USAID
FROM THE AMERICAN PEOPLE

icddr,b

Research Brief
Adaptation of midwives in Upazila Health Complexes in Bangladesh

Background

Considering the acute shortage of trained manpower for quality maternal health care services,
in 2010, the Government of Bangladesh took the initiative to develop the midwifery cadre.

New midwife posts were created at Upazila Health Complexes (UHCs) and Union Sub-Centres, and by July 2023, total 2,557 midwives had been posted at these facilities. With the USAID funding support to the Research for Decision Makers (RDM) project, a study was to understand the current state of the midwives' adaptation to their workplace, related challenges, and intended changes in maternal and newborn health (MNH) care service provision following the introduction of the midwives in the health system and to suggest suitable strategies to effectively utilize them for the expected outcomes.

The quantitative component encompassed testing the midwives' knowledge via a self-administered questionnaire; documenting the activities performed by the midwives following their standard operating procedure (SOP) through direct observation; assessing the quality of care (QoC) for pregnancy and delivery care through observation using the contextualized Standards-Based Monitoring and Recognition (SBM-R) tool; and conducting a semi-structured interview of the midwives to understand their roles, responsibilities, and level of coordination with the other cadres as well as the barriers and challenges to performing their tasks.

The qualitative component covered key informant and in-depth interviews of policymakers, program managers, facility heads, and trainers of the training institutes to understand the midwives' adaptation challenges in their workplace in performing their responsibilities; the limitations (if any) in the midwives' training in different types (public and private) of training institutes; and suggestions to overcome the challenges.

Methodology

An exploratory study was conducted from January 2022 to March 2023 in 24 UHCs where four midwives had been deployed for at least the previous year. Three UHCs were selected from eight districts, i.e., one from each of the eight administrative divisions of the country. A mixed method study design was employed using both quantitative and qualitative research methods.

Key findings:

• From the knowledge test for MNH care services, the midwives scored 80% or above on antenatal care (ANC), partograph use, and newborn care. However, for delivery, complication management, postpartum hemorrhage management, and family planning (FP) services, they scored 65%–77%.

• Regarding confidence in managing MNH complications, only 17% of the midwives (n=80) said they were confident, and the rest stated that they lacked confidence. The midwives also mentioned that within last three months, they usually needed the help of doctors and nurses for managing complications.

• Surprisingly, only 50% of the midwives had heard of their SOP; moreover, only 33% had read it, 10% could show a copy of it, and 5% had an orientation on it.

• Although the majority of the midwives said that they had seen a job responsibility document (85%), had a clear understanding of their job responsibilities (73%), and had an orientation on their job responsibilities (56%); only 20% could show their job responsibility document.

• The main reasons identified for this lack of knowledge on their SOP and job responsibilities were:

- ✓ no separate job responsibility training module for the midwives upon their initial training, as this was developed later;
- ✓ SOP was not initially included in the diploma curriculum;
- ✓ SOP written in English was difficult to understand by the midwives and thus were reluctant to read it;
- ✓ lack of trainers with a midwifery background.

• Our qualitative findings revealed that the midwives were not allowed to prescribe common drugs and advise on diagnostics during ANC, normal vaginal delivery (NVD), and postnatal care (PNC) services

• For referral of pregnant/labor patients with complications, midwives had to obtain a doctor's consent, which often caused a delay in providing care of referring a patient.

• From the facility observation, we identified that

- ✓ ANC, 53% of the midwives' assigned tasks were performed by them independently.
- ✓ However, for intrapartum care, only 31% of the tasks were performed independently at in-patient and labor room facilities,
- ✓ For PNC, 41% of the tasks were performed independently in outdoor settings.

• According to the midwives' report, they had good coordination with medical officers, Upazila Health & Family Planning Officers, and nurses but faced challenges in maintaining good coordination with consultants (obstetrics and gynecology [Obs/Gyne]), nursing supervisors, and support staff.

• The QoC assessment revealed that in 57% of the UHCs, the QoC for ANC provided by the midwives scored below 50%, though for NVD, 71% of the UHCs scored 75% or above.

• Our qualitative component reported that there were major gaps in supervision and mentoring of the midwives due to lack of supervisors with a midwifery background and no supportive supervision for the midwives due to unavailability of consultants (Obs/Gyne) in most of the UHCs.

• According to the midwives' report, in the midwifery diploma course, though most of the theoretical modules were completed, there were gaps in the practical modules. In addition, the midwives suggested a need to include new topics in both theoretical and practical modules.

• When the midwives and in-depth interview participants were asked about the barriers and challenges in the midwives' adaptation at the facility level, the key responses were:

- ✓ four midwives alone inadequate to ensure 24/7 maternity services;
- ✓ unavailability/irregularity of consultants (Obs/Gyne) at facilities;
- ✓ gaps in the orientation of midwives and their supervisors on SOP;
- ✓ lack of supportive supervision of midwives;
- ✓ no dedicated support staff (aya, cleaner, security guard) for labor room and maternity units;
- ✓ lack of facility readiness (infrastructure, equipment, logistics, etc.) to provide MNH care services; and no allocation of hospital quarters/dormitories for midwives.

• According to the key informant interviews, the key challenges and barriers faced at the central level for the implementation of the midwifery program were:

- ✓ insufficient manpower at the Directorate General of Nursing and Midwifery (DGNM) to effectively manage administrative activities
- ✓ frequent change/transfer of high officials causing delay in administrative activities.

Recommendations

Based on the findings the study, the program and policy level recommendations as follows:

Program level recommendations:

- ✓ Refresher training for midwives on their job responsibilities and SOP using the Bangla module should be initiated immediately
- ✓ An enabling environment should be created for midwives by addressing the gaps in dedicated support staff, equipment, and logistics to perform their tasks by maintaining quality
- ✓ At the facility level, all vacant Obs/Gyne consultant posts should be filled and their availability ensured for supportive supervision of the midwives.
- ✓ To improve the midwives' confidence level and coordination with other cadres for delivering quality MNH care services, a related guideline should be developed and implemented.
- ✓ A thorough assessment of the midwifery diploma course curriculum and its implementation process should be initiated covering both public and private institutes

Policy level recommendations:

- ✓ In each UHC, an additional four midwives should be posted for 24/7 smooth operation of midwifery services.
- ✓ Midwives should be allowed to perform their job responsibilities as per their SOP, including prescribing medicine, advising on diagnostic tests, and referring patients.
- ✓ The DGNM's capacity should be enhanced by providing additional directors and officers with a longer duration of stay for smooth operation of administrative activities.

68, Shaheed Tajuddin Ahmed Sarani Mohakhali, Dhaka 1212, Bangladesh
Phone: +880 (0)2-982-7001 to 10 | **Fax:** (+88 02) 9827075, 9827077
web: rdm.icddrb.org