# Annual Review

| Title: Strengthening Midwifery in Bangladesh | | |
|---|---|---|
| **Programme Value £14.5 million** | | **Review Date: June 2019** |
| **Programme Code: 204079** | **Start Date:** 25 July 2016 | **End Date:** 30 September 2021 |

**Summary of Programme Performance**

| Year | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Programme Score | **A** | **A+** | **A** | | |
| Risk Rating | **moderate** | **moderate** | **moderate** | | |

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|---|---|
| Dev Tracker Link to Business Case: | http://iati.dfid.gov.uk/iati_documents/5501354.odt |
| Dev Tracker Link to Log frame: | http://iati.dfid.gov.uk/iati_documents/5501466.xlsx |

**Acronyms:**

BMS - Bangladesh Midwifery Society
BNMC - Bangladesh Nursing and Midwifery Council
BRACU - BRAC University
C-section - Caesarean section
DFIDB - DFID Bangladesh
DGFP – Directorate General of Family Planning
DGNM - Directorate General of Nursing and Midwifery
GoB - Government of Bangladesh
ICM - International Confederation of Midwives
MoHFW - Ministry of Health and Family Welfare
NGO - Non-Governmental Organisation
RCM - UK Royal College of Midwives
SCI - Save the Children International
ToC - Theory of Change
UNFPA - United Nations Population Fund
VfM – Value for Money

## A. Summary and Overview (1-2 pages)

**Description of programme** (1/2 page)

The Strengthening Midwifery in Bangladesh programme[1] aims to contribute to a reduction in maternal and new-born deaths and caesarean section rates by supporting quality education for midwives and establishing midwifery as a profession in Bangladesh. This is in line with the UK Aid Strategy and (in particular) Sustainable Development Goals 3 – Good Health and Wellbeing – and 5 – Gender Equality.

Bangladesh's population growth rate is currently close to 1%[2], while the total fertility rate is 2.3 - projected to reach replacement level around 2025. However, the country's total population is still expected to reach or exceed 220 million by the year 2050[3]. Bangladesh has made significant progress in past years but did not achieve the Millennium Development Goal on reducing maternal mortality. The estimated maternal mortality ratio (2016[4]) is 196 per 100,000 live births – almost unchanged in Bangladesh since 2010; and rising among first-time mothers to 215 per 100,000 live births[5]. Haemorrhage and eclampsia account for 54% of all maternal deaths. 53% of births are attended by medically trained providers, with 50% of births taking place in health facilities. However, the rate of caesarean section (C-section) also increased from 23% to 33% between 2014 and 2017 and urban women are twice as likely as rural women, to deliver by C-section. Inequalities in use of facilities for birth has reduced significantly but the wealthiest women are still three times more likely to deliver in facilities than poor women. There are a range of minimally-trained

[1] This programme followed a previous phase – the 'Developing Midwives Programme'
[2] World Bank data, 2018
[3] Population Projection of Bangladesh: Bangladesh Bureau of Statistics, November 2015
[4] Bangladesh Maternal Mortality and Health Care Survey, 2016
[5] The Sustainable Development Goal target is to reach 70/100,000 by 2030.

community health workers operating in Bangladesh, such as traditional birth attendants (approximately 52,000), community-level skilled birth attendants (estimated 14,000), family welfare visitors (estimated 6,000), and junior midwives (estimated 6,000). These professions have been shown to have minimal impact on safe home delivery[6]. In 2017[7], the new-born mortality rate was 30 per 1000 live births and accounted for 67% of all deaths in under-five children. Only 7% of new-borns delivered at home received the recommended essential new-born care.

At the national level, the United Nations Population Fund (UNFPA) works (including through embedded technical assistance) with the Directorate General of Nursing and Midwifery (DGNM – part of the Ministry of Health and Family Welfare – MoHFW) to implement their responsibilities under the Fourth Health Sector Programme of the Government of Bangladesh (GoB). UNFPA supports DGNM to demonstrate leadership on commitments made on midwifery, developing national policy and strategy, recruitment, deployment, and advancement of structures and standard operating procedures for midwives. UNFPA and the Bangladesh Rural Advancement Committee (BRAC) University (BRACU) also work with the Bangladesh Nursing and Midwifery Council (BNMC), which is responsible for developing the regulatory framework, accrediting midwifery education institutions (including private institutions), standardising licensing exams, and registering all midwives in the country. UNFPA is working through the UK's Royal College of Midwives (RCM) to strengthen the Bangladesh Midwifery Society (BMS).

At the local level, UNFPA provides technical support to 38 government education institutions across the country, which are delivering the 3-year midwifery diploma. These institutions have been equipped with necessary teaching aids and skills labs. BRACU has established seven (private sector) academic sites across the country[8] in partnership with six Non-Governmental Organisations (NGOs) and is also delivering the 3-year midwifery diploma. BRACU is actively engaged in policy discussions, sharing best practice, and raising awareness of the midwifery profession.

**Summary supporting narrative for the overall score in this review** (1/2 page)

The Strengthening Midwifery in Bangladesh programme scored an A (met expectations) in this 2019 annual review. The programme is delivering well as intended – as an investment in the future. While this may be the midpoint of the programme, and early outcomes are starting to emerge, the midwifery profession is still only in its nascent stages. The three outputs: (1) Midwives well educated and trained according to international standards, (2) Institutional capacity for strengthening midwifery and (3) Enabling environment for midwifery created, have all individually scored A.

Since the design of the programme, two important changes in the project context have taken place. Firstly, the (positive) decision to recruit licensed midwives by the public health sector resulted in the loss of trained faculty members from private education institutions, including BRACU. This has necessitated a greater professional development offer and other incentives for faculty members to maintain teaching standards. Secondly, demand for skilled maternal-new-born care providers rapidly increased with the influx of forcefully-displaced Rohingya into the Cox's Bazar district. Both changes have drawn attention to the need for midwifery in Bangladesh but have also led to unforeseen shifts in the market for midwives.

Maternal healthcare in the refugee camps in Cox's Bazar is midwife-led, where nationally recruited midwives (many educated in institutions supported by this programme) work alongside internationally trained supervisors. The estimated maternal mortality rate in the camps is 179 per 100,000[9] - with a 95% confidence interval – lower than the Bangladesh national rate of 196. When we consider that the national maternal mortality rate is an average, and that the rate may be much higher in the poorest areas of the country which are more comparable to the conditions of the camps, this is a truly significant achievement

[6] Bangladesh Demographic and Health Survey, 2011, 2014
[7] Bangladesh Demographic Health Survey, 2017-'18 (preliminary report)
[8] There are currently 17 private educational institutes delivering the midwifery diploma course nationwide.
[9] Summary report: Reproductive Age Mortality Study, Rohingya Refugees Camp, Cox's Bazar Bangladesh. E.Handzel, A.Couture, K.Meehan, S.Doraiswamy, A.Biswas, H.Abdi, A.Halim, M.Hynes, C. Hardy. 2018.

for the DFID co-funded humanitarian health response. It also supports and provides some optimism with regards to the Theory of Change (ToC) for the programme.

Throughout the review, four central themes emerged:

1. **There is still a substantial capacity gap to be filled.** It is estimated that Bangladesh needs 22,000 midwives, to meet the needs of the current population and expected 3 million births per year, with adequate maternal and new-born healthcare. Maternal, new-born healthcare is a crowded and at times, confusing professional space in Bangladesh. However, access to skilled care providers remains the exception, rather than the rule. Of the 2,131 licensed midwives, 1,148 diploma midwives are currently deployed in the public sector[10] (218 are currently practising in the private/NGO sectors). 1,592 certified midwives[11] are also registered with the BNMC (of whom approximately 1200 are deployed). As the midwifery profession is in its nascent stages, there is a critical lack of senior supervision in practice and a fundamental lack of expertise among education faculty, most of whom are nurses who have been trained to teach the midwifery curriculum.

