, 65% from Joypurhat, and 60% from Comilla. It is interesting to note that the two leading preferences are for SBAs and TBAs, and there is a negative correlation between the two. At the two of the pilot centres, Jessore and Tangail, respectively 57% and 36% of the respondents preferred TBAs to SBAs. Only in Barisal, none preferred the services of TBAs.

Community Support and Level of acceptance

The community support and their acceptance of the SBA services were assessed through FGDs and interviews. Twenty-four FGDs were conducted with groups of 7 to 10 male or female community members. Participants included businessmen, students, teachers, NGO/health workers, farmers, service holders, UP chairmen /members, village doctors and religious leaders of age ranging from 30 to 45 years for the male and from 20 to 35 for the female groups. Community perception regarding maternal health problems and SBA’s services were assessed through these FGDs.

86 SBAs and district level administrators were also interviewed for their perceptions on the training programme. The findings are detailed in the following sections:

- Community perceptions regarding maternal health and SBA services: FGDs conducted with the male and female community leaders.
- Perception of the project personnel: FGDs with the project personnel, national trainers, Consultants and QA team members.
- Self-assessment as provider: Interviews with SBAs
Community perceptions
A number of FGDs was conducted to understand the perceptions of the community regarding maternal health and the SBA programme.

Maternal Health
- The most common maternal health problems mentioned were pre-eclampsia/eclampsia, malnutrition and anemia.
- The female groups also mentioned malpresentation, bleeding during pregnancy/delivery, retained placenta, excessive nausea/vomiting and loss of appetite.
- Some groups mentioned early marriage resulting in teen pregnancies.
- The participants of Tangail and Comilla mentioned poor communication system and scarcity of health centers.
- Both the male group in Comilla, one male group in Habiganj and one female group in Tangail identified lack of skilled providers as a problem.
- The female group in Habiganj cited violence against women as a problem.
- Other important factors identified were poverty and ignorance.

SBA Programme
- All of the FGDs reflected a positive impression on the importance of good quality services provided by SBAs.
- In five districts, FGDs recognized that the residing presence of SBAs in the community as a very important prerequisite for SBA services. Similarly, in Barisal, residing outside the community was identified as an obstacle for provision of regular services by SBAs. Some SBA’s cannot attend to deliveries on time or for emergency situations as they live at a distance.
- There was recognition of the benefits to maternal and newborn health through the SBA services.
- FGDs felt that SBAs still needed to work on raising awareness about their services.
- Some of the SBAs were found to be less motivated, perhaps because they think this job is an additional burden without any remuneration.
Skilled Birth Attendance: Review of Evidences in Bangladesh

**Project Personnel Perception**

A FGD was held at the OGSB office, where the participants (n=12) were project personnel/ experts, national consultants, WHO and UNFPA professionals, members of QA team and National Trainers.

The discussion produced the following conclusions:

- Most of the participants expressed satisfaction on effective implementation of the training programme.
- Most participants reported evidence of support from the national, district, upazila and community levels.
- Everybody mentioned the necessity of being more involved in a supervisory role, particularly during community clinical practice and after training.
- According to few participants, SBAs could not attend some of the deliveries because the TBAs were already involved.
- In some cases, SBAs are still perceived to be necessary to manage complications only.
- All agreed that ANC, PNC coverage and referrals had increased due to SBA's services.
- Programme managers blamed shifting priorities to Family planning and EPI for declining performance of SBAs in some areas.
- There is no accountability or incentives to perform well as SBA. Even though there is a satisfactory programme management, the supervisory support is poor and should be addressed.
- Further community support and awareness should be built through more active participation by the community leaders.

**Provider's Perception**

12 SBAs were surveyed and asked whether they had overall satisfaction and their reasons for satisfaction or dissatisfaction, if any. They were asked about the problems that they were facing in providing SBA services. They were also asked about incentives they received from the beneficiaries, which might have affected the response of the community to SBA services.

- 50% of the SBAs faced problems in the community. 44% of the time, the problems faced was created by the community leaders.
- One out of 12 SBAs faced problems from her husband and 2 SBAs faced problems from other members of the family. They were reported to prevent SBAs from working at the night.
- TBAs were allegedly spreading negative rumours about the competency of the SBAs. Community leaders rumoured that SBA will charge more and take the clients to the hospital.
They also stated that in some cases, the referred cases were not treated at Govt. Hospitals (UHC or District Hospital), rather those were further referred to private clinics to treat as private patients. The private clinics were expensive; so many women can not afford the charges. When those women went back to villages, the faith on SBA was decreased and the SBAs lost credibility.

When the SBAs were asked to suggest some solution to those problems, they proposed launches of intensive community based health education programmes, particularly targeting the expectant families (mothers/pregnant women/husbands/in-laws); getting community leaders, formal or informal including quacks/village doctors/ TBAs, to promote the images of the SBAs and their services; and getting better support from the relevant authorities.

Satisfaction with own services
Level and reason of provider’s satisfaction with SBA services was evaluated through interviews with the 86 SBAs. 92% of SBAs stated to be satisfied while only 7 SBAs mentioned their dissatisfaction.

The reason for satisfaction in 47% of the satisfied SBAs was the birth of a living child to a mother they had served. 57% of the SBAs were satisfied because they had achieved a positive outcome from their services, 37% for the acquired technical skills, 42% for priority community service and 3% for new incentives (i.e. gifts/ remuneration from patients). Less cited reasons were their heightened prestige in the community.

As reasons for dissatisfaction, the 71% of SBAs stated the absence of incentives for the additional work beside routine job, obstruction by TBAs and quacks in rendering services smoothly (14%) and community inhibitions/ restrictions to work and movement at night (28%).
The SBAs were also asked for their opinions on where they felt more support is needed to improve their performances/services in the community.

92% of the SBAs suggested to increase logistic support like supply of delivery kit, drugs, and provision of refresher training. 71% of SBAs claimed incentives (monetary) for referral, additional work, 71% asked for community support through community leaders support, rural organizational support, and launching publicity/advocacy activities.

Only 30% thought that they should be supplied with a mobile phone for client contact; and reimbursement for transport cost for travel between distant places.

**SBA’s Satisfaction with Support**

The SBAs frequently expressed their dissatisfaction with lack of follow-up support or supervisory support; the SBAs felt that they were not accountable for their performances.

The upazila level supervisors (UHFPO/UFPO/MO-MCH) seldom went to the field to supervise and monitor the programme. According to the SBAs, the supervisors never asked for any report on the performance of their activities on ANC, delivery or PNC. Some of the SBAs thought that the new services were an additional burden to the system, which is why the authorities did not give proper importance to the programme. This was a strong source of discouragement for the SBAs to perform on their SBA responsibilities. It also weakened the SBAs’ faith in the sustainability of the programme.

