

THE COMMUNITY MIDWIVES PROGRAM IN PAKISTAN

Introduction

Nearly 60%¹ of all births in Pakistan occur at home and are conducted by unskilled birth attendants. They are a major contributor to the high maternal mortality rate (276/100,000²) in the country. Training and deploying skilled birth attendants (SBAs) or Community Midwives (CMWs) in communities is considered an effective and cost efficient way or reducing the MMR. This policy brief describes the experience of Pakistan with CMWs, to examine implementation issues and lessons from this experience.

Rationale behind the CMW Program

The Ministry of Health established the National Maternal Newborn and Child Health Program (NMNCHP) in 2006, which received funding from district levels, the Federal PSPD for health and grants from DFID, USAID, UNICEF, UNFPA and other international agencies. The MNCH program introduced a new cadre of skilled birth attendants called "Community Midwives" (CMW). These were rural women from the same community as their clients. They were given 18 month of training in antenatal, intrapartum, postnatal and newborn care. The program aimed to train and deploy around 12,000 CMWs nationwide to increase coverage of MNCH services by skilled providers.

By Dec 2011, 4,700 CMWs were trained and deployed. External funding entities (such as USAID's PAIMAN and TACMIL) also contributed to the project by increasing institutional capacity of CMWs in some districts. Unfortunately, the effectiveness of the program cannot be assessed because of the absence of data on CMW deployment and the lack of surveys to measure maternal mortality following 2006-07.

Training of CMWs

Training of CMWs started in 2007/08. Candidates were trained by at least 4 tutors and 2 clinical instructors in designated midwifery schools, after which they received 6 months of practical training (on ANC, normal domiciliary deliveries, PNC and new born care) at practice sites in communities or health facilities with at least one instructor (WMO/LHV). Once the entire course was complete, CMWs received certificates from PNC and were eligible for practicing as a CMW, and were given a catchment area of around 5,000 people.

ELIGIBILITY CRITERIA FOR CMWs

1. Age: 18 to 35 years of age
2. Preferably married
3. Minimum Education: Matriculate in science subjects with at least 45% marks
4. Some work experience in the community
5. Permanent residents of the area

CMW Placement in Communities

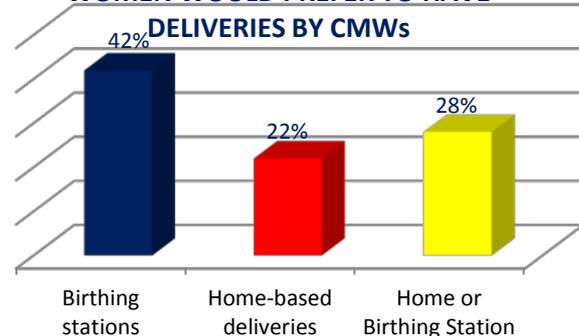
It was felt that the success of the program would depend on the CMWs' acceptance by their communities. In a study of community households' preferences for being serviced by CMWs, women were equally divided in their preference for home or birthing station (at the CMWs' homes) deliveries³. Reasons for opting for birthing stations primarily stemmed from concerns that homes lack necessary facilities for

SALIENT POINTS

- CMWs are internationally recognized as frontline workers that can reduce maternal mortality
- Challenges faced by the CMW program are acceptance by community, competition with other service providers, inappropriate skill set and lack of community involvement
- For the program to be a success, the deployment of CMWs should be in line with the wishes of the community **and** resolving procedural delays such as timely distribution of certificates as well resolving their financial considerations

deliveries; while those who preferred own homes did so for privacy and to conform to cultural values. Fully 60% preferred or considered birthing stations as a better option, suggesting that many women in communities would go to a facility if needed.

LOCATION WHERE COMMUNITY WOMEN WOULD PREFER TO HAVE DELIVERIES BY CMWs



Challenges faced by the CMWs, Communities and Program

Although the program has proved to be quite successful in countries like Indonesia and Malaysia, there are several implementation issues were experienced with the program in Pakistan.