2. **There is a lack of clarity about roles and responsibilities, at institutional and individual levels.** Communication and coordination need to be strengthened across the healthcare setting. Both BNMC and DGNM have expressed confusion over the overlap in their roles, particularly when it comes to education, and the need to avoid duplication. BNMC also raised their lack of independence as a major challenge. An education board leading on quality, accreditation, and examinations for midwifery and nursing could help resolve this. This is reflected on the ground, where a lack of coordination between some of the education institutes and clinical settings is leading to tensions and inefficiencies. Traditionally, nursing institutes have been built beside government medical college hospitals to allow for clinical training. However, this is not the ideal set-up for midwifery as these hospitals largely deal with complicated, difficult and emergency delivery cases. Student midwives in tertiary hospital settings have had to compete with medical students, graduates, post-graduate doctors and other trainees to reach the number of deliveries required for graduation. These other professional cadres must be trained in tertiary settings and are given preference over midwives. To reflect this, the focus of UNFPA and BRACU is now shifting to place student midwives in midwifery-led care centres in sub-district hospitals, where they are better able to meet the course requirements (see output 1). Within the healthcare setting, hierarchies and competition affect all staff. While doctors (including Obstetrics/Gynaecologists) sit much higher in the hierarchy, the system does not value either nurses or midwives adequately, which is generally noted to increase tensions between the two cadres. While these endemic tensions go beyond the scope of this programme, they may also hinder midwives from achieving their full potential. Programme partners are increasingly participating in professional events with other healthcare professions to raise awareness of these issues.

3. **Maternal healthcare provision has a disconnect between knowledge and experience.** Diploma midwives meet standards set by the International Confederation of Midwives (ICM) and are trained in evidence-based care. DFID, alongside UNFPA, is committed to promoting these standards, which are known to address 70% of maternal health needs. Diploma midwives are all young, as they are eligible to enter the midwifery training between 17 and 22 years of age (criterion set by the government). This means they tend to have high levels of enthusiasm (which must be harnessed and sustained) countered by a lack of experience as practitioners in their profession and of managing themselves in a workplace. Certified midwives, on the other hand, have a nursing diploma and often 10-20 years of experience practising in clinical settings, with six months of midwifery training. It will take a number of years before diploma midwives have consistent experience of routine practice, and in the interim, the skillsets of both types of care providers must be valued while the capacity gap discussed above remains. The GoB plans to slowly replace other

[10] 1,206 are currently pending a licensing exam, discussed in output 1. Reasons for a midwife to be licensed but not deployed include unsuccessful or pending civil service exam, time taken for police verification or personal choice.

[11] A certified midwife is a nurse who has received 6 months additional training in midwifery since 2010 and been deployed to work as a midwife in a government health facility.

categories of less-qualified providers/cadres (including certified midwives) over time, leaving only diploma midwives and doctors in this space.

4. **There is a challenge of professional development at every stage.** As noted above, the large capacity gap and disconnect between knowledge and experience means that there is demand and need across the board for further professional development and clearer career pathways. Faculty members teaching midwifery are very rarely midwives (due to the nascency of the profession), and their graduates are therefore more qualified for the role than the teachers. Teachers also often lack pedagogical skills, due to their clinical rather than teaching background. Efforts are already underway by BRACU to address this, and GoB is planning to develop national faculty through a Master of Science (MSc) Sexual and Reproductive Health, Bachelor of Science (BSc) Midwifery and MSc Midwifery. These national plans are some years off fruition. This will help to address the need for a tiered structure, which enables appropriately qualified and experienced senior supervision, both in education and clinical settings. Diploma midwives, while new in their field, are almost universally motivated to seek additional qualifications – whether to increase seniority or further specialise.
   This programme is rightly investing in the health system for the future, but with 47% of births still taking place at home, many women and girls are receiving no or inadequate support for safe pregnancy, delivery and post-partum care. Outreach services to attract these women into midwifery-led centres are important, but the number, capacity and infrastructure of these institutions remains insufficient, while larger challenges such as corruption/unofficial payments are also prevalent. There is therefore a question of whether DFID Bangladesh (DFIDB) health programming has a complementary role to play in creating shorter-term solutions as well. For example, whether the array of certified nurse-midwives, junior midwives and skilled birth attendant roles could be consolidated, and creative solutions found to develop pathways for them into the midwifery profession (without compromising on quality of care), or at least towards more delineated roles. This could potentially mean more skilled midwives more quickly, but there is a significant risk that this could instead undermine midwifery if ICM standards are not upheld and existing infrastructure is overburdened. DFID could consider this question with the Maternal Health Taskforce[12] in the year ahead.

**Recommendations for the year ahead** (1/2 page)

Both UNFPA and BRACU maintain quarterly workplans setting out what they will do in the upcoming period, and those activities should be sustained. Additional recommendations for the year ahead are below, and in each output section:

- UNFPA and DFIDB should consider (within their relative spheres of influence) how to improve delineation, coordination and communication mechanisms between (i) BNMC and DGNM and (ii) within the departments/wards where student midwives are working (UNFPA to make suggestions for how this could be taken forward by December 2019).
- DFIDB should consult with the Maternal Health Taskforce to explore the future roles of the many maternal-health para-professionals (see point 4 above). UNFPA, alongside BNMC and DGNM, should work with DFIDB's Better Health for Bangladesh sector programme, MoHFW and DGFP to ensure that the process of developing family welfare visitors strictly adheres to ICM standards (by December 2019).
- All partners should revisit their strategic plans for faculty development as a priority for the year ahead. (UNFPA and DFIDB to raise this in the Human Resource Taskforce[13] and share a plan/process for this by December 2019; BRACU to share revised strategic plan by December 2019).

[12] Part of the MoHFW network of consultative groups
[13] Part of the MoHFW network of consultative groups

- UNFPA should identify a more robust form of appropriate, dedicated clinical supervision for 3rd year midwifery students in government hospitals and upazila[14] health complexes, and urgently implement or propose adaptations wherever possible. Where barriers to this exist, these should be taken forward, where feasible, as policy issues (update by December 2019).
- UNFPA should advocate with the health ministry (update by March 2020) for:
    a. Designating more upazila health complexes with midwifery-led care centres as clinical education sites for the midwifery students
    b. Promptly initiating implementation of the proposed six-month residency for graduate midwives
    c. Establishing an education board for midwifery and nursing, to organise/administer examinations (recognising that this is a long-term goal).
- BRACU (with the support of UNFPA and DFIDB) should engage DGNM, BMS and BNMC to advocate for additional, successful elements of their model to be considered for scale-up nationally (update by March 2020).
- DFIDB, BRACU and UNFPA should commission an analysis of data held by the midwifery-led care centres to feed back into midwifery education (by March 2020).
- Licencing, recruitment and deployment of midwives may be affected due to the legal case that has delayed the licencing exam. The log frame should be reviewed to assess whether relevant milestones need to be adjusted to reflect the delay (by December 2019).
- Reporting expectations, deadlines and timeframes for BRACU and UNFPA should be clarified to facilitate future reviews. Similarly, Value for Money (VfM) indicators could also be aligned to the academic calendar (by December 2019).