Lack of a register for record-keeping at GOB level was also a concern.

**Incentives from the beneficiaries**

Spontaneous offers of incentives by the clients reflect a positive attitude of the community towards SBA services. 43 or 50% of the SBAs claimed that they did not receive any incentive for their services, while the other half claimed that they had received incentives of different kinds (table 16). The beneficiaries voluntarily offered all incentives.
All 15 SBAs in Tangail district received some form of incentives. Of them, 45% received cash and gifts of monetary value, and the remaining 55% received only in kind gifts.

14 SBAs received incentives for ANC services: 3 (21%) received in cash and gift, 11 (79%) received only in kind (gift and entertainment).

All of 43 SBAs received incentives for delivery services out of which, 27 SBAs (63%) received cash and gift, 16 (37%) received in kind (gift and entertainment).

12 received incentives against PNC services, of whom 12 (100%) received only in kind (gift and entertainment).

Table 16: Distribution of SBAs who received incentives

<table>
<thead>
<tr>
<th>Types of incentives received</th>
<th>For Antenatal care Services</th>
<th>For Delivery services</th>
<th>For postnatal care services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Money and gift</td>
<td>3</td>
<td>21</td>
<td>27</td>
<td>63</td>
</tr>
<tr>
<td>Gift and entertainment</td>
<td>11</td>
<td>79</td>
<td>16</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100</td>
<td>43</td>
<td>100</td>
</tr>
</tbody>
</table>
Evaluation of the Curriculum, Training Manuals

The curriculum, trainers and trainee’s manuals were assessed and compared with International Confederation of Midwife (ICM) standards for midwifery practice and competencies. The curriculum was also compared with the midwife training for community midwives in Indonesia and the community midwives training for FWVs in Bangladesh. This was done by experts from WHO Bangladesh.

During this evaluation study, the trainer’s and trainee’s manuals, including assessment tools i.e. checklists, were assessed by a team of experts from READ. WHO-Head quarter, WHO SEARO experts including Regional Advisor Nursing (RA-NUR) and Reproductive Health (RH) - Advisor, UNFPA-CST (Nepal) reviewed the curriculum and the training manuals.

Curriculum

According to the experts, the essential contents for community midwife training were included in the SBA curriculum/manuals. The objective of the training was to enable the trainees to conduct normal delivery and recognition and referral of the complicated cases. The curriculum emphasized on early recognition and first line management of cases with emergency or life threatening situation, referral and to exclude management of abnormal delivery and obstetric complications. Considering the level of the trainees and the intended nature of the job after the training, “nice to know” contents such as episiotomy, surgical hand wash and high level disinfection were either omitted or reduced. Since the level of participants and the duration of the course are at a level of auxiliary midwife or community midwife, the experts recommended to define the term “SBA” in the perspective of Bangladesh.

The process of development and approval of the curriculum involved intensive desk review by a group of experts followed by refinement through two national level workshops participated by experts and stakeholders. During orientation of national trainers and training of trainers, further improvement was done. Especially the learning process, training methods, materials and evaluation tools were updated. Later, the National Curriculum Committee approved those in the use of SBA training.

The curriculum and manuals were found to be adequate in most of the areas of knowledge and skills, however some areas were identified for further modification or improvement. The areas of knowledge and skills included in the SBA curriculum were found comparable to the Indonesian Community Midwife’s curriculum (Bidan di Desa) and Bangladesh Community Midwife Training Curriculum for Family Welfare Visitors (annex-5).
The content of the SBA curriculum was compared with the recommended *International Confederation of Midwives (ICM) recommended* six competencies for practicing midwifery.

The course was found to be adequate to provide enough scope for the trainees to be proficient in 12 areas of maternal and newborn care, with the ability to use 74 identified skills\(^\text{17}\), which were adapted from a list of minimum skills required off skilled attendants\(^\text{18}\) (SMIAG 2000b) within the context of Bangladesh. Some of the care areas are ANC, delivery care & partograph, PNC, breast-feeding, newborn care and family planning methods.

**Trainee’s Manual**

The manual was written in simple native language (Bangla) and illustrated. The contents are organised in lessons with set lesson objectives. The experts reviewed thoroughly and suggested to organize the lessons in three courses. The course objectives were also set as learning objectives.

The SBA curriculum and manuals contain most of the broad areas of basic and additional knowledge, clinical skills and attitudes essential for midwifery practice mentioned under ICM’s six competencies for practicing midwifery. Some of the public health and life saving skills (table-17) stated in the ICM statements were not included in the SBA curriculum. However, most of those life saving skills were not included on recommendation from experts considering 1) the short duration of the training and 2) the educational level of the trainees. Besides, some of the public health components are already part of their (FWA & FHA) job.

However, for obstetric complications the manuals enabled the trainees to identify complications such as, initiate primary management and to make referrals. Some of the top obstetric complications are prolonged/obstructed labour, malpresentation, post-partum haemorrhage, puerperal sepsis and abortion.

**Trainer’s Manual**

The Trainer’s manual was found to be teacher centred, and upon assessment, the experts recommended that the manual be reorganized to being learner-centred and to change the objectives to ‘learning objectives’.

For each learning objective, the trainer should evaluate whether trainees have achieved the specific objective before moving onto the next.

Since the format used in trainer’s manual did not fit standards, a format was suggested to fulfil the trainer’s need (Table-19)
They emphasized communication skills, community skills (skills for working with community and to mobilize community actions for MNH), newborn care and use of partograph. Checklists used in the training are task-oriented. The scripts for role-play and case study were found useful in learning process.

Some audit tools of the midwifery standards may be modified for assessing trainee’s competencies.

