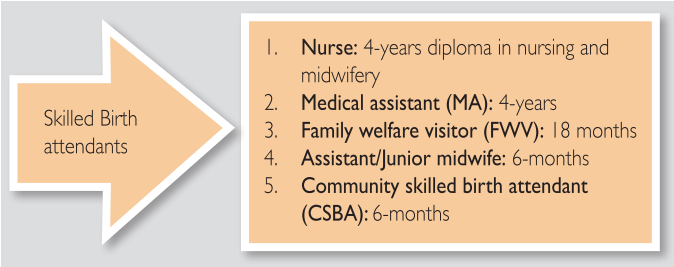
Improving the quality of nurse-midwives in Bangladesh: Addressing barriers of midwifery course in diploma in nursing and midwifery training

The Government of Bangladesh has initiated various strategies to achieve the MDG5 targets, one of which is increasing skilled attendance at birth to 50% and reducing the maternal mortality ratio to 143 per 100,000 live births by 2015. Apart from medical graduates, five categories of health professionals are considered as skilled birth attendants in Bangladesh (Figure 1). Among them, the 4-year trained diploma nurses are the key caregivers in maternal and neonatal health (MNH). The final year of nursing training course is devoted entirely to midwifery training. But very little is known about the quality of midwifery training and the enabling environment to provide MNH services in public sector hospitals in Bangladesh.

Figure 1: Categories of skilled birth attendants in Bangladesh (excluding medical doctors) and their training period



Objectives:

To explore the existing practices of nurses in MNH services, to understand the enabling environment for working in the obstetric wards and the barriers students face during the midwifery course in the final year of the Diploma in Nursing and Midwifery training in Bangladesh.

Methods:

Qualitative data were collected during 2007-2008 from six public sector primary to tertiary level hospitals in Bangladesh, from both a high performing district (Khulna) and a low performing district (Sylhet):

- Seven key informant interviews and 44 in-depth interviews were conducted with hospital managers, 'staff nurses', doctors, and support staff.
- Six final year 'student nurses' in the 4-year diploma in nursing and midwifery programme were also interviewed.
- Eight observations were carried out in obstetric wards to observe staff nurses' activities. Direct observations were also made in the classroom and practical sessions of midwifery courses.

Research Findings:

Labor and delivery management:

- After receiving an obstetric patient, the staff nurse usually took the labour history, checked blood pressure, temperature, and fetal heart sound, opened an intravenous (IV) channel, and drew blood for grouping and cross matching. After this primary assessment of the patient, they called the doctor.
- Staff nurses rarely had an opportunity to conduct a normal vaginal delivery in tertiary and secondary-level facilities, but did conduct deliveries, even with episiotomy at primary level upazila health complexes (UHCs).
- Staff nurses provided primary support for some maternal complications. For example:
  - For postpartum hemorrhage or retained placenta, they took blood for grouping and cross-matching, informed the patient's relatives about the necessity of donating blood, opened an IV channel, observed bleeding condition and called the doctor.
  - They shifted an eclampsia patient to a dark room, opened an IV channel, administered a mouth guard, inserted a catheter and airway tube, monitored patient's condition, and called the doctor.

In-service barriers for providing MNH care:

Most doctors or nurses were ignorant of the formal job description of a 'staff nurse'. Nurses reported facing some major constraints to providing MNH service in the hospitals:

- Staff nurses with additional emergency obstetric care (EmOC) training were not always assigned in labor wards.
- Nurses rarely got the chance to conduct delivery in the medical college hospitals due to high priority of trainee doctors.
- There is a severe shortage of nurses, particularly at primary level hospitals and in Sylhet district.

Barriers during the training period:

The majority of nurses did not learn how to conduct delivery or manage complication with hands-on training during their midwifery course. They developed midwifery skills mostly through on-the-job experiences, especially from primary level hospitals. The barriers during training reported by the student nurses were very similar to the staff nurses who passed from a nursing school ≥10 years earlier:

- **Lack of delivery practice:** Students affiliated in the tertiary level hospitals did not conduct the required 10-20 deliveries due to priority of internee doctors. As a result, if one student conducted a delivery, others in her batch filled up their own log-book. To overcome this problem, in Khulna students were sent to the secondary level district hospital for last two months of their midwifery course, and they could conduct required deliveries.
- **Inadequate duty in obstetric wards:** During the one year midwifery course, students are supposed to get practical training solely from obstetric wards. But in reality they were placed in other hospital wards leaving only 15 days to work in the obstetric wards.
- **Lack of proper linkage:** There was no active link between the nursing training centers (NTCs) and the training hospitals to ensure effective practical sessions. Moreover, no clinical instructor from NTCs was available to provide clinical guidance during practical sessions in hospital wards.
- **Teachers' efficiency:** There was an acute shortage of qualified teaching staff. Teachers without any formal training in obstetrics and gynaecology taught obstetric nursing classes and mostly failed to explain lessons properly. Teachers in the theoretical classes often did not follow the curriculum. There was no coordination between theoretical classes and practical sessions.

Conclusion and Recommendations:

The findings from this study provide useful insights into existing barriers of diploma in nursing and midwifery training. Very recently in 2011, the government of Bangladesh has changed the curricula to develop distinct cadres of 'nurses' and 'midwives'. In revised curricula, the 4-year diploma in nursing and midwifery has been changed to a 3- year 'Diploma in Nursing' and two new midwifery courses have been designed (under Health, Population, Nutrition Sector Development Programme, from 2011-2016). The following recommendations are made to address the identified barriers to ensure quality midwifery training that future nurses acquire midwifery skills adequately and are well utilized to achieve the MDG 4 and 5:

- A clear and specific job description and service guidelines based on internationally and nationally recognized standards of practice should be available for staff nurses so that they do not face these obstacles in performing their assigned responsibilities.
- EmOC trained nurses should be placed in the labour wards to utilize their skills.
- Proper links between the NTCs and affiliated hospitals should be developed to ensure students engage in practical sessions in real ward situations. Close monitoring by NTCs and the Bangladesh Nursing Council should be carried out on a regular basis.
- Trained teaching staff should be recruited for the NTCs, or after recruitment they should be adequately trained so that quality of training (classroom and practical) improves to contribute in MNH.

This Knowledge Translation brief was prepared by Parveen S; Quaiyum M A; Afroz A; Koblinsky M; Anwar I. It is based on the 'Role of Nurses in Maternal and Neonatal Health Care Programmes in Bangladesh' Project, being implemented by Centre for Reproductive Health of icddrb, Bangladesh. The study was funded by DFID. For more information, please contact Ms. Shahana Parveen, Research Investigator, Centre for Communicable Diseases (CCD), icddr,b, Mohakhali, Dhaka-1212, Bangladesh. Email: shahana@icddrb.org, Tel: 8860523-32 Ext. 2525, Cell:01819494749.

This is the product of a grant to icddr,b from the Maternal Health Task Force (MHTF) at EngenderHealth. The views expressed in this brief are not necessarily those of the MHTF and full responsibility for all contents remains with the author(s) of the Knowledge Translation Brief.