Strengthening Maternal Care: The Evolution of Midwives in Upazila Health Complexes in Bangladesh

Background

Given the significant shortage of trained personnel to provide quality maternal healthcare services, the Government of Bangladesh initiated the development of the midwifery cadre in 2010. New midwife posts were created at Upazila Health Complexes (UHCs) and Union Sub-Centers (USCs), and by July 2023, a total of 2,547 midwives had been posted at 411 UHCs (4/facility) and 903 USCs (1/facility). The Research for Decision Makers (RDM) project, supported by the United States Agency for International Development (USAID), conducted a study to assess the current state of midwives' adaptation to their workplace, identify related challenges, and anticipate changes in maternal and newborn health (MNH) care service provision following the integration of midwives into the health system. The study aimed to propose effective strategies for maximizing midwives' impact and achieving desired outcomes.

Adobe Stock Image

Methodology

An exploratory study was conducted from January 2022 to March 2023 in 24 UHCs. From each of the eight administrative divisions of the country, one district was selected based on the maturity of the midwifery program, and from each selected district, three UHCs were selected where four midwives had been deployed for at least one year. A mixed methods study was employed, using both quantitative and qualitative research methods.

The quantitative component encompassed several tasks: implementing a self-administered questionnaire to assess the midwives' knowledge; documenting the activities performed by the midwives following their standard operating procedure (SOP) through direct observation (Table 1); 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 semi-structured interviews with the midwives to gain insight into their roles, responsibilities, level of coordination with other cadres, and the barriers and challenges they face in performing their tasks.

Table 1: Assessment components for observing antenatal care (ANC) and normal vaginal delivery (NVD) care: key areas

Antenatal Care	Normal Vaginal Delivery
• Receiving the pregnant woman • Preparatory activities • History taking • Physical examination • Care based on findings • Advising on birth planning • Scheduling revisits	• Rapid initial assessment • Explanation of services • History taking • Clinical procedures • Assisting woman for safe birth • Immediate postpartum care • Monitoring mother and baby • Disposing of waste

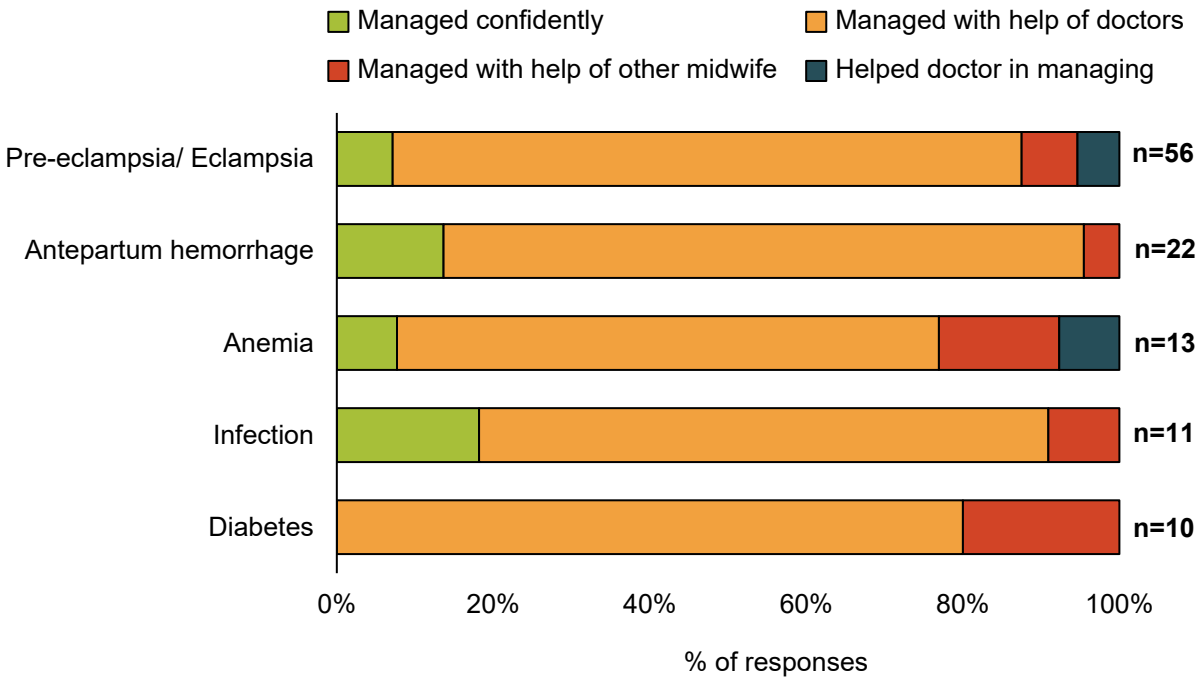
The qualitative component included key informant interviews and in-depth interviews with policy makers, program managers, facility heads, and trainers of the training institutes. These interviews aimed to explore the challenges midwives face in adapting to their workplace and fulfilling their responsibilities, assess any limitations in the midwives' training across various types of training institutes (public and private), and gather suggestions to overcome these challenges.

Key Findings

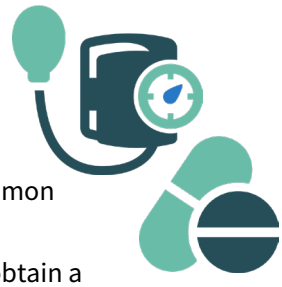
The key findings of the study are as follows:

- From the self-administered questionnaire to assess midwives' knowledge of MNH care services, the midwives scored 80% or above on ANC, partograph use, and newborn care. However, for delivery, complication management, postpartum hemorrhage management, and family planning (FP) services, they scored 65%–77%.
- Regarding midwives' confidence in managing different MNH complications, among the 80 midwives interviewed in this study, only 17% reported feeling confident, while the rest (83%) stated that they lacked confidence. For example, for ANC, when the midwives were asked about the number and type of complications, they had managed within the last three months and whether they managed the complications confidently, only a small proportion (<20%) mentioned managing complications confidently, while the majority mentioned requiring assistance from doctors and other midwives (Figure 1).