<table>
<thead>
<tr>
<th>#</th>
<th>Description: ICM Recommended Competencies*</th>
<th>Recommended ICM Basic Knowledge/ Skills, not included in SBA curriculum</th>
<th>Revisions in SBA Curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have requisite knowledge &amp; skills from the social science, public health &amp; ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, &amp; childbearing families.</td>
<td>Local custom, traditional beneficial &amp; harmful practices, advocacy &amp; empowerment strategies for women Understanding human rights, cultural norms &amp; practices surrounding sexuality, sexual practices &amp; child bearing, Health education for STDs/HIV/AIDS &amp; child survival, Signs &amp; symptoms of common STDs.</td>
<td>Basic knowledge is incorporated</td>
</tr>
<tr>
<td>2.</td>
<td>Provide high quality, culturally sensitive health education &amp; services to all in the community in order to promote healthy family life, planned pregnancies &amp; positive parenting.</td>
<td>Assess maternal nutrition &amp; its relation ship to foetal growth, Pelvic examina-tion for size of uterus &amp; adequacy of bony structures. Perform Life Saving Skills</td>
<td>Not incorporated on the basis of local consensus</td>
</tr>
<tr>
<td>3.</td>
<td>Provide high quality antenatal care to maximize the health during pregnancy &amp; that includes early detection &amp; treatment or referral of selected complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Provide high quality, culturally sensitive care during labour, conduct a clean &amp; safe delivery, &amp; handle selected emergency situations to maximize the health of women &amp; newborns.</td>
<td>Not included : episiotomy healing of lacerations (partial) Inspect cervix for lacerations</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Provide comprehensive, high quality, culturally sensitive postnatal care for women</td>
<td>Identify haematoma &amp; refer for care as appropriate</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.</td>
<td>Care beyond the age of 28 days</td>
<td>Knowledge/skills of newborn care from birth to 28 days</td>
</tr>
</tbody>
</table>

Table-17: Comparison between SBA curriculum and ICM recommended competencies and updates in the revised SBA curriculum
Revision of SBA Training Curriculum, Training Manuals

Table-17 shows the comparative results of the SBA curriculum and the ICM competencies and the updates made based on the consensus through national level workshops attended by stakeholders and experts.

Taking into account the recommendations from the “SBA Training performance evaluation” and experts, the following modifications/updates has been made as a further refinement of the SBA training documents:

- Training curriculum document was prepared to effectively communicate to others what this programme is all about.
- The acronym “Skill Birth Attendant” (SBA) has been defined in Bangladesh context
- Outcomes of the Pilot training in the Introduction section
- Philosophy for Community Midwife training in Bangladesh (beliefs about community midwifery training, e.g. ideal process for development of competencies—repetition of practice, hand on experience, proper guidance, trainee-centred etc)
- All objectives were revised, previously those were trainers oriented, now learner’s orientated
- Newly deigned Curriculum Framework
- Curriculum Structure with List of courses (table-18), description, details of course outlines and study plan (from beginning to the end) including “duration of training, venue of training, training design, criteria and number of trainers and trainees was suggested
- Three theoretical course evaluations were included, rest are same as before.
- Reorganized and updated Course Evaluations, Study Materials and Course Outline that includes Course Title, Course Description, Course Objectives, Course Requirements, Teaching-learning Activities

**Table-18: Course outline with allocated hours for SBA training**

<table>
<thead>
<tr>
<th>Course</th>
<th>Title</th>
<th>Duration (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Theory</td>
</tr>
<tr>
<td>Course-I</td>
<td>General Aspect of Maternal and Neonatal Health Care</td>
<td>21</td>
</tr>
<tr>
<td>Course-II</td>
<td>Obstetrics</td>
<td>34</td>
</tr>
<tr>
<td>Course-III</td>
<td>Newborn Care</td>
<td>11</td>
</tr>
<tr>
<td>Course-IV</td>
<td>Clinical Midwifery Practice</td>
<td>96</td>
</tr>
<tr>
<td>Course-IV</td>
<td>Community Midwifery Practice</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>162</strong></td>
</tr>
</tbody>
</table>
Number of Credits was assigned as hours for classroom teaching, practice in model/dummy or simulation, clinical/field practice for each course.

Emphasis for SBAs work was given on providing antenatal care, managing normal delivery, postnatal and new born care and family planning. For obstetric complications and emergencies, the lessons were modified so that they will be able to detect early and refer; they will only know to carry out first line management in case of obstetric emergencies and immediately refer. And thus the training curriculum has been organized accordingly.

Learning objectives for each session was critically reviewed and prepared which could be now in measurable terms.

More information on interpersonal communication and behaviour change communication has been provided.

New issues like HIV/AIDS, Psychologic impact after major problems in pregnancy, childbirth and postnatal period, code of ethics for midwifery practice, tuberculosis, malaria have been added.

Teacher-centred orientation (trainer’s manual) has been changed to learner-centred, and thus learning objectives are used.

A format used in trainer’s guides for training of Family Welfare Visitor found to be more beneficial than the one currently used for the SBA training. Therefore the format has been modified as follows:

<table>
<thead>
<tr>
<th>Session No.</th>
<th>Learning Objectives</th>
<th>Content</th>
<th>Duration</th>
<th>Training methods</th>
<th>Teaching-learning activities</th>
<th>Training or teaching-aids/materials</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

Table-19: Suggested format for SBA trainees manuals
Chapter 4
SBA Training: Standardisation

In order to protect the public - and the practitioners also - it is important to provide licenses and regulate the SBA themselves, the institutions in which they work and the programme and the establishments used in the training. It is essential to install re-accreditation or re-licensing mechanisms for the SBAs and the supervision models, so that there are continued updates and assessments of performance, while the quality and sustainability of the programme are maintained.

Taking this into consideration, WHO along with OGSB, have developed draft guidelines for Accreditation and Registration for SBA Training. The draft has been reviewed and finalized in a technical meeting with the major stakeholders.

Under the guidelines, the process, prerequisites for certification, registration and accreditation were outlined, which were designed to ensure the quality of the SBA training, the standards and norms applied to the training institutes, trainers, curriculum, protocols, and performance evaluation of trainees. Once the accreditation mechanism is in place, the GOB, NGO and private institutions meeting the accreditation criteria can do this training without help from development partners.

Consultation Workshop

On September 2nd 2003, WHO Bangladesh organized a Consultation Workshop on "Finalization of Guidelines for Accreditation and Registration, Skilled Birth Attendant Training Pilot Programme". The workshop included sessions on presentations and discussion on the Guidelines for Accreditation and Registration followed by the adoption of the Guidelines.

Experts from national/development partners and national level stakeholders participated in the workshop. Both the sessions were presided by Director General of Health Services. Secretary, MOHFW, was present as Chief Guest.

Acting Registrar, BNC, presented a paper on Certification and Registration of SBA Trainees by BNC. The presentation on
Guidelines for Accreditation and Registration, SBA Training Pilot Programme was delivered by Medical Officer (RH), WHO Bangladesh.

The guidelines were discussed in detail and updated with recommendations generated during the workshop. The updated “Guidelines for Accreditation and Registration of SBA Training Programme” was adopted and published by BNC on September 11, 2004. These Guidelines will assist GOB in its efforts of scaling the SBA Training programme into a sustainable project, while ensuring quality in all the components of the training.

**Guidelines for Accreditation and Registration, SBA Training**

**Definition**

Accreditation implies official recognition, general acceptance and assurance of quality of a particular training programme.