## B: DETAILED OUTPUT SCORING (suggest 1 page per output)

| **Output Title** | Midwives well educated and trained according to international standards | | |
|---|---|---|---|
| Output number per LF | 1 | **Output Score** | ***A*** |
| Impact weighting (%): | 40 | Impact weighting % revised since last AR? | N |

| **Indicator(s)** | **Annual Milestone(s) for this review** | **Progress** | **Cumulative Milestones** (Oct 2016 – May 2019) | **Progress (not scored)** |
|---|---|---|---|---|
| 1.1 Number of births attended by midwife students | UNFPA: 28500<br>BRACU: 1176<br>Total: 29,676 | **A. Output met expectation**<br>UNFPA: 25145<br>BRACU: 4758<br>Total: 29,903 | UNFPA - 69,500<br>BRACU – 10,788<br>Total: 80,288 | UNFPA – 98,841 (142%),<br>BRACU – 15,574 (144%)<br>**Total: 114,415** |
| 1.2 Number of midwifery-led care centres supporting midwifery skill building, established | UNFPA: 27<br>BRACU: 2 | **A. Output met expectation**<br>UNFPA: 27<br>BRACU: 2 | UNFPA – 27<br><br>BRACU-2 | UNFPA – 27<br>BRACU-2 |
| 1.3 Number of graduate midwives meeting minimum standards | UNFPA:1000<br>BRACU: 184<br>Total: 1184 | **A. Output met expectation**<br>UNFPA: 1206<br>BRACU: 179<br>Total: 1375 | UNFPA: 2,975<br>BRACU: 396<br><br>Total: 3,396 | UNFPA – 3,337 graduated to standards (111%),<br>BRACU – 401(101%),<br>**Total: 3,738** |
| 1.4 Number of students admitted in BSc-in-midwifery course | No target till 2020 | Not applicable | | |

Indicator 1.1 As part of the diploma in midwifery, students are required to assist 40 births each at clinical attachment sites. UNFPA over-achieved the target by 42% while BRACU did the same by 44%. BRACU

[14] An upazila is a sub-district – secondary level care site.

has more flexibility in reaching the 40 births target as they can track the patients as well as relocate students to partner clinical sites with high patient loads. GoB health facilities, where UNFPA support is provided, do not have that flexibility but do have a high patient load. UNFPA and BRACU have created log books for students' clinical experiences, including the required 40 births, 100 (Ante-natal Care (ANC) and 100 Post-natal Care (PNC) sessions. Enhanced guidance is also being developed by BRACU and UNFPA for clinical preceptors and formalising relationships between educational institutions and clinical sites, to increase supervisory capacity, graduate and service quality. Weak monitoring of the clinical practices of (GoB-institute) student midwives in the medical college hospitals was evident during the field visit. The main complaint against these clinical sites by student midwives is that they are impeded from assisting deliveries.

Indicator 1.2. As tertiary-level hospitals cater to more complicated cases, UNFPA has helped DGNM establish midwifery-led centres in the upazila health complexes where the likelihood of normal childbirths is much higher. 27 upazila health complexes are acting as clinical practice sites for the 38 government midwifery institutions. These are providing midwifery-led care with support from UNFPA and sub-implementing partners Save the Children International (SCI) and the Obstetrics and Gynaecology Society of Bangladesh (OGSB). This includes mentorship, autonomy in the labour room, and additional education opportunities in antenatal and post-natal care, as well as family planning, Visual Inspection with Ascetic acid screening programme for cervical cancer, emergency triage, gender-based violence prevention and response, adolescent health care including first time young mothers, post-abortion care, and prevention and response to sexually transmitted infections. BRACU has also established two 24/7 midwifery-led care centres since last year. A BRACU graduate midwife is also running her own midwifery-led care centre in Sylhet with increasing patient load. The review observed that there is a need for greater integration of family planning into midwifery services as is reflected in DHS data[15] and the impact evaluation baseline results. This is expected to improve over time through existing efforts within the programme.

Indicator 1.3. Government institutions and BRACU hold their respective graduation exams at the end of each calendar year which is followed by the licensing exams held by the midwifery council, early in the next year. Currently, the ratio of students successfully graduating (per enrolled), and the ratio of graduates successfully becoming licensed (per graduated), is in line with the expectations of the programme.

Indicator 1.4. There is no set target for this indicator for this review. However, BNMC/DGNM have already submitted the curriculum for BSc midwifery to the health ministry for approval and plan to start the roll-out of the course next June (teaching may not begin until 2021).

**Lessons identified this year, and recommendations for the year ahead linked to this output**

- UNFPA should identify a more robust form of appropriate, dedicated clinical supervision for 3rd year midwifery students in government hospitals and upazila health complexes, and urgently implement or propose adaptations wherever possible. This may involve a strengthening or scale-up of the existing mechanism delivered by SCI, or greater involvement of faculty/preceptors. Such supervision should have the technical expertise to be able to adequately assess whether students are correctly diagnosing patients and delivering evidence-based care to the standard expected for graduation. Where barriers to such a system exist, these should be taken forward, where feasible, as policy issues (update by December 2019).
- UNFPA should advocate with the health ministry (update by next annual review) for:
    a. Designating the upazila Health Complexes with midwife-led-centres as clinical education sites for the midwifery students so that students can assist in deliveries
    b. Promptly initiating implementation of the proposed six-month residency for graduate midwives
    c. Establishing an education board for midwifery and nursing, to organise/administer examinations (recognising that this is a long-term goal).

[15] Bangladesh Demographic and Health Survey, 2014

| **Output Title** | Institutional capacity for strengthening midwifery | | |
|---|---|---|---|
| Output number per LF | 2 | **Output Score** | ***A*** |
| Impact weighting (%): | 40 | Impact weighting % revised since last AR? | N |

| Indicator(s) | Annual Milestone(s) for this review | Progress |
|---|---|---|
| 2.1 Number of trained (masters' degree for UNFPA) faculty members in academic sites (at mid-academic year for BRACU) | UNFPA: 30<br>BRACU: 55% | **A. Output met expectation.**<br>UNFPA: 30<br>BRACU: 95% |
| 2.2 Number of staff positions in DGNM with dedicated responsibility for midwifery. | 4 | **A. Output met expectation.**<br>4 |
| 2.3 Number of supportive supervision visits to midwifery education programmes carried out by the Bangladesh Nursing and Midwifery Council. | 4 | **A. Output met expectation.**<br>4 |
| 2.4 Organisational capacity of Bangladesh Midwifery Society (BMS) to advocate for midwifery profession and create demand for midwifery services. | 40% on MACAT[16] scores | **A. Output met expectation.**<br>40% |
| 2.5 Recovery of direct costs for each paying student of BRACU | 25.79% | **A. Output met expectation.**<br>25.83% |

*The indicators above are not cumulative, so no additional columns have been included for this indicator.*

Indicator 2.1. The low capacity in numbers, time and expertise of midwifery faculty is a barrier to the advancement of the profession. English proficiency, critical thinking and analytical skills have been identified as gaps even among the most senior midwifery educators. UNFPA is working with technical assistance from Auckland University of Technology to address the challenge for GoB. A Government Order was issued identifying six dedicated midwifery faculty members at each public educational institution. They are progressively being enrolled in Dalarna University's online Masters in Sexual and Reproductive Health course (the establishment of which was supported by the Swedish Embassy). 39 current midwifery faculty, including 37 from 36 public institutes (funded by DGNM) and 2 from BRACU institutes (funded by BRACU), are currently enrolled, while 60 have already graduated. Efforts are also underway to develop a tiered system of tertiary education for midwifery (service and faculty). This update is pending approval with MoHFW.

