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Nursing in Bangladesh: Rhetoric and reality

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Abstract

In the past decade concern has been raised through independent channels that nurses in Bangladesh do not provide active hands on care directly to patients as envisioned when the British nursing model was first introduced decades ago. The objective of the study was to observe the activities nurses engaged in during their working hours on major medical and surgical wards. A total of 24,587 min of nursing activities were recorded by three observers in 18 hospitals between the hours of 05.00 and 23.00 h over a 3 month period. These were compared with reports of the nurses about their activities, and indirectly with the activities outlined in the nursing curriculum. Nurses in government hospitals spent only 5.3% of their working time in direct contact with their patients. Paperwork and indirect patient care occupied nurses for 32.4% of their time while 50.1% fell under the category of unproductive time such as time away from the ward and chatting with other nurses. Hospital support workers and patients' relatives acted as nurse surrogates. When asked how they spent their day, nurses reported what the curriculum specifies but not what was observed. As a consequence policy decisions have not consistently reflected this reality. By contrast, nurses in the hospitals outside the government system were found to spend 22.7% directly with patients. A deeper understanding of nurse's behaviour on the wards is required to determine the desired role of the nurse that will, in turn, feed into nursing policy and decisions related to resource allocation.

Keywords: Bangladesh; Time-use; Nurses; Government hospitals

Introduction

Half a century after the introduction of British-style nursing into Bangladesh in 1947, the original care model appears to be in jeopardy. The curriculum still adheres to the Florence Nightingale model which emphasizes basic nursing care of patients as the primary activity (Coates, 1960) but some experts question whether patient care and contact occur (Chowdhury, 2002). Adaptations to this model have occurred in Britain, as elsewhere, such as the introduction of new cadres of nurses attached to primary health care programmes, patient allocation approaches, and a move away from using learner nurses as extra manpower. These changes responded to the global emphasis on Primary Health Care and client needs as well as to the new technologies introduced into the hospital ward. However, caring and touch have remained axiomatic with nursing (Chang, 2001). The structural changes have not taken place in Bangladesh where almost all nurses are still attached to

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hospitals practising a task-oriented style nursing, student nurses are employed on the wards for most of their learning time (Harun & Banu, 1996), and technology has remained unchanged. Despite this, English remains the official language of nursing schools and hospitals.

In spite of the stability in duties and hospital setting, nursing activities in Bangladesh appear to have evolved, but in a way that may not have been planned or foreseen. While a situation analysis of nurses activities conducted in 1986 reported nurses spending 46% of time on basic nursing care activities (Harun et al., 1989), these findings are not consistent with other reports, which unanimously conclude that nurses are not active in 'hands on' nursing care (Chowdhury, 2002; Gosker, 1998; Wahab, 2000). The former Deputy Minister for Gender Issues and Nursing of the Ministry of Health in Bangladesh conducted a systematic tour of hospitals to review the nursing situation. He concluded that 'In most cases the general view is the nurses do not nurse' (Chowdhury, 2002). To determine whether this was indeed the case, we conducted a systematic observation of nursing activities in government hospitals and non-government ones.

Current information on nursing activities in Bangladesh is based on somewhat biased or unsystematic reports. When nurses observed their counterparts for two hours during the busy morning shift, they found that 46% of the time was spent in nursing care (Harun & Banu, 1989). Yet in a later study, reports from ward nurses concluded that 13% of nurses' time was spent on nursing care during the morning shift (Anderson, 1996). The latter figure, if correct, raises questions about the direction of nursing in a country where morbidity is high and patient satisfaction low (Mendoza Aldana, Piechulek, & al-Sabir, 2001; Zaman, 2004). Observational studies from other developing countries, such as Nigeria and India, find considerably more time spent in direct patient care (Archibong, 1999; Ukanda, Sharma, & Saini, 1999). In South Africa's Kwa-Zulu-Natal state, the most frequently observed tasks were taking blood pressure, interpreting for the doctor, recording, taking vital signs, and taking a history from the patient (Uys, Groenewald, & Mbambo, 2003). These were also the most common tasks of primary care nurses in rural Cameroonian health centres, with the additional tasks of prescribing treatment (27% of the time) and explaining illness to patients (12%) (Isely, 1980). The preferred methodology is direct observation of nursing activities in what is known as time-motion studies, though they may be supplemented with additional data from other sources such as self-reports and non-nurse informants (Bratt et al., 1999; Burke et al., 2000). Consequently, this multi-method Bangladeshi study was conducted to observe nurses' activities in different hospitals and compare these with activities reported by nurses and those specified by the curriculum.

With 99% of nurses in Bangladesh employed in hospitals (Hadley & Thanki, 2002), it was important to capture their activities in the four common types of hospitals: the teaching hospitals at tertiary level to which student nurses are attached; district hospitals, acting as second level referral hospitals; hospitals providing specialist services and the primary level facilities. The patient load in the different levels of hospital varied with tertiary level hospitals admitting 40–100 patients per ward and secondary referral hospitals seldom admitting as many as 50 to a ward. The 31 bed primary level facilities had low occupancy rates, and specialist hospitals varied in their patient loads. In addition to government hospitals, there exist non-governmental and private-run hospitals. As these function separately and perhaps differently from government hospitals, they were included in the sample and compared with the former.

The nursing curriculum provided a source of activities we might expect to observe on hospital wards. Although the curriculum was revised in 1993, with a much stronger community focus, and a strong emphasis on preventive and psychological care, these changes had largely not been implemented. The 3-year course resembles the 'learn-as-you-work' approach to basic nurse training inherited from Britain (The General Nursing Council for England and Wales, 1952). Over 350 activities are included in the training such as general and disease specific physical management, psychological care, monitoring, diagnostic procedures and infection control (Bangladesh Nursing Council, 1993). It was therefore possible to compare observed activities with those detailed in the nursing curriculum.

Three categories of nurses were observed: the student (at tertiary level only), the Senior Staff nurses and the Ward in Charge. While the Senior Staff Nurse is now the only cadre still being trained, for each ward a nurse is required to act as Ward in