The overall objective of accreditation is to ensure quality in each component of the training. More specifically, the objectives are to:

- Ensure acceptable training and service standards at the Training Institutes, both at national and district levels, to implement the SBA competency based training;
- Ensure technical quality of the training process;
- Recognize the qualified SBAs and enhance their professional development.

**Key Components**

The five key components of the SBA Training Programme need to be accredited.

a. Training centres and its physical facilities
b. Trainers and instructors
c. Training curriculum and methodology.
d. The trainees.
e. Performance assessment criteria for skills and competencies

Minimum criteria and standards for each of the components are as follows:
a. Training Centre for SBA Training

- The training institutes must fulfil the minimum criteria.
- The Training centre must have an organizational status with administrative, functional and financial control under a set of regulation/ body.
- The training facilities must have adequate in room(s), training aids etc. and in accordance with the number of trainees.
- There should be sufficient caseload and case mix for adequate clinical exposure/ practice of the trainees in all types of skills required.
- A dormitory arrangement is preferable for intensive skill based training.

b. Trainers for SBA Training

A pool of 15 trainers is needed for each district, where the SBA Training will be conducted. Two third of them will be clinical persons (doctors, nurses, FWVs) and the rest will be health professionals related with programme management and coordination at district level. Only qualified trainers having undergone the prescribed TOT for SBA Training, organized by the competent authority, will be eligible to provide training in the SBA programme.

For supportive supervision during community clinical practice, senior nurse midwives having experience in home deliveries will be responsible for supervision and will stay with the trainees.

c. SBA Training Curriculum & Methodology

The standard National SBA Training Curriculum used for the Pilot and refined after the pilot phase, will be used. It has been approved by the National Curriculum Committee at the MOHFW, based on the recommendation of DGHS, OGSB and BNC. The National SBA curriculum defines the areas and competencies for instruction and the instructional methodology for the general aspect of maternal and neonatal care, obstetrics and newborn care.

d. SBA Trainees

The minimum selection criteria of SBA Trainees were prepared on the recommendations from the SBA NAS and further improved by senior level decision makers’ inputs.

The number of trainees must be according to the caseload in the training centres i.e. 15 trainees when the caseload is approximately 100 facility based deliveries per month.
e. Assessment of Trainees’ Performance

The assessment of the trainees is a continuing in-course assessments, mid-term and end of training evaluation.

1) **The SBA training in-course performance assessment** covers the knowledge and skills assessment, using set questionnaires and checklists. Another tool is the logbook used to record each patient managed by the participants.

2) **Midterm evaluation** is carried out before the participants go to the community for their field practice to assess the adequacy of their knowledge and skills by the national trainers.

3) **End of course evaluation i.e., Final Examination**: BNC conducts the final examination: written test with oral and practical examination by a panel of examiners from BNC, OGSB and district clinical trainers. BNC provides certificates to successful candidates as SBA.

**Role of Bangladesh Nursing Council (BNC): (Accreditation, Certification and Registration)**

The above five components are to be accredited through a formal accreditation process.

**Setting up of the Accreditation Body**:

The Accreditation Body has been formed under the legal and functional framework of the BNC. The function of the accreditation body is to set the criteria, oversee and approve the norms and standards of training centres/institutes, trainers, protocols, training methodology, assessment, evaluation, certification etc.

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**Selection Criteria**

- Age 20 to < 45 years
- Maturity in approach/attitude and comfortable in addressing and working in Reproductive Health.
- Education: minimum SSC
- Service experience > 2 years
- Must be residing in the place of posting
- Willing to stay for 6 months at district for training
- Willing to work as SBA for at least 5 years after the training
- Willing to provide service at any time when ever she is called for

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**Role of BNC**

- Accreditation of training component
- Certification of qualified SBA trainees
- Registration as licensed practitioners for community SBA services
Assessment and accreditation of the Training Centres /Institutes:
Initial assessment and follow up visits are to be done by the members of the Accreditation Body and BNC. Accreditation is given to the Training institutes/ facilities based on the fulfilment of the agreed upon criteria and standards, through an external training site assessment.

Approval of Revised SBA curriculum
The National SBA Curriculum/manuals need to be revised and updated periodically as needed. Initial revision has been done on the basis of recommendations from the performance evaluation of SBA Pilot Training Programme and the external evaluation (WHO/UNFPA experts) of the curriculum. The revised curriculum needs to be approved by the BNC and the National Curriculum Committee.

Adherence to the standard SBA training methodology by trainers.
The methodology for the SBA Training is outlined in the SBA Trainers manual. Trainers are to be selected according to minimum criteria set under the accreditation process.

SBA certification by BNC
Certificate is given to each qualified candidate through a formative assessment during and at the end of the course, which forms the basis of registration by BNC.

Registration by BNC
The FWA and FHAs, who get SBA certification from BNC are eligible for registration. They are registered as SBA by Bangladesh Nursing Council under BNC Ordinance LXI, 1983, to be a licensed practitioner in the community. Renewal of registration will be done every five years based on skills revalidation.
Chapter 5
SBA Training: Scalability

The SBA services are a part of the Essential Package of Services under Health, Nutrition and Population Sector Programme (HNPSP) 2003-06, delivered within the health system at the community levels. There is a large number of eligible FWAs and FHAs working in the GOB health infrastructure who can be utilized in the SBA Training and subsequently provide skilled attendance at the community level. The needs for human resource development mentioned in Bangladesh National Maternal Health strategy (2001) could be met by training these eligible FWAs/ FHAs or similar NGO female health workers.

For sustainable scalability of this programme, capacity of district centres to implement quality SBA training, the capacity of BNC to accredit the district training centres as functional training units and the relevant resources should be ensured.

Presentation on performance evaluation and Scalability

The findings of the Evaluations on the SBA Training Pilot Programme and the After Training Performance, were presented by OGSB in a meeting chaired by the Honorable Minister, MOHFW on the May 11, 2004. The meeting was attended by Director Generals of Health Services, Family Planning, NIPORT and DNS, Depty Register, BNC, OGSB, WHO representative, UNFPA and UNICEF.

In her keynote presentation on “Scaling up of the SBA training and services”, the WHO Representative proposed a phase wise expansion of the programme and an organogram for “Organizational Set Up of National SBA Programme”, indicating the key functions of DG Health Services, DG Family Planning, BNC and OGSB in the SBA Training and Services (annex-6) at each administrative level.