Education faculty in BRACU sites has very high turnover as the strong demand for service delivery draws teachers out of schools and back into clinics. The establishment of dedicated (midwifery-focused) faculty in GoB institutes may have had an (anecdotal) negative outcome, as some clinicians allege a drop-off in quality of graduates (more on graduate knowledge retention can be found in section G). This may be because midwifery faculty have less practical experience as midwives (as they are former nurses), and students are consequently focused more on midwifery theory. DGNM is currently trying to embed rules to prevent faculty in government institutions from switching out, however a market-based approach which creates incentives for qualified educators to stay could be more effective in the long run. A hybrid approach - making continued clinical practice mandatory for faculty, as is the case in other types of medical education, could help to address both issues.

Indicator 2.2. Through our support to UNFPA, DFIDB funds six full-time technical assistance posts in the DGNM and BNMC, focused on midwifery, in addition to four positions which are self-funded by GoB. The programme has also worked with DGNM to consider how to firmly integrate midwifery into its structure more sustainably (DGNM was formerly the Directorate of Nursing only). A revised organogram for the entire directorate, with job descriptions for all proposed midwifery and nursing positions, has now been

[16] MACAT is an ICM developed Member Association Capacity Assessment Tool.

developed and submitted to the MoHFW for approval (June 2019). If approved, this would significantly increase the number of positions.

Indicator 2.3. BRACU and BNMC are working closely together to ensure non-government education institutes meet a high standard and are part of the broader national framework of midwifery education. BNMC regularly visits all sites, taking note of observations which are jointly reviewed. BRACU undertakes a monthly email survey of principals at each academic site, which is also shared with BNMC. BRACU fed into the development of an accreditation system for non-government institutes and has proposed to include the private/ NGO sector education providers in accreditation committees, which is currently pending approval from MoHFW.

Indicator 2.4. ICM developed a Member Association Capacity Assessment Tool (MACAT). The tool helps an ICM member association assess its own opportunities for strengthening and development, checking 96 questions across a broad range of capacity measures. The Royal College of Midwives (RCM), sub-partner of UNFPA, supported the Bangladesh Midwifery Society (BMS) in assessing its organisational capacity. This led to the first election in September 2018, electing 15 board members, of which ten are diploma midwives, three are BMS staff, and two are certified midwives. BMS has 1,756 members, mostly diploma midwives, and 7 divisional committees around the country. A stipend and letter of invitation facilitates board members outside of Dhaka to attend meetings. BMS will review its constitution – which is nearly ten years old – over the summer. Plans for the review include changing the composition of divisional committees and establishing a more systematic complaints mechanism. BMS offers 46 continuing education online courses through its website, free to members. A total of 522 members have enrolled in the courses and 321 have completed courses.

Indicator 2.5. 70% of the 4$^{th}$, 5$^{th}$ and 6$^{th}$ batches of midwifery students at BRACU institutes are fee paying (30% places are reserved for scholarship students from underprivileged backgrounds). The collection of these fees amounts to the recovery of 25.83% of the cost of each student. BRACU found their current charges are lower than similar private institutions and providing a higher standard of education. As such they have planned to slowly increase the charges over time (reflected in BRACU academic sites' sustainability plans).

According to BRACU, their NGO partner schools are sustainable and will continue at the end of the programme, independent of DFID. Each school has developed a sustainability plan, two of which were examined as part of this review. While one school anticipates continuing at surplus at the end of programme, the other does not, however both have three similar challenges:

- Substantially increasing student fees (although significant variation in total cost to student)
- Assumption of increasing student numbers (with associated pressure on the teacher to student ratio and infrastructure)
- Scholarships are the main financial hurdle and will inevitably drop off

Overall this will reduce access to the profession for poorer students and could lead to a potential drop-off in quality (due to larger class size), however, it could be argued that these negative outcomes (which will not manifest during the life of the programme) could be offset at the national level by the growing benefits for women and girls accessing reproductive and maternal-new-born healthcare (further discussed in VFM section). This would entail a trade-off between evidenced poverty reduction for direct beneficiaries and longer-term unattributable results. As DFIDB looks towards the end of the programme in 2021, it will need to consider if and how access to midwifery education and jobs can remain attainable for poorer and more marginalised students.

**Lessons identified this year, and recommendations for the year ahead linked to this output**

- All partners should revisit their strategic plans for faculty development as a priority for the year ahead, particularly in the public sector regarding pedagogy, English, and critical thinking skills. These plans should consider going beyond training and stricter contracts to consider market influences and incentives for faculty, as well as career pathways. (UNFPA and DFIDB to raise this

in the Human Resource Taskforce and share a plan/process for this by December 2019; BRACU to share revised strategic plan by December 2019).

- BRACU (with the support of DFIDB and UNFPA) should engage DGNM, BMS and BNMC to advocate for additional, successful elements of their model to be considered for scale-up within the national course curricula in GoB institutions. The placement of students and new graduates in the community for learning about the wider determinants of maternal health, and the role of experienced clinical supervisors providing hands-on training during clinical practice/ third year are examples of these elements. (update by March 2020).

| **Output Title** | Enabling environment for midwifery created | | |
|---|---|---|---|
| Output number per LF | 3 | **Output Score** | ***A*** |
| Impact weighting (%): | 20 | Impact weighting % revised since last AR? | N |

| **Indicator(s)** | **Annual Milestone(s) for this review** | **Progress** | **Cumulative Milestones** (Oct 2016 – May 2019) | **Progress (not scored)** |
|---|---|---|---|---|
| 3.1 Number of policy issues influenced through policy advocacy | UNFPA: 3<br>BRACU: 2 | **A. Output met expectation.**<br>UNFPA: 3<br>BRACU: 2 | UNFPA: 8<br>BRACU: 4 | UNFPA: 9<br>BRACU: 4 |
| 3.2 Number of events organised for increasing public awareness | UNFPA: 2<br>BRACU: 3 | **A+. Output moderately exceeded expectation.**<br>UNFPA: 3<br>BRACU: 6 | UNFPA: 5<br>BRACU: 7 | UNFPA: 6<br>BRACU: 11 |
| 3.3 Number of licensed midwives with membership with Bangladesh Midwives Society | UNFPA: 950<br>BRACU: 79<br>Total: 1029 | **A+. Output moderately exceeded expectation.**<br>UNFPA: 969<br>BRACU:392<br>Total: 1,361 | UNFPA: 950<br>BRACU: 79<br>Total: 1029 | Total: 1,361 |

The GoB maintains very high commitment to the midwifery sector and improvement of maternal and new-born care. DGNM plans to complete the broad implementation of their midwifery strategy within five years.

Indicator 3.1 UNFPA enjoys particularly close ties with DGNM, making it highly effective in policy influencing and advocacy. BRACU is also a significant stakeholder and contributor. In the past year, policy successes have included the approval of a Midwifery Policy by MoHFW, for which an action plan is now being developed, the development of a BSc curriculum, and a policy which requires faculty teaching midwifery to have a masters' degree (pending approval). A single admission test system for midwifery students across the country in both public and private institutions has also been adopted, although is contested by the private sector. Partners are currently engaging in dialogue with DGNM around plans to change the diploma curriculum from a semester format to an annual course, which is intended to reduce the workload of BNMC but could negatively affect the quality of learning, and a possible single final graduation exam for midwifery across all institutes.

