Facilitating learning for auxiliary nurse midwives around maternal mental health in Southern Nepal.

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2021

Case report

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Cite this paper as:

Ireland, J., Havelock, D., Lawrie, A., Ghimire, S., (2021) Facilitating Learning for Auxiliary Nurse Midwives around Maternal Mental Health in Southern Nepal, *JMAN Journal of the Midwifery Association of Nepal*, **2**(1): 105-108.

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ABSTRACT

Mental health, in particular maternal mental health, has been low on the global agenda until relatively recently. Consequently, it has not featured much in Nepal on the curriculum for maternity care workers.

Auxiliary Nurse Midwives are key maternity care providers in rural Nepal. They are sources of information and potential agents for change in their communities. To increase awareness of maternal mental health, training was designed by Nepali and UK experts. Training was run by UK-based volunteers (some ex-pat Nepalis) with Nepali interpreters - all health care and/or education professionals. This paper describes the planning and a reflexive and responsive approach to workshops based on the needs of participants.

Keywords: *Community; Depression; Education; Maternity; Stigma*

INTRODUCTION

Auxiliary Nurse Midwives (ANMs) are key maternity care providers in rural Nepal. They receive 18 months' training which includes little on maternal mental health issues. Although mental health is an important issue in maternity care, this has not been widely recognised in low-income countries such as Nepal.

Any intervention to improve knowledge about maternal mental ill health must begin with local awareness-building and reducing stigma. Suicide among women in Nepal (20 per 100 000) is estimated to be the 3rd-highest rate in women in the world.[1.] However the true number is unknown owing to the absence of reliable national statistics. It has been estimated that 16% of all maternal deaths were attributed to indirect causes such as homicide.[1] Mental illness is often

stigmatised in a country that has fewer than two psychiatrists per million people and even fewer psychologists. Mental health services are limited to a few hospitals in larger cities.

To begin to fill the gap in ANM training, a team from Nepal's Tribhuvan University and Bournemouth University and Liverpool John Moores University in the United Kingdom (UK) collaborated in 2015-17. Funded by the Tropical Health & Education Trust (THET), the team focused on basic training needs of around 80 ANMs.

In addition to delivering an innovative training programme, the team recognised the importance of designing a curriculum for future use. With logistical support from the charity Green Tara Nepal, training took place in classroom settings in Nawalparasi. Each programme was delivered three times by the volunteers so that the local health posts were able to remain staffed, releasing ANMs on different days. This paper outlines the contribution and experiences of three UK health professionals. They were the third team (of six) to travel to Nepal.

Training was co-designed by UK – based Nepali staff using the results of a needs assessment done as part of the first round of workshops.[2] Having Nepali team members helped ensure the cultural competency of the intervention. UK volunteers brought experience in mental health education/practice and a commitment to cultural competence. Volunteers had gathered from the literature and the ANMs that: (1) time with service users was short; and (2) that mothers-in-law usually control attendance and accompany women. The team had knowledge of Kolb's learning styles[3] and chose a range of teaching and learning methods to reach all learners: (1) practical exercises; (2) lecture; (3) reflective narrative approach and (4) Participant-led practical exercise: forum theatre.

Overview

Training focused on six-related issues:

1. Everyone can experience poor mental health at any period in their lives

2. Poor mental health and suicide is a global issue

3. Pregnancy, childbirth and parenthood can exacerbate poor mental health and can have severe consequences

4. ANMs are role models and are best placed to minimise stress and anxiety in women

5. ANMs can minimise their own stress by taking time for themselves to relax and support each other

6. This in turn, can lead to them being more compassionate to women, listen and build trusting relationships where women feel safe to share feelings and prevent anxiety and stress.

1. PRACTICAL EXERCISES

(i) The Five Aspect model[4] (Figure 1) is a psycho-social model which aligns with the midwifery/social model of childbirth.[5] Its simplicity helps to make problems seem less overwhelming and allows practitioners to apply such problem solving in their own lives.