The meeting agreed with the following proposals:

Phase-wise expansion

The proposed phase–wise expansion of SBA training includes:

1. HNPSP Phase: Strengthening training of SBAs and intensifying the monitoring and supervision of after training performances of the SBAs from July 2004 to June 2006 as part of HNPSP implementation;
2. Post HNPSP Phase 1: Continuation of SBA training and services covering additional Upazilas from July 2006 to June 2010; and

3. Post HNPSP Phase 2: continuation of SBA training and services covering entire rural Upazilas from July 2010 to June 2015.

The overall goal of the programme is to achieve a reduction of 50% and 75% in the country’s maternal mortality by 2010 and 2015 respectively.²¹

The proposed objectives are to:
- Organize and strengthen 30 functional district training centres by 2006 and 60 centres by 2010;
- Strengthen and improve the quality of the SBA training programme;
- Organize efficient management of SBA services including supervision, follow-up and reporting of SBA services from national to field level; linkage to referral services;
- Raise the performances of SBAs, particularly on ANC, deliveries, PNC in terms of quality and coverage of services;
- Mobilize community and create an enabling environment to support the SBAs.

Operational Targets for Scalable Model

Calculations in Table 18 were made based on calculations of number of upazilas to be covered per year by the district training centres for SBA training. It is estimated that the SBAs can cover nearly 51% by 2010, 55% of deliveries by 2015.

Table 20: Estimated Coverage of Deliveries by SBAs at the last year of Phase wise Expansion

<table>
<thead>
<tr>
<th>Year</th>
<th>No of upazilas</th>
<th>Estimated Deliveries in covered upazilas</th>
<th>No of districts providing training</th>
<th>Number of SBAs trained</th>
<th>Total delivery conducted by SBAs</th>
<th>Percentage of deliveries by SBAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>cumulative</td>
<td></td>
<td>New</td>
<td>cumulative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>110</td>
<td>558800</td>
<td>30</td>
<td>900</td>
<td>2650</td>
<td>254400</td>
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<tr>
<td>2010</td>
<td>360</td>
<td>1828800</td>
<td>60</td>
<td>1800</td>
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<tr>
<td>2015</td>
<td>464</td>
<td>330000</td>
<td>60</td>
<td>1800</td>
<td>18850</td>
<td>1809600</td>
</tr>
</tbody>
</table>

Expansion Strategies
**GOB’s commitment to Reducing Maternal Mortality**

GoB is committed to successfully scale up the SBA training and services in Bangladesh. MOHFW will consolidate the HNP sector programme with particular focus on services geared to the achievement of the four i-PRSP social development goals and targets that are within the mandate of the MOHFW and which will directly contribute to MDGs. Reduction of maternal mortality is one of the HNP services priorities. They key strategies for reducing maternal mortality are:

- Public information campaign to raise awareness of problems during pregnancy, child birth, postnatal period including newborn.
- Increased skilled birth attendance (% of births attended by skilled personnel)
- Strengthening comprehensive EmOC at UHCs and MCWCs
- Health voucher programme to increase demand for maternal and neonatal health services and to insure against the costs for child birth including services during pregnancy and postnatal period by skilled attendant.
GOB actions for Implementation and scaling up

- A meeting chaired by Hon’ble Minister, MOHFW decided on the phase-wise scaling up of SBA programme and the proposed organogram for the national SBA Programme and implementation of monitoring mechanism.

- A National Steering Committee under the chairmanship of the Hon’ble Minister, MOHFW has been formed to provided policy guidance to this programme.

- Additional Secretary, MOHFW has been designated as the National Focal Point for the SBA Training and Services Programme, to coordinate the activities by Government and development partners.

- Training of FWA/FHAs under SBA Training programme is included in the Annual Operation Plan of the HNPSP 2004-2006. GOB has identified the programme as one of the important components of services for reducing maternal and neonatal mortality. The programme and budgetary provision for this programme has been incorporated in the HNP Sector Investment Plan 2003-2010.

Programme Sustainability and Implications

Demand for skilled care at birth exists in the community. In the pilot areas, majority of the mothers expressed their preference for SBA services to those rendered by TBAs. The challenge is to reduce the gap between preference and actual use of SBA services. Currently, in the Pilot areas, where SBAs are working, SBAs cover about one third (29%) of the targeted mothers for delivery care, while the TBAs cover nearly half of the target.

The proposed scaling up of the training and strengthening of the services of SBAs in the community is certainly a positive step towards promoting and sustaining SBA services.
Chapter 6
Discussion

SBA Training and Services is an innovative approach for improvement in maternal and child mortality in a country like Bangladesh, where the coverage of child birth by skilled attendants is only 13%, including home and institutional deliveries.

The coordinated efforts from national to field level made the piloting successful. The roles and responsibilities at all level were clearly defined. A continuous monitoring of all the processes was established by MOHFW through a well-qualified team comprising of 3 National Consultants (WHO, UNFPA), two medical officers and two nurse midwives, led by a Focal Point (Prof. of Obs-Gyn and President, OGSB). The inputs for improvement in each step were prepared through a consultative procedure by Focal Point, National Consultants and UNFPA-NPPP, WHO-MO-RH and GOB programme managers.

Activities and steps under the framework of the piloting contained the Preparatory Phase, Implementation Phase and an Evaluation Phase. The evaluation of the piloting was integrated as an important component to provide inputs for future expansion.

The Preparatory Phase of the project took a long time, starting with NAS (2001) to implementation of District SBA Training (March 2003). But by August 2002, the framework for piloting, including all the phases under the programme, was agreed upon among MOHFW, OGSB, WHO and UNFPA.

The planning and designing of the piloting was based on the needs of the market and evolved through a systematic NAS within the country. The responses and initiatives from the government were excellent, reflecting their strong commitment toward MDGs 4 & 5. The technical role of OGSB, a professional association, was remarkable.

The implementation of the SBA Training programme was quite satisfactory. Coordinated effort from both the directorates, institutes and organizations under the National SBA Training Coordination Committee was substantial. Level of coordination and commitment was truly reflected in organizing the training that functionalized three facilities (DH, MCWC, FWVTI/NI) under DGHS, DFP, NIPORT, and DNS. National level planning workshop followed by district, upazila level advocacy workshops contributed significantly to upraise the commitments and efforts by all the stakeholders.