Indicator 3.2. Public awareness events, including rallies, roundtable discussions, and TV talk shows have been organised by DGNM for international midwifery day (5 May). BRACU academic sites also organise midwifery 'open school' days and pop-up fairs to raise awareness on the role of a midwife and provide free services. Such events aim to attract students and their guardians to the course. UNFPA and BRACU have shared the experience so far of developing the midwifery profession in international and national fora such as the Ob-Gyn society of Bangladesh conference, the national task force on health workforce and Women

Deliver. This participation helps to create space for midwives in the overly crowded arena of maternal healthcare providers, as well as in building GoB ownership and policy support.

Indicator 3.3 BMS has increased its membership through its easy-to-use online registration platform. The society is focused on raising public awareness on midwifery, providing technical and emotional support to deployed midwives, and supporting the professional development of midwives through online education courses. As BMS continues to grow it has significant potential to become the independent/civil society voice representing midwives, although it is not yet taking on that role.

**Lessons identified this year, and recommendations for the year ahead linked to this output**
Through this review, issues were raised which could form the basis of future policy engagement:

- Application of accreditation standards to government education institutions (which are currently only applied to private/NGO institutes).
- Separation of licensing and (public sector) graduation exam responsibilities, which are both currently administered by BNMC, to avoid conflicts of interest. A separate education board for organising the exams could be established for this.
- Change in the mandatory requirement that the midwifery diploma is a fully residential course. BRACU is confident that a non-residential first year (theory only) would reduce the cost and improve sustainability without affecting the quality of education.

## C: THEORY OF CHANGE AND PROGRESS TOWARDS OUTCOMES (1-2 pages)

**Summarise the programme's theory of change and any major changes in the past year** (1/2 page)

Developing a competent cadre of midwives to work in the public and private health sectors will lead to more safe births and immediate new-born care, ultimately contributing to a reduction in maternal and new-born deaths in Bangladesh. Despite some changes in the results framework in the past year (discussed below), most of the underpinning assumptions for the ToC stated in the business case remain applicable. However, the ability to retain trained faculty and for students to access adequate supervised clinical practice in the public midwifery education centres are both concerns. Licensed midwives are largely being absorbed by the government system (in sub-district health facilities) and the Rohingya camps, which while still working with poorer and deprived communities, is not what was originally intended in the Business Case. Considering the need for mentoring and supervision in their initial years of service this is actually aa pragmatic arrangement. Given these shifts in assumptions, DFIDB should re-examine to what extent we believe the ToC will hold.

**Describe where the programme is on track to contribute to the expected outcomes and impact, and where it is off track and so what action is planned as a result in the year ahead** (1/2 page)

The following indicators report to Outcome 1: Licensed midwives increasingly provide midwifery care, and Outcome 2: Professionalisation of midwifery.

| Indicator(s) | Milestone(s) for this review | Progress |
|---|---|---|
| 1.1 Percentage of graduate midwives licensed | UNFPA: 90%<br>BRACU: 97% | Total: 60.1%<br>Achievement would be 112% (overachieved) had the 2019 licensing exam taken place. 1206 graduates awaiting licensing. |
| 1.2 Percentage of licensed MWs employed in midwifery care | UNFPA: 95%<br>BRACU: 95% | UNFPA: 92.8%; BRACU: 94%<br>Out of 2131 total licensed midwives, 2092 have been recruited by GoB; 1148 deployed to sub-district facilities. |
| 1.3 Percentage of Midwives working in difficult areas (as defined by GoB[17]) | UNFPA: 600<br>BRACU: 32% | UNFPA: 944 (51% of whom are awaiting deployment) |

[17] Based on GoB's "Hard-to-Reach Areas: Providing Water Supply and Sanitation Services to All"

| | | |
|---|---|---|
| | | BRACU: 75% |
| 2.1 Percentage of licensed midwives using on-line registration system of BNMC | 50% | 100% |

The programme is broadly on track or still able to achieve the expected outcomes. The number of births attended by licensed midwives (in service) is on track to exceed the annual milestone tracking impact, based on data most recently reported in March 2019.

Indicator 1.1. Currently, only 60.1% of the graduate midwives have been licensed which is significantly short of the 90+% target. This is because a legal challenge against BNMC has delayed the administering of licensing exams in February 2019 (further elaborated under risk). BNMC is working closely with the MoHFW to resolve this and have sought additional advocacy and support from DFIDB and other partners of the programme.

If a resolution is achieved permitting the licensing exam to go ahead, this indicator would likely be achieved by 112%. 55% (221) of the BRACU graduates and 64% of the public sector midwives have been licensed and the rest (1026 government including 179 BRACU) are awaiting the BNMC licensing exam. The existing licensing exam, however, relies heavily on multi-choice questions, weakening its ability to demonstrate learning outcomes. To strengthen the quality of the exam, a new 'mock' licensing test was administered in 38 schools with technical assistance from UNFPA. The 'mock' test included scenario-based problems. Unfortunately, this test showed a substantial lack in students' abilities to think critically - a problem across the board in the country's basic education system. There is an urgent need to equip midwives (and faculty) with critical thinking, decision making and autonomy skills to lead towards the expected impact on maternal and infant mortality, and C-section rates.

Indicator 1.2 While this milestone appears to be on track, there is a distinction to be made between 'employed' or 'recruited' and 'deployed' or 'working'. There is extremely high demand for trained midwives in Bangladesh, making it feasible for many graduates to find appropriate employment, largely in the public sector. However, the bureaucracy of the government system has persistently slowed down the deployment of midwives, reducing their ability to impact change working in their communities. This is further indicated below. UNFPA is advocating to expedite the process for recruiting and deploying the third batch of midwives.

Indicator 1.3 While UNFPA appears to have exceeded this milestone, 51% of the most recent batch of 944 licensed midwives (from Feb 2018) are recruited but awaiting deployment. Deployment is expected this summer, and most are working in the private sector or in other roles while they wait. BRACU has exceeded the milestone as majority of its graduated, licensed midwives are now working in the Rohingya refugee camps. The definition of 'hard to reach areas' for this indicator is fairly broad, but adequate for the inclusion ambitions of the programme.

**Explain major changes to the log frame in the past year** (1/2 page)

Based on recommendations made in the last annual review, several changes have been made in the log frame during the reporting year. The changes resulted in better sequencing of outputs and outcomes and articulation of measurable indicators. Major changes include:

| Changes | Original Log frame | Revised Log frame |
|---|---|---|
| Outcome 2 is now Outcome 1 | OC-1: Midwives well educated and trained according to international standards | OC-1: Licensed midwives increasingly provide midwifery care |
| Outcome 1 is now Output 1 | OC-1: Midwives well educated and trained according to international standards | OP-1: Midwives well educated and trained according to international standards |
| Output 2 is now Outcome 2 | OP-2: Institutional capacity for strengthening midwifery | OC-2: Institutional capacity for strengthening midwifery |

| | | |
|---|---|---|
| Output 1 is now Output 2 | OP-1: Midwives well educated and trained according to international standards | OP-2: Midwives well educated and trained according to international standards |
| An indicator was dropped from Output 3 as it was already achieved and would have remained the same for the rest of the programme period. | Number of academic sites equipped as per minimum standards and accredited for midwifery education (trained faculty, equipment, education materials); | |

**Describe any planned changes to the log frame as a result of this review** (1/2 page)

- Licencing, recruitment and deployment of midwives may be affected due to the legal case that has delayed the licencing exam. The log frame should be reviewed to assess whether relevant milestones need to be adjusted to reflect the delay. The log frame should also be reviewed as part of regular programme management (by December 2019).