Research showed that the community members are unaware about the availability and purpose of CMWs. This is due to ineffective communication strategies and the non-engagement with the community at the time of deployment. One study showed that the MNCH program does not envision a role for the community in the successful implementation of its strategies, and sees them as **nothing but consumers**.⁴

Other problems encountered by the CMWs are:

- **Insufficient training:** CMWs receive only six months of fragmented practical training. Research showed that 16% of CMW graduates had never conducted a delivery independently in hospitals, whereas 46% had never conducted one independently in the community.⁵

- **Procedural issues in deployment and certification:** Delays in certification and deployment of CMWs results in them seeking jobs elsewhere, and making them frustrated and demotivated workers.
 - **Inadequate skill sets and referrals:** CMWs are not referring to health facilities when needed, and thus are affecting medical outcomes. 68% did not know what to examine in mild bleeding and 57% did not know how to manage it
 - **Financial issues:** CMWs are given a stipend of PKR 2,000 with an additional training allowance of PKR 1,500^{2, 6}. They feel that this is their salary from the Government without realizing (due to lack of communication about this goal) that this is a temporary compensation to allow them to establish in the communities.
 - **Mobility and security problems:** The young age and marital status of the CMWs poses threat to their security while in the community.
 - **Acceptance by the communities:** The typical CMW is young and unmarried and thus, deemed as untrustworthy or inexperienced by the community. In fact the most accepted CMWs are those who are relatives of existing traditional birth attendant and therefore receive referrals and recommendations from them.
 - **Lack of Coordination with the other service providers:** Lady Health Workers and Lady Health Supervisors do not refer to the CMWs, thereby limiting their outreach and scope⁶.
 - **De-motivation:** The title: “Community Midwife” is unacceptable to many CMWs, who feel that it does not depict their level of expertise thereby limiting their acceptance⁷.
6. Alternate models of financial viability such as compensating CMWs through the Zakat or Bait-ul-Mal, or other Social Welfare Departments or vouchers for poor women may be tested.
 7. **Revisit the CMW Strategy:** The MNCH Programs must review their approach towards home-based deliveries through CMWs since majority of households prefer deliveries at birthing stations. These may be women that can be induced to avail existing underutilized government facilities, provided certain quality, ease of access and service standards can be ensured. This would mean that CMWs may be serving only those women who insist on home deliveries.

Recommendations

In light of all the problems described above, the literature suggests the following remedial measures:

1. **Community integration for better uptake:** The CMW program should be reviewed to incorporate comprehensive community participation and community representatives should be a part of their selection procedure. Also linkages should be created with existing community agents like the LHWs and LHS.
2. **Improve Skill-set:** It is necessary to ensure that the CMWs acquire a high standard of skill-set that is based on appropriate practical experience and better communication skills.
3. **Clearer Job Descriptions and Coordination:** Review the job descriptions of LHVs, LHWs and CMWs to remove the overlap of functions. There should be a system where each provider has and understands their particular role and coordinates and refers to others as needed.
4. **Health Facility Linkages:** The CMWs must be linked with health facilities 24/7 so that they can refer difficult cases as needed.
5. **Alternate financial viability models:** CMWs are hesitant in asking poor clients for their fee and seem to consider their (temporary) stipend as a salary. Appropriate business skills training that allows them to become better entrepreneurs (perhaps consider the potential as an entrepreneur as a criterion for admittance into the program) and to manage their practice.

- 1 Pakistan Demographic and Health Survey 2006-07, Federal Bureau of Statistics
- 2 Technical Resource Facility (TRF); Assessment of the Quality of Training of Community Midwives in Pakistan; 2010. UKAID, AusAid, HLSP
- 3 The Human Development Resource Foundation, Preference of birthing place: A mixed methods national study of Communities, Households, Community Midwives and MNCH Programme; February 2012.
- 4 Akhtar, T. Community participation – a missing essential from the primary health care approach in the community midwives programme. Summary report of a study on assessment of community participation in the Community Midwives Programme. Khyber Medical University, Peshawar, Pakistan (2012) 11 pp. 5
- 5 Anon. How far can I go? Social Mobility of CMWs in AJK. Children First, Islamabad, Pakistan (2012)
- 6 Government of Pakistan, Ministry of Health; PCI National Maternal Newborn and Child Health (MNCH) Program 2006-2012; November 2006.
- 7 Faisal A. Are CMWs Accessible in Punjab & Sindh? 2012. Arjumand And Associates, Islamabad, Pakistan

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