**Mile stones**

- Need Assessment study
- MOHFW decision on piloting and approval of SBA Curriculum in 2002
- Piloting of the SBA Training in 6 districts.
- Accreditation, certification and Registration by BNC
- Evaluation of the pilot training and after training performance of SBAs
- MOHFW’s decision on scaling up, formation of National Steering Committee and designation of National Focal point for further actions.
The findings of the evaluations of the training programme and after training performance revealed a promising prospect in moving towards achievement of MDGs. The external evaluation and inputs by the SEARO-WHO experts, improved the curriculum and manuals to an acceptable level. The skills and abilities achieved in the Bangladesh SBA Training fulfilled most of the criteria mentioned under the definition of skilled attendants (ref doc- WHO, ICM, FIGO) with little discrepancies. They were given the abilities to identify and refer the obstetric complications with first line management only. Exclusion of the “skills for management of complications and the additional skills (for skilled attendant)” from the Bangladesh SBA curriculum was based on the national level consensus. However the acronym Skilled Birth Attendant i.e. “SBA” has been chosen on purpose and defined to fit the needs of Bangladesh.

Since it is a competency based clinical training, the caseload and case mix at district facilities was very important to achieve individual (trainee) performance targets. Placement of the trainees for 8 weeks at the community levels, under continuous supervision of trained Nurse-midwife (a project staff), enabled them to work in their locality with confidence. Formative final evaluation/ examination was conducted by BNC for certification and registration i.e. a license from BNC was required for the SBAs to practice midwifery at the community level.

The performance evaluation clearly revealed that the SBAs had been performing their defined functions as skilled attendants such as ANC, conducting home deliveries, PNC, newborn care, referral of obstetric complications with first line management in the community. The knowledge and skills retained reflected in the current assessment was quite encouraging. The changes in their additional responsibility as SBAs were very visible.

The majority of the beneficiaries (84-92%) expressed full satisfaction with the services received from the SBAs, whereas, the TBAs, still the more popular service used for home deliveries, were identified as the group achieving the greatest degree of ‘dissatisfaction’. This reinforces the SBA’s satisfaction with their work because this assignment allowed them to serve their own community and to save lives.

The challenges for improving SBA services are to revise the job description of FWA and FHA, especially FHAs. To uphold the courage and morals of the SBAs, supportive supervision, medical supplies and logistics in the field are essential. The local supervisors, community, or family should also provide support to this new activity. It is necessary to ensure that the SBAs reside in their area of work so that they can make regular house calls; raise awareness about SBA services in the villages, particularly among the mothers, husbands and in-laws and allow the community to recognize the positive impact created by the SBA services. Moreover, continued periodic evaluation and refresher training should be

Visible Changes in SBAs
- SBAs continuing MNH services in community
- Already covered one third of home deliveries in their areas
- SBAs are smart, skilled, as recognized by community
- Admired by community for their clinical services: 50% got some financial appreciation from the beneficiaries
in place as a part of the programme to fill up the deficiencies/ gaps identified through annual skill validation or evaluation. Although the findings from the evaluation are very positive, the concern with the low level of supervision after the training is a threat to its sustainability.

BNC’s adoption of guidelines for accreditation and registration is a milestone towards long-term success. The expansion strategy adopted by the GOB is a great achievement. Now the role of the concerned should be directed towards, i) supervision of SBA services after the training to help make them more accountable, ii) establishing periodic evaluation and revalidation of skills through BNC iii) making functional EmOC facilities available iv) supporting the SBA services with adequate medical supplies and logistics. Furthermore, to raise acceptance of the SBA services, awareness campaigns that every delivery needs skilled attendance, birth planning workshops, establishing community support systems and demand side financing are essential. The success of the SBA programme lies in a coordinated effort from all sectors.

Thus the Bangladesh SBA programme could be a model for other developing countries, where the skilled attendance is still low and human resources for midwifery practice are scarce.
References


2. NIPORT, Bangladesh, ORC Macro, Maryland, Johns Hopkins University, Maryland, ICDDR,B Bangladesh; Bangladesh National Maternal Health Services and Maternal Mortality Survey 2001: Final Report.


6. Programming for Safe Motherhood, Guidelines or Maternal and Neonatal Survival, Health Section, Programme Division, Unicef Head Quarters, 1999


Annex

Annex-1: Skilled attendant: the required skills and abilities

Core skills and abilities

All skilled attendants must have the core midwifery skills. The additional skills required will vary from country to country, and possibly even within a country, to take account of local differences such as urban and rural settings.

All skilled attendants, at all levels of the health system, must have skills and abilities to perform all of the core functions listed below.

- Communicate effectively cross-culturally in order to be able to provide holistic ‘women-centred’ care. To provide such care skilled attendants will need to cultivate effective interpersonal communication skills and an attitude of respect for the woman’s right to be a full partner in the management of her pregnancy, childbirth and the postnatal period.
- In pregnancy care, take a detailed history by asking relevant questions, assess individual needs, give appropriate advice and guidance, calculate the expected date of delivery and perform specific screening tests as required, including voluntary counselling and testing for HIV.
- Assist pregnant women and their families in making a plan for birth (i.e. where the delivery will take place, who will be present and, in case of a complication, how timely referral will be arranged).
- Educate women (and their families and others supporting pregnant women) in self-care during pregnancy, childbirth and the postnatal period.
- Identify illnesses and conditions detrimental to health during pregnancy, perform first-line management (including performance of life-saving procedures when needed) and make arrangements for effective referral.
- Perform vaginal examination, ensuring the woman’s and her/his own safety.
- Identify the onset of labour.
- Monitor maternal and fetal well-being during labour and provide supportive care.
- Record maternal and fetal well-being on a partograph and identify maternal and fetal distress and take appropriate action, including referral where required.
- Identify delayed progress in labour and take appropriate action, including referral where appropriate.
- Manage a normal vaginal delivery.
- Manage the third stage of labour actively.*
- Assess the newborn at birth and give immediate care.
- Identify any life threatening conditions in the newborn and take essential

* Active management of the third stage of labour includes: using oxytocic drugs, clamping and cutting the cord, and applying controlled cord traction.
life-saving measures, including, where necessary, active resuscitation as a component of the management of birth asphyxia, and referral where appropriate.

- Identify haemorrhage and hypertension in labour, provide first-line management (including lifesaving skills in emergency obstetric care where needed) and, if required, make an effective referral.
- Provide postnatal care to women and their newborn infants and post-abortion care where necessary.
- Assist women and their newborns in initiating and establishing exclusive breastfeeding, including educating women and their families and other helpers in maintaining successful breastfeeding.
- Identify illnesses and conditions detrimental to the health of women and/or their newborns in the postnatal period, apply first-line management (including the performance of life-saving procedures when needed) and, if required, make arrangements for effective referral.
- Supervise non-skilled attendants, including TBAs where they exist, in order to ensure that the care they provide during pregnancy, childbirth and early postpartum period is of sound quality and ensure continuous training of non-skilled attendants.
- Provide advice on postpartum family planning and birth spacing.
- Educate women (and their families) on how to prevent sexually transmitted infections including HIV.
- Collect and report relevant data and collaborate in data analysis and case audits.
- Promote an ethos of shared responsibility and partnership with individual women, their family members/supporters and the community for the care of women and newborns throughout pregnancy, childbirth and the postnatal period.