Figure 1: Midwives' confidence in managing antenatal complications



- Surprisingly, only 50% of the midwives had heard of the MNH SOP; moreover, only 33% had read it, 10% could show a copy of it, and 5% had had an orientation on it.
- While the majority of the midwives reported having seen a job responsibility document (85%), having a clear understanding of their job responsibilities (73%), and receiving an orientation on their job responsibilities (56%), only 20% were able to present their job responsibility document when asked.
- The main reasons identified for the lack of knowledge on the MNH SOP and job responsibilities were:
  - Absence of a separate job responsibility training module for midwives during their initial training, as this module was developed later.
  - SOP was not initially included in the diploma curriculum.
  - SOP was written in English and was difficult for the midwives to understand.
  - Shortage of trainers with a midwifery background.



- The qualitative findings revealed that the midwives were not allowed to prescribe common drugs and advise on diagnostics during ANC, NVD, and postnatal care (PNC) services.
- For the referral of pregnant or laboring patients with complications, midwives had to obtain a doctor's consent, which often caused a delay in referring patients.
- The register book is not formatted based on service providers' type to document service statistics, and in some facilities, only the providers' names are recorded.
- In order to assess services provided by the midwives as compared to the other cadres, while extracting data from the facility registers, it has been found that among the 24 facilities studied, service data for midwives could be separated from 20 (83%), 23 (96%), 12 (50%), and 10 (42%) facilities (%) for ANC, NVD, PNC and newborn care respectively.
- Facilities from which data could be separated by provider type showed significantly higher average monthly service numbers by midwives compared to other cadres for each of the following: ANC (290 vs. 6), normal delivery (40 vs. 9), PNC (64 vs. 3), and newborn care (45 vs. 3).
- The register lacked provisions for recording services such as sexual and reproductive health and rights, health education, and FP counseling, which midwives are supposed to provide based on their job responsibilities.
- From the facility observation, we identified that:
  - For ANC, only 53% of midwives who were assigned tasks performed them independently.
  - For intrapartum care, only 31% of the tasks were performed independently by the midwives at inpatient and labor room facilities.
  - For PNC, only 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 [OB/GYN], 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.

- The qualitative component revealed major gaps in the supervision and mentoring of midwives. These gaps were due to a lack of supervisors with a midwifery background and the absence of supportive supervision for midwives due to the unavailability of consultants (Obs/Gyn) in most of the UHCs.
- Midwives reported that while most of the theoretical modules were completed, there were gaps in the practical modules in the midwifery diploma course. In addition, the midwives suggested the 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 to the midwives' adaptation at the facility level, key responses included:
  - Four midwives per UHC are inadequate to ensure 24/7 maternity services.
  - Unavailability/irregularity of consultants (Obs/Gyn) at facilities.
  - Gaps in the orientation of the midwives and their supervisors on SOP.
  - Lack of supportive supervision for the midwives.
  - No dedicated support staff (e.g., *aya* [female attendant], cleaner, security guard) for labor rooms and maternity units.
  - Lack of facility readiness (e.g., infrastructure, equipment, logistics, etc.) to provide MNH care services and no allocation of hospital quarters or 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 staff at the Directorate General of Nursing and Midwifery (DGNM) to effectively manage administrative activities.
  - Frequent changes or transfers of high officials cause delays in administrative activities.

Recommendations

Based on the study findings, program and policy level recommendations are 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 enable them to perform their tasks and maintain QoC.
- At the facility level, all vacant OB/GYN consultant posts should be filled, and their availability should be 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, four additional midwives should be posted 24/7 for the 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.
- There is a need to redesign the facility service register to accommodate all the services for which midwives are responsible, along with provisions to distinguish the services provided by the midwives.
- The DGNM's capacity should be enhanced by providing additional directors and officers with a longer duration of stay in the directorate for the smooth operation of administrative activities.

Contributors

Mahbub Elahi Chowdhury, Scientist, icddr,b

Anadil Alam, Assistant Scientist, icddr,b

Aklima Chowdhury, Sr. Field Research officer, icddr,b

Hosne Ara Beena, Project Research Physician, icddr,b

Md. Mahbubur Rahman, Research Intern, icddr,b

Shafayatul Islam Shiblee, Statistical Officer, icddr,b

Acknowledgments

We acknowledge the contribution of the DGNM for supporting us by providing relevant information and documents for planning the study.

We are thankful to the Directorate General of Health Services (DGHS) for providing all the support needed for conducting this study in DGHS facilities.

Suggested Citation

Chowdhury M.E., Alam A., Chowdhury A., Beena H.A., Rahman M., Islam S. (2024). Research Brief: Adaptation of midwives in Upazila Health Complexes in Bangladesh. Chapel Hill, NC, USA: Data for Impact.

For more information

D4I supports countries to realize the power of data as actionable evidence that can improve programs, policies, and—ultimately—health outcomes. We strengthen the technical and organizational capacity of local partners to collect, analyze, and use data to support sustainable development. For more information, visit https://www.data4impactproject.org/

This article was produced with the support of the United States Agency for International Development (USAID) under the terms of USAID's Research for Decision Makers (RDM) Activity cooperative agreement no. AID-388-A-17-00006 and of Data for Impact (D4I) associate award no. 7200AA18LA00008. Views expressed herein do not necessarily reflect the views of the U.S. Government or USAID. FS-24-700