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Accountability in the development of midwifery in Bangladesh

UNFPA BANGLADESH

INCREASING women's access to quality midwifery services has become a focus of global efforts to realize the right of every woman to the best possible health care during pregnancy and childbirth and in the period after birth. The scope of practice of a midwife is the management of the normal physiological processes of pregnancy, labour, birth and postpartum period up to six weeks, including care of the newborn. During this time the midwife works with the pregnant woman and her family, providing highly skilled midwifery and women-centered care. The midwife as autonomous practitioner is responsible and accountable for her practice.

In Bangladesh about 194 women die per 100.000 live births due to causes related to pregnancy, childbirth and in post-partum period (Source: Bangladesh Maternal Mortality Survey BMMS 2010). Till now, the number of women giving birth at home by unskilled personnel is about 68% (Source: BMMS 2010). Midwives are considered to be the key professionals for providing skilled care for maternal health. The Government of Bangladesh has already started to educate midwives, and political leaders are committed to reduce maternal and newborn mortality and morbidity.

MYCCWIKISPACES

The development of the midwifery profession gained momentum after the Prime Minister's speech at the General Assembly of the UN in 2010 where she committed to the development and deployment of 3000 midwives by 2015 and 7000 in a few more years.

Midwives will provide services in Upazilla health complexes 24 hours 7 days a week as soon as their posts have been created. In case any complication arises, midwives will refer mothers to hospital to receive emergency services from obstetricians and other specialists, and newborns with problems will be referred to pediatricians when required.

So far, 710 midwives have been educated. Two pathways to increase the number of midwives have been developed: (a) "skill-up"of existing nurse-midwives, and (b) scaling-up by the three year direct-entry Diploma in Midwifery programme.

The Certificate in Midwifery programme, a short-term solution (skill-up) was developed jointly by the Bangladesh Nursing and Midwifery Council (BNMC), the Directorate of Nursing Services, the Directorate General of Health Services, the Obstetrical and Gynecological Society of Bangladesh (OGSB), WHO and UNFPA and commenced as a pilot project in three selected training sites in 2010. Existing nurse-midwives from the public and now also from the private sector with 2 years of working experience, aged below 45 are admitted to the training. There are 20 training centers to educate Certified Midwives all over the country.

The three-year direct entry Diploma in Midwifery education, the long-term solution (scale-up), was developed in 2012 and commenced in December 2012 with 525 students in 20 training sites. The next batch will start in December 2013.

Existing faculty are mainly senior staff nurses. The nursing colleges and institutions lack posts for nursing or midwifery instructors and nursing and midwifery lecturers. UNFPA is supporting the educational sites with training equipment.

There are several levels of accountability in regard to midwifery in Bangladesh.

Generally, accountability is the process whereby public service organizations and individuals within them are held responsible for their decisions and actions, including their stewardship of public funds, fairness, and all aspects of performance, in accordance with agreed rules and standards, and fair and accurate reporting on performance results vis-à-vis mandated roles and/or plans.

UNFPA and WHO are supporting the Government of Bangladesh to plan, implement, monitor and evaluate the midwifery programme. Regarding accountability, UNFPA has established mechanisms within the organization and in all their operations and in external partnerships. UNFPA is accountable to their donors and has to ensure that funds are used to achieve development results.

The Directorate General of Health Services oversees the midwifery programme, the Bangladesh Nursing and Midwifery Council (BNMC) is responsible to ensure quality in education and the Directorate of Nursing Services overlooks the placement of midwives. Those who are in charge of the Midwifery programme, their activities and guidance are held accountable for efficient and effective management.

Though the Bangladesh Government showed their commitment to educate midwives, so far, 710 certified midwives have been trained, the creation of the posts has not yet been done. If the posts are not created, already trained midwives will not be able to work in their field of expertise, lose their competencies and mothers and children in Bangladesh will be deprived from their right to have a safe delivery.

A midwifery act, professional rules and regulations are under development and coordinated by the BNMC. Regulations will define the scope of practice of the midwife as an autonomous professional but will also provide a code of conduct and ethics for the profession and a mechanism for complaints and discipline. In other words: the midwife receives a framework in which she will be able to offer services but at the same time she is accountable for her actions.

Finally, midwives themselves are accountable to ensure safe pregnancies and deliveries, provide quality services to their client, the pregnant woman, the women in labour or the mother and child in the post-partum period. This is based on the right of every women to be accompanied by a competent midwife.

Saving the lives of mothers and newborns through quality services of midwives, will benefit the society in human and economic development. Quality midwifery services that are coordinated and integrated within communities and are being integrated in a supportive health system will ensure that a continuum of essential care can be provided throughout pregnancy, birth and beyond.