Skilled attendants working at the primary care levels in remote areas with limited access to facilities should also be able to do the following:

- Use vacuum extraction or forceps in vaginal deliveries.
- Perform manual vacuum aspiration for the management of incomplete abortion.
- Where access to safe surgery is not available, perform symphysiotomy for the management of obstructed labour.

Advanced (optional) functions that may also need to be performed by selected skilled attendants working at a referral facility include, but are not limited to, the following:

- Perform Caesareans sections.
- Manage complications during pregnancy and childbirth.
- Administer blood transfusions.

The exact set of additional and advanced skills must be determined and agreed upon nationally, depending on need, country context and policy and regulatory framework. In some cases, where the skilled attendant is the only primary health care worker, additional functions may also include, for example, identification and management of gynaecological problems, management of nutritional problems and initial treatment for injuries.
Annex-2: 74 identified Skills for SBA Training in Bangladesh

- Hand washing
- Gloves wearing
- Decontamination
- Sterilization
- Waste disposal
- Antenatal history taking
- Antenatal physical examination
- Antenatal counseling
- Provide antenatal care
- Identification of high risk pregnancy and referral
- Calculation of expected date of delivery (E.D.D)
- Assessment of foetal heart rate
- Health education and counseling on: danger signs of pregnancy, family planning and nutrition
- Birth planning
- Measurement of pulse
- Measurement of blood pressure
- Measurement of weight
- Measurement of height
- Measurement of Albumin in urine
- Measurement of sugar in urine
- Hemoglobin estimation
- Iron and Folic acid distribution to pregnant
- Breast examination
- Tetanus immunization
- Counseling on Breast milk (antenatal and post-natal)
- Counseling on empowerment of women
- PV examination
- Catheterization
- History taking of a labour patient
- Clinical examination of labour patient
- Supportive care during labor
- Management of 1st stage of labour
- Management of 2nd stage of labour
- Management of 3rd stage of labour
- Partograph plotting
- Cord cutting
- Examination of placenta
- Post natal history taking
• Post natal physical examination
• Post natal counseling
• Management of minor problem during post natal period
• Diagnosis of complication during post partum period, primary management and referral
• Newborn care
• Newborn resuscitation
• Position and attachment for breast feeding
• Management of minor problem during breast feeding
• Counselling for Breast feeding
• IV injection
• IM injection
• IV infusion
• Primary management & referral of APH
• Primary management & referral Pre-eclampsia
• Primary management & referral of Eclampsia
• Injection of MagSO4 for the management of convulsion
• Injection of Diazepam for the management of convulsion
• Give antibiotic for the management of UTI in pregnancy
• Diagnosis, primary management and referral of IUD
• Diagnosis, management of anaemia and referral of severe anaemia
• Diagnosis, primary management and referral of abortion
• Diagnosis, primary management and referral of Foetal distress
• Diagnosis, primary management and referral of Ectopic pregnancy
• Diagnosis, primary management and referral of malpresentation
• Diagnosis, primary management and referral of prolong and obstructed labour
• Diagnosis, primary management and referral of rupture uterus
• Diagnosis of premature Rupture of membrane, primary management and referral
• Diagnosis of PPH, primary management of PPH and referral
• Aortic compression for the management of PPH
• External bimanual compression of uterus for the management of PPH
• Diagnosis of puerperal sepsis, primary management and referral
• Selection of different family planning methods for the clients
• Distribution of oral pill, condom and injectable contraceptives
• Use of different instrument during normal delivery
• Identification and use of drugs during pregnancy and labour
• Record Keeping and reporting
### Annex-3: Minimum Performance Target

#### Minimum Performance Target in Health facilities

<table>
<thead>
<tr>
<th>S#</th>
<th>Activity</th>
<th>Assist/Observe</th>
<th>Perform</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Antenatal Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History taking, examination, management and counseling</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>High risk pregnancy, identification and counselling</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Health education session</td>
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<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Abortion: Diagnosis</td>
<td>3</td>
<td>3</td>
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<td>3</td>
<td>Normal labour</td>
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<tr>
<td></td>
<td>History taking, examination, management and counseling</td>
<td>10</td>
<td>20</td>
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<tr>
<td>4</td>
<td>Prolonged labour/obstructed labour: Diagnosis</td>
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<td>2</td>
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<td>5</td>
<td>Partograph</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>Malpresentation: Diagnosis</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Postpartum Haemorrhage: Diagnosis and Management</td>
<td>2</td>
<td>2</td>
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<td>8</td>
<td>Postnatal Care</td>
<td></td>
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<tr>
<td></td>
<td>History taking, examination, management and counseling</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Breast feeding management and counseling</td>
<td>5</td>
<td>10</td>
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<td>9</td>
<td>Puerperal sepsis: Diagnosis and Management</td>
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<td>2</td>
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<td>10</td>
<td>Neonatal care</td>
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<tr>
<td></td>
<td>Identification and management of minor problem of newborn</td>
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<tr>
<td>11</td>
<td>Selection and counselling for Family Planning method</td>
<td>3</td>
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#### Minimum Performance Target in Community

<table>
<thead>
<tr>
<th>S#</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Registration of Pregnant women</td>
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</tr>
<tr>
<td>2.</td>
<td>Antenatal care</td>
<td>20</td>
</tr>
<tr>
<td>3.</td>
<td>Health Education Session for Birth Planning, Care of Pregnant women, Danger Signs, Nutrition, Breast Feeding</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Normal Delivery</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Post natal care</td>
<td>10</td>
</tr>
<tr>
<td>6.</td>
<td>Newborn Care</td>
<td>10</td>
</tr>
<tr>
<td>7.</td>
<td>Family Planning counseling</td>
<td>10</td>
</tr>
</tbody>
</table>
### Annex-4: List of randomly selected SBAs by District, Designation and Union