## D: VALUE FOR MONEY (1-2 pages)

**Assess VfM compared to the proposition in the Business Case, based on the past year** (1 page)

**Economy:** Education faculty turnover continues to be a constraint for the BRACU programme. Recruitment into a government midwifery post is a highly desirable option for faculty, providing long-term secure income. The average turnover rate for BRACU faculty for the period of October 2017- September 2018 was 37.5% (). This was largely due to GoB recruitment of midwives (where faculty returned to jobs in clinical practice). The turnover rate for the period since September 2018 is only slightly lower at 32.14%. This reduces the return on investment in faculty members and increased costs associated with training newly recruited teachers.

**Efficiency:** The total cost per graduate[18] at BRACU has reduced from BDT 1,400,000 (£13,123[19]) to 1,390,000 (£13,030). This is because a higher number of students enrolled in the 2018 academic period, with a dropout rate of almost zero. Increasing parental engagement throughout the three years of the course, forming student committees, recruiting a Counsellor and establishing a 24/7 complaints mechanism have all contributed to the reduction in student dropout. It is important to note that despite the increase in enrolment (and class size), there has been an overall improvement in learning, indicated by the Cumulative grade Point Average (CGPA) of the 2018 graduates compared to 2017. For instance, a lower proportion of students received a CGPA of 2.7 and below (5.1% of 2017 graduates/ 2.2% of 2018 graduates), and a higher share of students received a CGPA of 4 (5.1% of 2017 graduates/7.8% of 2018 graduates).

**Effectiveness:** The programme has exceeded the expectation that 90% of the graduates would be able to obtain a midwifery license (in practice, 99.55% of the graduate students passed the licensing exam). Once licensed, most midwives enter relevant employment (notwithstanding current delays in the licensing examination, which impede deployment). Most BRACU licensed graduates are working in the public or private sectors (192 out of 221 licensed midwives).

**Cost-effectiveness**: The business case estimated that the UNFPA component would save the lives of 12,000 new-borns and 865 mothers over a 5-year period and the BRACU component would save 10,500 lives over a 20-year period. Given the changes in the context and delays in the deployment of midwives, these numbers may need to change, though it is too early to say. A cost-effectiveness analysis completed before the final year of the programme would be helpful including to inform any future decisions about DFID support to the midwifery profession in Bangladesh. For example, this study could assess the value

[18] The diploma is a three-year course
[19] £1= BDT106.68

for money of services provided by midwives under the UNFPA (larger scale) and BRACU (higher quality) components and the cost-effectiveness of technical assistance.

**Equity:** Maternal/new-born health interventions are part of the Disease Control Priorities (3rd edition) package (for universal healthcare), and 'mega-buys' for investments in health – the evidence for return on investment is robust and extensive, including on reaching the most vulnerable. Reducing maternal and infant mortality are key indicators for improving gender equality in any context. As identified above, some of the programme assumptions from the Business Case most linked to leave no one behind – for example, that midwives will deliver services in their own deprived communities – have not held in practice. The ability of this programme to reach the most-marginalised and poorest students in the long term is also challenged by the push towards sustainability in BRACU academic sites. DFIDB should re-examine the assumptions, ToC, and priorities of our support as we move closer to programme end. However, as the ToC still largely holds, we do expect poor women and girls, and all future generations across Bangladesh will benefit in the medium-long term from this programme.

**Explain whether and why the programme should continue from a VfM perspective, based on its own merits and in the context of the wider portfolio** (1 page)

The programme overall continues to represent good value for money, and sustainability is emerging for some aspects. The gains that have been made will be further embedded and built on through the remaining programme period. Both UNFPA and BRACU anticipate some form of continuity at project end with the renewal of DFID funding. UNFPA has other potential sources of funding, including support from Sweden and Canada, and is driven largely by government commitment, which shows no sign of waning. BRACU currently contributes approximately £1 million to the programme, sourced from BRAC's enterprise activities. Each academic site working with BRAC has developed a sustainability plan, which, although requiring significant adaptations, suggests these institutions will not close.

The delivery of both public and private midwifery education supported by this programme has had a tangible positive impact on individual women's, girls' and families' lives. This impact is likely to become evident at scale with time. While there are improvements still to be made in the education space, the largest challenges remain with building institutional capacity, structures, and ensuring an enabling environment for the profession. DFIDB's broader health portfolio includes other technical assistance programmes working to strengthen the Bangladesh health system. A cost-effectiveness analysis or more substantial value for money assessment would help to understand where DFID is best placed to have the greatest impact in future.

## E: RISK (½ to 1 page)

**Overview of programme risk (noting the rating from p.1) and mitigation**

The overall risk rating of the programme continues to be moderate, while identified risks are within DFID's risk appetite. Risks, including fraud, are regularly discussed with partners during quarterly review meetings. Priority risks and suggested mitigation measures identified over the review period are outlined below.

**External Context:** A court case against the Bangladesh Nursing and Midwifery Council has indefinitely delayed the licensing exams that were scheduled for February 2019. This will have an impact on the scheduled recruitment and deployment of midwives to government sub-district health facilities.
**Mitigation:** The health ministry and UNFPA are lobbying relevant authorities to permit a special arrangement allowing the midwifery licensing exams to proceed as midwifery services are urgently required. There are early indications that this may succeed. We will follow up over the summer. BNMC will continue efforts to resolve the court case.

**External Context:** The Directorate General of Family Planning (DGFP) has proposed to upgrade family welfare visitors through additional training to meet the standard of ICM midwives.

**Mitigation:** UNFPA, BRACU and DGNM have already emphasised the need to develop a strong and unique identity for midwives, for example using pink uniforms. UNFPA, BNMC, and DGNM should work with MoHFW and DGFP to ensure that the process of developing family welfare visitors strictly adheres to ICM standards and that care is taken in any future licensing. Creative solutions are needed to fill the capacity gap in maternal-new-born service provision, but quality of care must be paramount.

**Delivery Risk:** There is an acute shortage of trained midwifery teachers in the country as it is a new profession. Loss of trained faculty members to service provision in the public health system is negatively affecting the ability of both BRACU and UNFPA-supported institutions to deliver a quality diploma course. While experienced midwives providing services to patients is filling a capacity shortage on one hand, it reduces the ability to continue to fill that gap in the longer term.
**Mitigation:** The education institutions are currently unable to match the benefits offered by a government job. BRACU has adopted several incentives to mitigate the risk, including i) a faculty professional development offer (e.g. skill development workshops by expert visiting midwives, Dalarna online MSc course, working with Auckland University of Technology, study visits to Cambodia and India, and participation in global seminars); ii) exploring alternative human resources, such as medical graduates with public health expertise; and iii) 'core faculty' roles whereby each partner is required to retain at least two faculty members for at least three years. UNFPA has supported DGNM to develop a potential career pathway for midwives and opportunities for continuous professional development, including awards and recognition.

**Delivery Risk:** BRACU partners will not continue to provide quality education beyond DFID funding period which may affect sustainability.
**Mitigation:** Assurances have been received and planning is underway by BRACU and each academic site to mitigate this risk. Both sustainability plans seen as part of this review were well thought out and pragmatic, though could be improved with the addition of a timeline for decision making. DFIDB will need to continue to raise this risk in quarterly review meetings to track progress.

**Delivery Risk:** Government students have faced restricted access to necessary books and skill lab equipment because faculty members fear damage or loss to the equipment. Ongoing restrictions will negatively affect learning outcomes.
**Mitigation:** UNFPA has engaged Underprivileged Children's Education Programme, a local NGO, to develop a student-managed system for access to the library and the skill lab around the clock. Members of the student committees are responsible for the system. Ongoing monitoring (including spot checks) and advocacy are needed.