Myths and fears

FAARIA TASIN

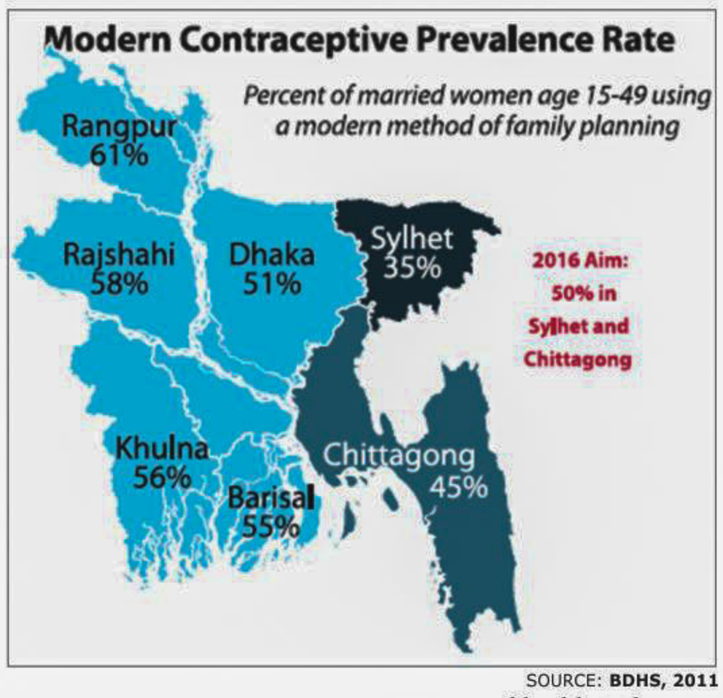
UNIVERSAL access to reproductive health (RH) is one of the sub-targets for the Millennium Development Goal number five which is to improve maternal health. One of the major barriers to improve the universal access to reproductive health is myths and fears associated with RH.

In rural areas of Bangladesh, there is prevalence of local knowledge about RH that differs significantly from the medical/scientific school of thought. For instance, there is a certain belief regarding menstruation that a woman should not visit specific places or avoid certain foods during that time. These ideas deriving mainly from the elderly members of the population, can present challenges to girls beginning their menstrual cycles. As a result, girls are kept in the dark about proper medical knowledge and are stopped from reaping the benefits of modern medical innovations.

A more common fear regarding RH is the stigma associated with HIV/AIDS. In Bangladesh the concept of HIV/AIDS usually carries a negative connotation with it and anyone suffering from the disease is looked upon with a sense of skepticism. In addition, misinformation regarding prevention and spread of HIV/AIDS is rampant. These two factors coupled together stop many men and women from accessing medical support as they are afraid to get tested or admit positive results for fear of stigmatization. Due to this, statistical data on those living with HIV/AIDS is not accurate and is likely to be an underestimation.

Another socially-created anxiety is that surrounding the exposure to sex education in Bangladesh. There is a popular belief that sex education and exposure to sex-education materials will lead to more adolescent sexual activity. This puts many to risk as they are kept in the dark regarding many STDs and their preventions leading to greater health hazards. Moreover, many people can shy away from seeking medical support upon contraction of STDs due to the stigma attached to that.

Another problem is that many men and women withdraw from consulting with nurses or doctors of the opposite sex. For instance, a male patient often finds it uncomfortable to openly discuss his problems relating to RH with female doctors or nurses. Conversely, a female patient feels reserved to talk about her problems with health providers of the opposite sex. This inhibition serves as a barrier for many from attaining RH support.



SOURCE: **BDHS, 2011**

In order for RH programs and policies to be effective, it is important that these policies take into account the role of religious attitudes in Bangladesh. A considerable degree of RH organizations received favorable cooperation from community religious leaders. However, when it came to topics of intimacy between unmarried people, these leaders refused to cooperate. This leaves a certain section of people outside the circle of RH services.

An interesting point to note is that Sylhet and Chittagong need the highest priority when it comes to reproductive health services. Modern contraceptive prevalence rate is the lowest and the rate of unmet need for family planning is the highest in these two divisions. It should be pointed out that Sylhet and Chittagong also have the lowest secondary school enrolment rates, implying they are lagging behind in education compared to other divisions. Lack of education can be one of the reasons why awareness about RH is low in those divisions.

Access to proper RH is crucial as it not only ensures good health to the parents but also to the children. Attention must be given in order to eradicate the barriers in order to improve access to RH in Bangladesh otherwise Millennium Development Goal number five 'Improving maternal mortality' would not be attained.

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"Be attentive to the adolescents"

Renowned population expert ***Professor Dr. A K M Nurunnabi*** *talked to* ***A.B.M Shamsud Doza*** *of* ***The Daily Star*** *on the present situation of universal access to reproductive health in Bangladesh.*

The Daily Star (TDS): What is the present status of universal access to reproductive health in Bangladesh?

