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Are CMWs Accessible in Sindh?

A Study Funded by the Maternal and Newborn Health Programme Research and Advocacy Fund

Summary Report

Conducted by Arjumand And Associates

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Disclaimer

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Are CMWs Accessible in Sindh?

As one of the measures for decreasing high maternal mortality, the MNCH Programme in Punjab introduced a cadre Community Midwives (CMWs) who are trained skilled birth attendants. By June 2010, CMWs were trained in 18 out of 23 districts of the province, hence this study was proposed. However, their official deployment was delayed that took place only two weeks before the initiation of the fieldwork for the study. The research focused on the activities that were carried out by the CMWs during the gap between the completion of the training and official deployment. It also gauged whether those CMWs who are now officially deployed are accessible to the low income community women or not?

This research was conducted as a qualitative study in 9 randomly sampled districts and explored both the hindering and facilitative factors to accessibility. Focus group discussions (FGDs) were conducted with randomly sampled CMWs in each district (9), group interviews with families of CMWs selected through purposive sampling (18) and in-depth interviews with community women who were delivered by CMWs (9) and by *daiyan* (9). The accessibility was assessed in multiple dimensions including economic, social, cultural, psychological and geographical forms. It identified factors that hinder and facilitate accessibility of CMWs to the women and of women to the CMWs.

The deployment of the CMWs was substantially delayed

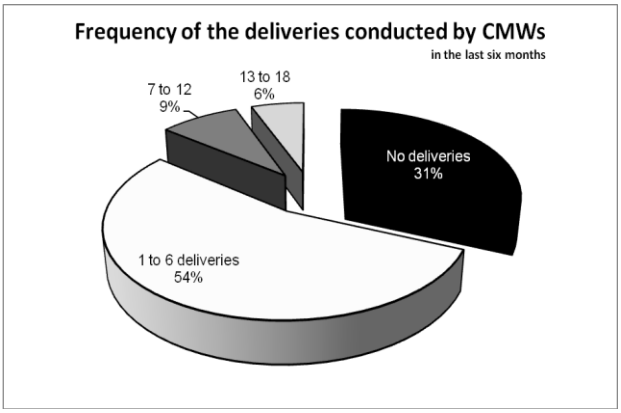
It was found that the deployment of the CMWs was substantially delayed in Sindh and took place in mid May 2011, only 2 weeks before the initiation of the fieldwork.

The duration between completion of training and their deployment ranged from 20 to 22 months. During the long gap between their completion of training and deployment, the participant CMWs reported that:

- Some sat at home and did not do any professional work
- Some worked irregularly from their home or in the community
- Some worked in private sector, NGOs or PPHI
- Some joined another training programme

Utilisation of CMWs by community women is very limited

Out of the total 70 participant CMWs of the FGDs, 48 (68.6%) CMWs reported that they have conducted deliveries during the last six months. However, the frequency of the deliveries conducted by them was very low.



Factors that Inhibit CMWs in Reaching Pregnant Women and Pregnant Women in Accessing CMWs

5 key inhibitory factors

Not aware of the existence of CMWs was found to be the most dominant factor responsible for inaccessibility. During IDIs with women who had their delivery conducted by a *dai*, 4 out of 9 respondents informed that they were not aware of existence of the CMWs as a trained birth attendant, even though they lived within walking distance from a CMW.

Lack of trust in CMWs was reported in all the 9 sampled districts as one of the major factors that hinder the pregnant women in accessing them. Community people lacked trust in capability of the CMW, therefore, they avoided them. Also, people mistrust CMWs as they are young & unmarried, and they have relatively more trust in the *daiyan*.

Preference for private doctors was mentioned in 8 out of 9 districts, where CMWs said that women in their areas preferred private doctors. This implies that women have the ability to afford private facilities and CMWs have not been deployed in poor rural communities.

Transport issues created problems for CMWs and women in accessing in 7 out of 9 districts. CMWs' families shared that roads leading to CMW's home are undeveloped and vehicles cannot pass. Some families also stated that even though public transport was available, it was not affordable for women's families.

Lack of instruments and non-availability of medicines hindered CMWs in conducting deliveries during the long gap between training and deployment. It was mentioned in 5 districts that community people cannot appreciate the difference between a *dai* and trained CMW if they provided services without proper instruments and facilities.

Other important inhibitory factors

Availability of accessible free services to the women emerged as an inhibitory factor in 5 districts. Participant CMWs stated that Civil Hospital was near their community and women went there to avail free services. This again reflects that the CMWs in some areas have been deployed in urban areas, rather than in rural communities.

Inability to pay appeared as an inhibiting factor for women to access the CMW. During IDIs with women who have called d*ai* for delivery, 2 out of 5 respondents mentioned that they were unable to pay CMW fee and called the *dai.* CMWs in 3 districts also stated that people avoid calling them as they fear that CMW will charge a high fee.

Family restrictions hindered some CMWs in 4 districts to work in their communities. The restrictions emerged in varying forms such as CMWs stated that family did not allow her to work outside home, prohibited them to work at night and did not allow travelling alone when any attendant from family was unavailable.