**Safeguarding Risk:** There is a risk of violence, sexual exploitation, abuse and harassment of midwifery students and female faculty members. This risk is increased as the course is residential and clinical services must be provided round the clock. All academic sites have male staff in senior positions who are not always gender sensitive. Midwives are faced with a high degree of responsibility at a young age, and do not always feel competent in clinical settings. Anecdotally, midwives are often scared something will go wrong with a patient, particularly at night, which increases their vulnerability to exploitation and abuse.
**Mitigation measures:** DFIDB is in the process of completing Enhanced Due Diligence Assessments for both UNFPA and BRACU. All partners have been made aware of DFID's expectations around gender inclusion and safeguarding. Partners are required to immediately report any real or suspected cases to DFID, although our ability to track and influence safeguarding in GoB institutes is limited. SCI's clinical mentors could more closely monitor and report on intimidation in clinical settings and other safeguarding issues, and this could also be added to the end-line surveys of the impact evaluations (see section G below). In addition, i) BRACU has appointed a counsellor and established 24/7, direct mobile access to her for students, faculty members and staff. The counsellor regularly visits each academic site and holds clinics with individuals and groups; ii) student committees have been set up in each of the BRACU academic sites and the 38 government institutes to identify, quickly report and support the involved members; iii) student hostels each have a resident hostel manager, 24/7 guards and CCTV for security of the students and staff.

During the review period, staff on-site were questioned about escalation and reporting pathways. Further communications to remind staff to take allegations seriously and escalate quickly would be useful.

**Fiduciary Risk:** Misuse of funds allocated to partners.
**Mitigation:** BRACU is implementing an online financial management system that requires immediate scanning and uploading of all bills and receipts daily. These are checked by the BRACU financial team regularly and audited by internal (BRACU) and external (DFID commissioned) audits. They also pay visits to downstream partners to undertake six-monthly asset checks and quarterly spot checks, and to orient new staff and provide training as required. Quality spot checks by UNFPA Administration and Finance Officers are carried out in all implementing partners' offices annually to mitigate this risk profile.

## F: DELIVERY, COMMERCIAL & FINANCIAL PERFORMANCE (1-2 pages)

### Performance of partners and DFID, notably on commercial, and financial issues (1-2 pages)

Both UNFPA and BRACU have delivered at pace in line with agreed work plans and approved log-frame targets. UNFPA submitted two six-monthly reports and BRACU submitted four quarterly financial and narrative reports during 2018-19. All the reports were submitted on time and revised following DFIDB comments and feedback. Review of these reports show both the partners are on track in terms of implementation.

Performance of partnership(s)

BRACU has effectively maintained partnerships with the six NGO implementing partners who manage the academic sites, as well as with Auckland University of Technology and British Council providing technical expertise. The academic sites are collaborating with 22 public and private health facilities to create opportunities for clinical practice. A Technical Advisory Group has facilitated collaboration among public and private institutions at a senior level and a Partners' Coordination Committee has helped to improve overall project management, meeting three times during the reporting period.

UNFPA is working closely (including as embedded technical assistance) with DGNM. Downstream partners include Save the Children International, BBC Media Action and UCEP, and collaborations with the Royal College of Midwives, and Dalarna University.

BRACU and UNFPA are also working in close collaboration. UNFPA is a member of BRACU's technical advisory group and actively participates in relevant activities, while UNFPA has ensured BRACU's participation in several national activities. DFIDB meets UNFPA and BRACU on a quarterly basis and additionally as required. DFIDB also attends Partners' Coordination Committee meetings for wider consultation. The wider Health, Population and Nutrition Sector Programme also monitors UNFPA's performance through review of the relevant operational plan.

The Obstetrics and Gynaecological Society of Bangladesh is responsible for all technical advice to the government on reproductive health. They have to date been greatly supportive in increasing awareness and raising the profile of the midwives. It will be important to continue engaging them for policy support, technical oversight and referral.

Financial Performance

Overall financial performance of both the partners has been satisfactory and both maintained variance at less than 5% throughout the period, with realistic forecasts and consistent expenditure. UNFPA provides a six-monthly financial report and BRACU reports on a quarterly basis. Both have adequate details on different line items. The project is on track in terms of financial implementation, 94% for BRACU and 100% for UNFPA as of 31 March 2019.

The payment modality for UNFPA is six-monthly in advance, contingent on thorough review and approval of the finance report. UNFPA finds the current payment modality difficult to manage, but DFIDB does not

consider there to be enough grounds or scope for any change in this regard. UNFPA uses 'Atlas', an Enterprise Resource Planning (ERP) online accounting system for financial control and human resource management. UNFPA provides the necessary personnel to the DGNM for admin-finance support as well as proper accounting and continuous oversight. In addition, UNFPA conducts assurance activities such as spot checks, monitoring and audits annually to ensure funds are spent for the intended purpose.
The James P. Grant School of Public Health at BRACU adheres to the BRACU Finance Manual for their financial management. BRACU finance staff conduct six-monthly financial monitoring visit to partners' offices. Until 2018, BRAC Internal Audit Department audited 100% of the invoices from seven academic sites and the Dhaka hub on an annual basis. The last internal audit report covered the period from October 2016 to December 2017 for the hub and all academic sites; all recommendations were followed up during the 2018 calendar year. BRACU also introduced Enterprise Resource Planning (ERP) software as part of BRAC wide system improvement initiative, in January 2018, which allows immediate review of uploaded invoices. A programme-commissioned annual external audit takes place every year in line with International Auditing Standards; the last external audit was completed in November 2018 and provided an unqualified view on the project's financial statements for the period of July 2017 to June 2018.

Commercial Performance
As per the Contribution Arrangement (CA) and Framework Arrangement, UNFPA follows its own procurement policy and procedures for project procurements and reports to DFID on a six-monthly basis on procurement progress and plans. To date, all provisions in the CA have been complied with.

BRACU procurements are carried out in accordance with their own procurement policy and the Accountable Grant (AG) Agreement. BRACU provides quarterly updates to DFIDB on assets as part of regular reporting. DFIDB has made BRACU and other partners aware of DFID's definition of fraud, value for money and reporting procedures, including by sharing guidelines and discussion during quarterly Partners' Coordination Committee meetings.

Assets Monitoring and Control
UNFPA procured teaching aids and equipment in 2017 and 2018 and distributed these to 38 nursing institutes in the country. An asset register has been maintained by the recipients to monitor the appropriate use and control of the assets. All programme assets are systematically recorded and reported in the registers. As part of this review, DFIDB conducted a spot check of assets of the Chattogram Nursing College on 29 May 2019 and found the assets list to be comprehensive and all assets were found in good condition. Asset registers are also maintained by the seven academic sites of BRACU and verified every six months. In addition, these were audited during both the BRACU internal audit and external annual audit.

| | |
|---|---|
| Date of last narrative financial report(s) | 15 May 2019 |
| Date of last audited annual statement (s) | 03 February 2019 |

## G: MONITORING, EVIDENCE & LEARNING (1-2 pages)

**Monitoring** (1/2 page)

**Government and UNFPA:**
At **central level**, the monitoring committee of DGNM is ultimately responsible for oversight of the programme (as it contributes to the national midwifery agenda). Several M&E tools are being used, including a detailed five-year M&E plan and M&E log frame. Descriptive technical notes provide a clear definition for each indicator, ensuring consistent data is captured and analysed to understand progress. Checklists are used to support monitoring and have been field tested and revised. Under the leadership of the DGNM committee, monitoring visits (including both government officials and UNFPA representatives) were carried out to the educational and training sites as well as to the midwifery-led care centres. At **local level**, Civil surgeons, Quality Improvement (QI) committees, Upazila Health Family

Planning Officers (UHFPOs), and District Public Health Nurses (DPHNs) play a monitoring role. UNFPA field officers regularly visit educational and service provision sites.