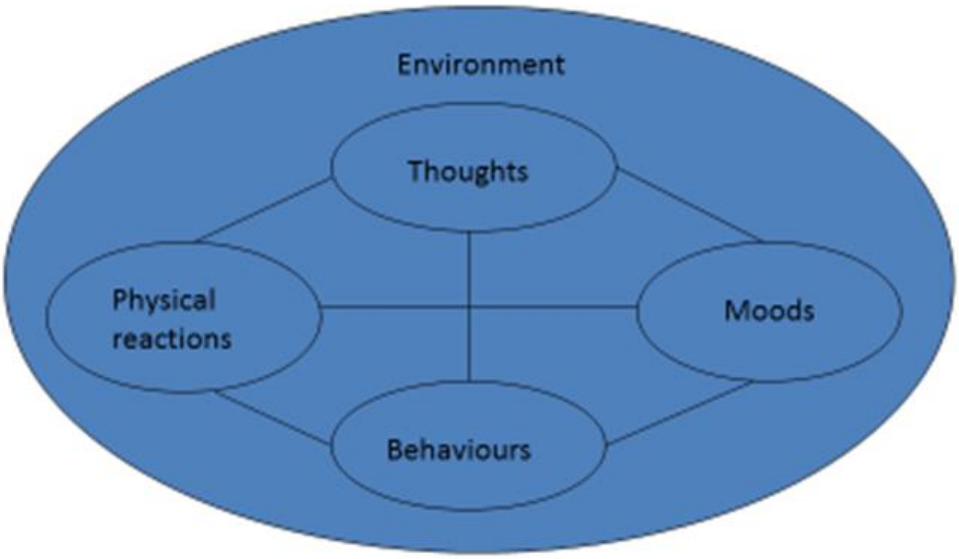

Figure 1 The Five Aspects Model[3]

Photograph 1 Sampada Translating During Session

Photograph 2 ANM Holding Buttons

(ii) Using a selection of buttons, the ANMs were asked to select buttons and build up a progressively larger representation of the supporting people and resources in their lives. This is also the subject of a separate paper.[6]

2. TRADITIONAL LECTURE

Presenting a lecture using slides required planning around the timing of electricity supply. In UK practice, clinical guidelines recommend using the two Whooley questions (see Box 2) for 'case finding' of depression.[7] Routinely asking these questions may help reduce stigma. ANMs discussed how they may find opportunities to ask these questions without a mother-in-law or partner present.

The Whooley questions are a starting point - a 'no' to both questions helps to rule out major depression, but it will not pick up major anxiety disorders. This opened a discussion about how

ANMs can ask questions about mental wellbeing and was practised during the Forum Theatre activity.

3. REFLECTIVE NARRATIVE APPROACH

One of the facilitators (AL) recalled her own experiences of interactions with maternity staff when she was pregnant (before she had become a midwife). She shared how attitudes and approaches of some staff had provoked anxiety in her because it had undermined her self-confidence. Others had built trusting and empowering relationships by showing her compassion. This allowed her to share her anxieties. This had lessened her fears and helped her to feel in control. This simple message was powerful and encouraged a lot of comments from participants, several of whom clearly want to practice with compassion and have found it difficult to do in their present roles.

The group shared ideas amongst themselves about their attempts to alter their birth centre environments to make them 'homely' and how they could use gentle tones of voice and encourage active birth. AL and translator (SG) led a relaxation session and a discussion of how cared for staff are more likely to be able to give compassionate care to women.

4. PARTICIPANT-LED EXERCISE: FORUM THEATRE[8]

Forum theatre is used to act out problems and solutions as suggested by the audience who are not merely spectators but 'spectactors'. We co-created several scenarios which the ANMs told us occurred in their practice.

Two ANMs acted as the parts of a young pregnant woman and her mother-in-law. Mothers-in-law often decide how much (if any) maternity care the woman receives.[9] A third volunteer acted as ANM at the local health post. The UK facilitator applauded the courage of the 'spectactors'

reminding everyone that stepping in to suggest what may seem like a simple or obvious idea from the audience is actually very difficult to play out in person. The facilitator also ensured that no 'magic' solutions are allowed. For example, in our role play, a spectactor could not suggest that the daughter-in-law should 'stand up to' her mother-in-law as this would simplify a complex cultural construct. The facilitator may remind the spectactor that this may make home life very difficult and ask 'is there a realistic way that this character might try to achieve the same goal?

In a brief follow-up the players provided feedback: they shared ways that worked well for them. One outcome is that ANMs now routinely ask to speak to each pregnant woman in private during at least one appointment when they address issues which may be difficult for women to discuss with their mother-in-law present.

Conclusion

We spent breaks together, singing, dancing, and playing traditional instruments, which was as important as the planned activities.[10] The team felt that putting theory into practice worked well when it was based on feedback from ANMs and evaluations at the end of the sessions. Despite the potential of 'losing' some subtlety in translation[11] the UK team felt that with our translator (SG) we shared a lot of learning in the groups rather than simply delivering information.

Acknowledgements

We like to thank the ANMs, all UK volunteers, Green Tara Nepal and the funders, THET.

The THET Nepal team comprises: Edwin van Teijlingen, Padam Simkhada, Shyam K. Maharjan, Bhimsen Devkota, Lokendra Sherchan, Ram Chandra Silwal, Jane Stephens, Krishna Acharya, Collette Fanning, Bishnu G.C., Ram K. Maharjan, Bibha Simkhada, Jillian Ireland, Geeta

Sharma, Samridhi Pradhan, Sean MacKay, Ish Fawcett, Andrea Lawrie, David Havelock, Liz Murphy, Rose Pringle, Sapana Bista, Chrissy Reeves & Flora Douglas.

Competing interest

None declared.

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