A.K.M Nurunnabi (AKN): Universal access to reproductive health has improved a lot. Contraceptive prevalence has been improved and the current rate is 61%. That is quite an achievement. You can call Bangladesh a contraceptive society.

Having said that, we should also be aware of the drop out rate. In the last demographic health survey, we found that more than 50% of the users dropped the usage of methods in a year, which has reduced to 36%, according to BDHS 2011. That is an improvement, but 36% is also a very high number in terms of dropout of contraceptive method.

If we look at the total fertility rate, it is almost near replacement level. So, that is an achievement. But there are also gaps in terms of hard-to-reach areas, poor people, uneducated people, people living in slums. They have little access to reproductive health facilities. Their conception rate is low and TFR is very high.

Proper antenatal care needs four visits to complete a safe delivery process for a childbirth. But we find very few women go to the experts or the health clinic or any trained personnel to complete the four visits. Therefore, rate of antenatal care is very low. Postnatal care is also not that high in proportion, because we see that neonatal mortality is very high compared to the mortality under five and compared to the other mortality rates.

We have health infrastructures like community clinics, Union centres and centres, Upazilla health centers, and clinics where one can obtain reproductive health care services. But these are far from adequacate. These infrastructures lack facilities, services, trained personnel and awareness about accessing those facilities.

If you look at the unmet need for family planning, it is still 12% in Bangladesh. If we can meet that 12%, right now, the total fertility rate will come down to 1.8, which would reduce the population significantly.

If we can do that, especially for those who are less educated, ultra poor, living in chars and slum areas it will be a great achievement. The family size of these people is big and the complicacy related to reproductive health, i.e. maternal mortality rate, is higher than that of the educated and urban people.

In the urban areas, we do not have a concerted effort for reproductive health from the government side, although there are efforts from the non-government side through donor agencies. City corporations are conducting those programmes. However, that is not enough. Our urbanisation rate is growing so rapidly. There are 33-35% of people living in the urban area now. City corporation authorities do not have enough capacity to handle the situation there. So there are achievements as well as shortcomings.

Although in terms of overall mortality -- maternal mortality and child mortality -- we are progressing and have received UN award. We may receive another award for reducing maternal mortality.

We are lagging behind in terms of neonatal mortality, which happens due to the complicacy arising out of reproductive health problems, especially for the mothers who are under 18. This is a serious concern for Bangladesh. Our legal age of marriage is 18, but the girls are getting married at 15.6 years on average according to BDHS, 2011. It is child marriage. Child marriage is occurring for 66% girls in Bangladesh. Even if we have success, we cannot sustain that success because of this child marriage and early child bearing. This problem is further exacerbated by limited access of adolescent girls and mothers to reproductive health. 35% of the girls are becoming mothers by 19 years of age. So, with an immature reproductive system, a child is being forced to become a mother of a child. So, the health of mother and child are at risk, and both suffer from malnutrition and reproductive health complications.

TDS: On the whole, adolescents do not have that much access to universal reproductive health services. Why is it so? What should the government do to reach them?

AKN: The problem is with our perception about adolescents. They are regarded neither as adult nor as child. They are in no man's land situation, and the major changes that go through the body and mind of a person is at that age. In health facilities, we do not have adolescent friendly environment. Although the government is trying to focus on this, but when you visit a hospital or a clinic, you do not see a place, a room, or any facility that is only meant for the adolescents. It is because of the perception of the society as well as the lack of communication between the adolescents and the social network. They cannot express themselves to their parents or teachers; the only place they can express their needs and other queries is to their peers. Peers are also of their age, they do not have the knowledge to substantiate the catering of the need of adolescents. We need to be very careful as well as attentive regarding this issue.

If we become attentive to the adolescent group, then the population rate of Bangladesh would be reduced drastically. For example, the adolescent fertility rate in Bangladesh is one of the highest in the world, 124/1000, which is not desirable. Adolescents are one fourth of the people of our country and they are not being addressed very seriously. So be attentive to the adolescents

TDS: What are the priority areas that we should emphasise on?

AKN: We should priorities on: (i) family planning; (ii) emergency obstructive care, (iii) maternal care and childcare, and (iv) provision of services.

We have enough policies in this nation; we need implementation and execution.

Both the government and NGOs should be attentive to urban health situation, not only the reproductive health but also the overall health situation. Dhaka is a mega city. Almost 38-40% people are living in slums of this mega city. Poor slum dwellers do not have access to reproductive health services. We should be particularly attentive to their need.

'Disadvantaged people,' it may be adibashis, small minority group in terms of region, in terms of profession, in terms of anthropological identification, should be prioritised and brought in the forefront.