The **BRACU** sites and activities are monitored by i) the BRACU secretariat and ii) NGO implementing partners. The central team monitors implementation of programme activities and delivery of the course curriculum to standard in all seven sites, as well as finances and logistics. During the past year, three Project Coordination Committee meetings and one Technical Advisory Group meeting were held to review overall progress and exchange technical experience respectively.

**From the secretariat**, Senior Instructors in the Midwifery Education Team are each responsible for one academic site, where they monitor and mentor the faculty members and provide on-the-job training. Following the introduction of an online ERP system that requires daily uploading of bills and receipts, monitoring visits (and associated time and cost) by the management team have reduced by one third. Independent visits by the Counsellor, the 24/7 hotline, and anonymous question box, as well as student committee members, helped monitor possible safeguarding issues. **Locally**, partners monitor day-to-day management and academic activities and first-line of defence systems for fraud and safeguarding issues.

Throughout the previous year, DFIDB monitored the programme by reviewing partners' narrative and financial reports, holding quarterly meetings and through field visits. Three field visits were carried out, to both government and BRACU institutes/academic sites in Dhaka, Sylhet, and Chattogram. The latter two visits informed this review. DFIDB sits on the Technical Advisory Group and the Partners' Coordination Committee of BRACU and utilised these platforms to drive key management priorities like risk management, fraud and safeguarding.

**This mid-term review** was carried out by a team of DFIDB staff members, led by a Social Development adviser, and including an Economist, Programme Manager, and Health Adviser (Lead Adviser for the programme). The review considered the quarterly BRACU and six-monthly UNFPA progress reports, partner sustainability plans, draft report of the Research on the long-term impacts of trained midwives on health outcomes in Bangladesh, and two field visits to Chattogram and Sylhet. The review also took into consideration the recent review of the GoB's fourth health sector programme by independent reviewers.

**Evidence** (1/2 page)
There has been no substantial change in evidence from the programme design stage. Well-trained and deployed midwives in government, NGO health facilities and Rohingya camps are high in demand and increasingly delivering babies safely, according to health centre records.[20]

DFIDB and the DFID South Asia Research Hub have commissioned an impact evaluation study: Research on the long-term impacts of trained midwives on health outcomes in Bangladesh. The baseline study has been completed by Oxford Policy Management and Mitra and Associates, and a draft report shared.

The findings of the draft report echo the status of maternal health and services as found in the latest demographic health survey 2017, and in this mid-term review. The maternal mortality ratio has plateaued, as has the total fertility rate, with a low level of integration of family planning into maternal healthcare provision. An increasing concern is the very high C-section rate, especially in the private sector (over 70%). Antenatal (82%) and postnatal care (50%) and births (52%) supported by medically trained attendants have continued to increase. The study noted the potential resource that midwives represent in helping Bangladesh to overcome these challenges.

At programme level, the study identified well-known constraints of inadequate and poorly skilled faculty members, and lack of space in government education centres and dormitories. The study shows that while the retention of knowledge across the years/batches of diploma midwives is fairly consistent, it is poorer overall than expected – midwives averaged scores of 67– 75% across the 4 test scenarios. The study also

[20] Project database – records are kept in each health centre where midwives are deployed and these are collated by UNFPA.

provided qualitative evidence in anticipation of issues with retention of midwives, particularly in less desirable deployment locations (as is currently experienced with nurses and doctors in rural settings). For example, Upazila Health Complexes and district-level hospitals are the most desirable places to work for midwives. Nearly 71% of interviewed midwives had a migration plan, and almost all had a desire to pursue higher education.

**Learning** (1/2 page)

Systems-level learning, while not necessarily flexible and adaptive, is taking place through the programme. Several lessons identified through BRACU's model of implementation have been incorporated into the government's education model and scaled up. However, the midwifery-led care centres are generating an enormous amount of data. Where this is anonymised, it could potentially be a significant resource for better understanding and learning. DFIDB, BRACU and UNFPA should commission an analysis of data held by the midwifery-led care centres to feed back into midwifery education (March 2020).

Two observations on the field visits should be explored further by UNFPA within the educational institutes. Firstly, it was noted that most of the equipment, dummies, and posters, represented white/Caucasian mothers and babies[21]. It would be interesting to find out if other procurement options were available, that might have been more suited to a Bangladesh context. Secondly, cultural taboos around women's bodies (and the need to keep them hidden) were evident among students while performing simulations, to such an extent that it was notably impractical, for example impeding new-born-mother skin-to-skin contact. Anecdotally, this drops off after more experience in clinical practice, but it is worth checking with regards to both quality of care, and whether the curriculum or environment in education institutes could be adapted to create a more pragmatic, body positive environment.

**Progress on recommendations from previous reviews** (1/2 page)

**UNFPA will, by end of the project year, ensure:**

| | Recommendations 2018 | Status |
|---|---|---|
| 1 | Finalisation of action plan to implement midwifery policy | Completed |
| 2 | Addition of English modules to the government curriculum and translation of course content into Bengali. | On-going. English modules have been developed and are under review by the BNMC. The decision on Bangla translation of the course has not been agreed by the government. Advocacy will continue. |
| 3 | Continuation of the web-based masters' programme, simulation training and faculty mentorship for all dedicated midwifery faculty members | On-going for the life of the programme |
| 4 | Changing of current accountability rules for skills-lab equipment to allow access and practice by students. | Completed |
| 5 | Assigning 6 dedicated midwifery faculty members in all the institutes and approval of the revised organogram for DGNM and BNMC. | Completed |
| 6 | The first ever election of the Bangladesh Midwifery Society is held by October | Completed |
| 7 | Orientation for sub-national officials on midwifery in areas where midwives are deployed. | Completed |

**BRACU will, by end of the year:**

| | Recommendations 2018 | Status |
|---|---|---|
| 1 | Complete introduction of all the 33 revised modules | Completed |
| 2 | Document and disseminate experience of introducing birthing chair and reaching disabled women as well as the importance of community engagement for the course | Completed. |

[21] These products are produced in a very limited range of skin tones not reflecting the diversity of mothers in the UK and around the globe. Local partners chose white-skin options during procurement processes.

| | | |
|---|---|---|
| 3 | Pursue partners to get approval of their business plans by their respective governing bodies, for the continuation of the course beyond the project period | On-going. The business plans for five of the six partners have been endorsed by their respective governing boards and the sixth one is under review by the board. |

**DFID will,**

| | Recommendations 2018 | Status |
|---|---|---|
| 1 | Revise the log frame to reflect current realities engaging all concerned, by end of September 2018 | Completed |
| 2 | Support the South Asia Research Hub in completing the baseline data for the impact study by the end of March 2019 | Completed |
| 3 | Commission independent qualitative studies on the experience of midwife-led maternity care centres and empowering young women through midwifery | Completed. BRACU commissioned three studies[22]. Two have been completed and one is on-going. |

[22] (1) Experience of Childbirth for mothers using the birthing chair at a midwifery led centre in Dhaka, Bangladesh: James P. Grant School of Public Health, BRAC University, Dhaka, Bangladesh. (2) Midwife-led care in low- and middle-income countries; Michaela Michel-Schuldt, University of Technology, Sydney. Will be presented in ICM Conference in 2020. (3) Developing and implementing community enhanced standards for midwifery centres in Bangladesh. On-going study by Jennifer Stevens, UNFPA, Bangladesh.