<table>
<thead>
<tr>
<th>District</th>
<th>Name</th>
<th>Designation</th>
<th>Union</th>
<th>Mouzas/Ward no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangail</td>
<td>Ms. Shahanaz Akhter</td>
<td>SBA (FWA)</td>
<td>Kalia</td>
<td>Kalia, Ward No. 1</td>
</tr>
<tr>
<td>Tangail</td>
<td>Ms. Sheuli Rani Bonik</td>
<td>SBA (FHA)</td>
<td>Kalia</td>
<td>Borochaona, Kutubpur, Ward No. 2</td>
</tr>
<tr>
<td>Hobigonj</td>
<td>Ms. Johora Akhter</td>
<td>SBA (FWA)</td>
<td>Ahmedabad</td>
<td>Unit- 3/Kha</td>
</tr>
<tr>
<td>Hobigonj</td>
<td>Ms. Roksana Akhter</td>
<td>SBA (FWA)</td>
<td>Gazipur</td>
<td>Unit 2/Ga</td>
</tr>
<tr>
<td>Jessore</td>
<td>Ms. Ayesha Khatun</td>
<td>SBA (FHA)</td>
<td>Gonganandapur</td>
<td>Atulia, Goalhati, Ward no. 1</td>
</tr>
<tr>
<td>Jessore</td>
<td>Ms. Afroza Khatun</td>
<td>SBA (FWA)</td>
<td>Bakra</td>
<td>Bakra, Borokalshi, Ward no. 1</td>
</tr>
<tr>
<td>Joypurhat</td>
<td>Ms. Salma Begum</td>
<td>SBA (FWA)</td>
<td>Gopinathpur</td>
<td>Abadpur, Vanurkandha, Hossain Nagar</td>
</tr>
<tr>
<td>Joypurhat</td>
<td>Ms. Ferdousi Begum</td>
<td>SBA (FHA)</td>
<td>Tilokpur</td>
<td>Nur Nagar, Manikpur, Tilokpur</td>
</tr>
<tr>
<td>Comilla</td>
<td>Ms. Maya Rani Sarker</td>
<td>SBA (FWA)</td>
<td>Eliotgonj (South)</td>
<td>Doulatpur, Mubarakpur, Eliotgonj, Victala, Unit-2/Kha</td>
</tr>
<tr>
<td>Comilla</td>
<td>Ms. Ferdousi Akhter</td>
<td>SBA (FWA)</td>
<td>Mohammadpur (East)</td>
<td>Chapatoli, Maligowan, Khairkola</td>
</tr>
<tr>
<td>Barisal</td>
<td>Ms. Smriti Mistri</td>
<td>SBA (FWA)</td>
<td>Chakhar</td>
<td>Chakhar, Unit- 2/ka</td>
</tr>
<tr>
<td>Barisal</td>
<td>Ms. Firoza Begum</td>
<td>SBA (FWA)</td>
<td>Banaripara</td>
<td>Boro Bhaithshor</td>
</tr>
</tbody>
</table>
Annex-5: Comparison of skills between SBA, Bidan di Desa and FWVs Curriculum

Below is the comparison among, 6 month SBA training in Bangladesh, 12 months Bidan di Desa (Community Midwife) midwifery education in Indonesia, and Bangladesh Community midwife Curriculum for FWVs. The SBA Training curriculum covers 8 major areas of skills for pregnancy, childbirth and neonatal care. The BDD curriculum covers 15 areas of skills in midwifery and child care. Since the trainees of the Bangladesh SBA training are mostly family Planning filed health workers they had already some training on areas numbered as 8-15. Competency in all the skills mentioned under care area has been attained using checklist in Bangladesh SBA Training (competency based training).

(√-mark indicates that the skills and related knowledge is included in the particular curriculum, nm-mark for not included, ? -mark for not known)

<table>
<thead>
<tr>
<th>SI No</th>
<th>Area of Care or Service</th>
<th>Skills</th>
<th>Bangladesh SBA Curriculum (6 months)</th>
<th>Indonesia BDD Curriculum (12 month)</th>
<th>Bangladesh FWV Curriculum (6 month)</th>
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<td>Measure BP, Weight &amp; Height, Assess FHR</td>
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** Analyzed and complied by Dr. S. Hanna MO-RH & Dr. M. Abdul Halim National Consultant WHO, Bangladesh
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<th>Indonesia BDD Curriculum (12 month)</th>
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<td>Measure Wt</td>
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## Skilled Birth Attendance: Review of Evidences in Bangladesh

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<th>SI No</th>
<th>Area of Care or Service</th>
<th>Skills</th>
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<th>Indonesia BDD Curriculum (12 month)</th>
<th>Bangladesh FWV Curriculum (6 month)</th>
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<td>5.</td>
<td>Newborn care</td>
<td>Immediate care of the newborn Newborn Resuscitation</td>
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<td>6.</td>
<td>Abortion</td>
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<td>7.</td>
<td>Family Planning Methods</td>
<td>Selection &amp; Counseling</td>
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<td>8.</td>
<td>Midwifery management and nursing</td>
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<td>✓</td>
<td>Not included in the curriculum</td>
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<td>9.</td>
<td>Early child development for infants and under-five children</td>
<td>All the trainee's included in the program had previous in-service training on these subjects</td>
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<td>10.</td>
<td>Identify deviations in child development and conduct emergency intervention, counseling, refer</td>
<td></td>
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<td>11.</td>
<td>Identify problems related to the Reproductive system &amp; women’s life cycle</td>
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<td>12.</td>
<td>Community health related to MCH &amp; FP</td>
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<td>13.</td>
<td>Health education &amp; training</td>
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<tr>
<td>14.</td>
<td>Midwifery services at village, health center and hospital level</td>
<td>Included 13 weeks hospital &amp; 8 weeks village level midwifery practice</td>
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<td>15.</td>
<td>Supervise health volunteers and TBAs</td>
<td>Not included</td>
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</table>
Annex-6: Proposed Organizational set up of National SBA Training and Services Programme

Proposed Organizational set up of National SBA Training and Services

- **National Level**
  - National Steering Committee headed by Hon'ble Minister, MOHFW
  - Task force chaired by Secretary National Focal point: Additional Secretary
  - Accreditation and Certification Nursing Council, WHO, UNFPA
    - SBA Training Coordination and Management - DGHS
    - SBA Services Management, Supervision, Performance Reporting - DGFP
    - Training Organization, Monitoring & Quality Control - OGSB
      - OGSB in 13 Medical Colleges, District Hospitals

- **Divisional Level**
  - Divisional Director Health
    - Civil Surgeon
  - Divisional Director FP
    - DDFP

- **District Level**
  - District Coordination Committee chaired by CS, co-chaired by DDFP, members DH, MCWC, FWVTNI

- **Upazilla Level**
  - UHFO/ MO (EOC)/ Nursing Supervisor/ SSN Supervision/Monitoring Training
  - MO (MCH-FP)/UFPO/Senior FWV Supervision & Monitoring of Services

- **Union Level**
  - MA/MO, HI, AHI, FWV or SACMO, FPI Supportive Supervision, Reporting

- **Village Level**
  - SBAs