Low financial returns are resulting in low motivation level for the CMWs in 5 out of 9 districts. CMWs expressed that their 'salary ' is very low, and their family expresses displeasure about it. Some CMWs shared disappointment that their expectations of salary were from 8,000-10,000 PKR on deployment, which was not met.

Inhibitory factors reported in a few districts

Antagonism by female doctors in the community, lack of self confidence among CMWs, unavailability of space to conduct deliveries, taking care of CMW's own children, non-cooperation by area *dai* and/or LHW, security concerns, people speak against the CMW, and caste differences (CMW is from low caste and people do not come to her or people are from low caste and CMW does not visit them)

Factors that facilitate CMWs in Reaching Pregnant Women and Pregnant Women in Accessing CMWs

5 key facilitative factors

Clients living close by or relative played most dominant role in conducting deliveries for the CMWs in 8/9 districts. CMWs shared that the deliveries that they have conducted from their homes or in neighbourhood were only of the women who were their relatives, or those of living close-by. The families of CMWs also expressed the similar viewpoint.

Motivation of women by CMWs, their families or satisfied clients increased the accessibility of CMWs services in 8/9 districts. CMWs shared that they visited women at their homes and motivated them. Families

in 2 districts increased awareness about CMW in community by distributing leaflets and some women mentioned that they availed the services of the CMW because other community women had recommended her.

Free services or flexible and lesser fee was mentioned as one of the supporting reasons for utilisation of CMWs in 6/9 districts. It was shared that women sought CMWs' services if they provided either free services or charged flexibly or lesser than other trained providers.

Support from family members in various forms supported CMWs in accessing women in 6/9 districts. Strong support from any family member (husband, brother, etc.), availability of any family member to accompany, or family member being a health worker resulted in better performance by the CMW.

Cooperation by health workers facilitated the work of the CMWs in 6/9 districts. The area *dai* and/or LHW introduced them to community people and collaborated with the CMW which resulted in generating more clients.

Other important facilitative factors

Awareness about CMWs' education and training was mentioned as a helping factor in making people inclined for availing their services.

Availability of instruments was mentioned as a factor for increasing accessibility in 4 districts by the CMWs.

Satisfaction with profession facilitated some of the CMW for working in their communities. People have started to give them respect (6/9 districts) and they felt proud of their achievement (5/9 districts).

Facilitative factors mentioned in 1 – 2 districts

CMW family has their own transport, past good experience of community people with the CMW, and the CMW is accessible via cell phone

Discussion and Recommendations

The study shows that CMWs are working in only a limited geographical area around their homes, as they have not been assigned any areas. However, even in these areas not many women are aware of their existence, and even if aware, many lack trust in them. The programme should play an important role by increasing the awareness of community people about the introduction of these skilled birth attendants in the community, with emphasis on their education, training and competence. They should also compare CMWs with *daiyan* and highlight the CMW's advantages over the *dai* and increase the community people's trust on CMWs. This measure will not only help to introduce them far and wide but also to build community people's trust on them. All possible measures for this awareness and advocacy should be utilised, including community resources (promoting advocacy by satisfied clients, cooperation by LHWs and other health department staff) and mass media (TV, radio).

Proper and adequate information about CMWs among the community people is also likely to decrease their derogatory and insulting comments on CMWs and minimize this inhibitory factor in provision of services by the CMWs.

Recommendation 1. **The programme should increase the awareness of the community people about CMWs and advocate CMWs as trained and competent birth attendants to increase trust in them and also decrease derogatory remarks about them.**

Many CMWs mentioned that their areas are close to the facilities in the city and a noticeable number of people have the capacity to pay the private doctors or clinics, hence they prefer to use those services for delivery. This reflects that the current deployment of some CMWs is in an urbanized setting rather than a rural area. The Programme needs to look at this aspect carefully, especially during selection of trainees in the future.

Recommendation 2. **Assign areas to the CMWs with rural setting**

A delivery kit (instrument, medicines and other supplies) has not been provided to many of the deployed CMWs. These should be distributed on priority basis so that CMWs can begin their practice as birth attendants. The availability of these items and their utilisation will help the community women to perceive the difference between CMWs and *daiyan*.

Recommendation 3. **Provide delivery kit to all CMWs**

An important inhibitory factor in performance of CMWs task is family restriction on their accessibility to pregnant women. These restrictions are due to multiple reasons, such as restrictions on working outside the home, time of delivery (night), caste of the pregnant women, and others. The Programme needs to identify and highlight those families that are not applying these restrictions and use them as role models for convincing other families that are applying these restrictions.

Recommendation 4. **Increase Family support to CMWs by showing role models to the families**

While awaiting official deployment, some CMWs have taken up jobs in the private sector, NGOs and PPHI, and are earning good salaries. They are unlikely to give up these jobs unless they begin to earn an equal or higher income as a CMW. Therefore, the CMWs should be encouraged to start functioning as CMWs after the job hours and change over to a full-time CMW when their income begins to match that of the current employment.

Recommendation 5. **Facilitate gradual change over to those who have taken other jobs**