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Are CMWs Accessible in Punjab?

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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Are CMWs Accessible in Punjab?

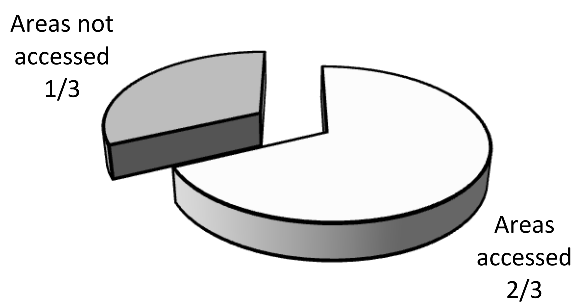
The MNCH Programme in Punjab introduced a cadre of Community Midwives (CMWs) who are trained skilled birth attendants, as one of the measures for decreasing high maternal mortality. By June 2010, about 2,200 CMWs were trained and deployed in all 36 districts of the province. This study seeks to gauge whether these deployed CMWs are accessible to the low income community women or not?

This research was conducted as a qualitative study in 18 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 (18), group interviews with families of CMWs selected through purposive sampling (36) and in-depth interviews with community women who were delivered by CMWs (18) and by *daiyan* (18). 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.

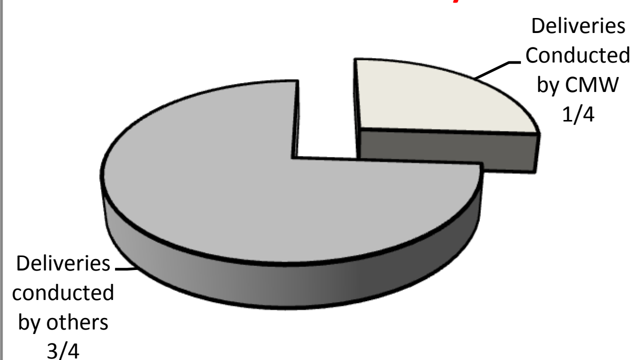
Results show that the current accessibility of CMWs is low

The study reveals that CMWs in Punjab are unable to reach pregnant women in all areas assigned to them, which on an average is limited to two-thirds of the assigned areas. In the accessible areas, they conducted about a quarter of all deliveries that took place in the last 6 months

Assigned areas being accessed by the CMWs



Deliveries conducted by CMWs



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

5 key inhibitory factors

Inability to pay CMW fee is one of the dominant factor in inhibiting accessibility. CMWs in 16 out of 18 districts stated that community people consider their fee as expensive and hence call *daiyan* as birth attendant. This reason was quoted by half of the women interviewed, who chose *dai* as their birth attendant.

Lack of trust in CMWs was reported in 13 out of 18 districts as one of the factors that hinder pregnant women in accessing them. CMWs said that they are new, therefore, people do not know about them and also people mistrust CMWs as they are young and unmarried.

Past good experiences of women with *daiyan* is another factor mentioned in 12 out of 18 districts. CMWs shared that the women in their communities preferred *dai* because their previous delivery/ies were conducted by *dai* without any complaints. Also, women said during interviews that they preferred *dai* because she massages them, takes care of newborn and performed household chores (preparing food, washing clothes etc).

Distance to and from pregnant women's home hindered CMWs in accessing women in all the 18 districts. CMWs said that some areas in their assigned region are too far to go for conducting deliveries. Due to the distance, women living in far away areas are also not calling the CMWs for deliveries and are utilizing area *dai*.

Restrictions imposed by family on the CMW limits her movement (mentioned in 13 out of 18 districts). Examples of restrictions are: (a) family members disallow CMW to go to client's home for conducting delivery, (b) restrictions on the movement of CMW at night, (c) unavailability of any family member to accompany her, and d) restrictions on the work for meagre returns.

Other important inhibitory factors

Non Availability of Necessary Medicines and Supplies with the CMWs to conduct safe deliveries restricts them from performing deliveries in 11 out of 18 districts. This also restricts pregnant women from approaching CMWs as they do not perceive any difference between CMW and *dai*.

Antagonism by community health providers is hindering the CMWs in 10 districts. *Daiyan* and LHWs speak against the CMWs and refer clients to any other health facility (especially private for receiving commission). LHS in 2 district asked LHWs to refer clients to government facilities.

Families have access to other competing choices in the community.. CMWs in 8 districts and women in 6 districts mentioned that free government facilities are available in their areas. CMWs in 4 districts mentioned that people in their assigned areas are near to city and have access to other choices.

Derogatory comments by community people are hindering the CMWs in 8 out of18 districts. These insults and major attacks on character result in de-motivation and even complete restrictions from the family of the CMW.

Inhibitory factors reported in a few districts

Engagement in family affairs by CMWs, taboos (infertile CMW, fear of *pachhawan*/*nazar*/black magic), religious & caste differences, negative consequences of being CMW (threats of being kidnapped, breaking of engagement and divorce)

1 very critical inhibitory factor reported in ALL districts

Dissatisfaction and frustration with the job was shared by the CMWs in ALL the districts. The CMWs reported that they and their families were very unhappy with their employment. Their expectations that they were led to form during recruitment were not met and they feel trapped as they cannot leave the profession because they have signed the bond.

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

4 key facilitative factors

Clients living close by, an acquaintance or relative played a key role in conducting deliveries for the CMWs in ALL 18 districts. This finding not only shows that their access is limited but also shows that both "close vicinity" and "knowing the family" support the accessibility to pregnant women for delivery. Majority of community women (14/18) who trusted CMW for conducting their delivery said that the CMW was well known to them and lived in neighbourhood.

Training, education and competence of CMW if given value by a woman/family serves as supportive factors in utilizing CMWs services. CMWs in 11/18 districts and women in 15/18 districts said that distinguishing CMWs as educated and trained birth attendants from *daiyan* facilitates accessibility.

Advocacy by satisfied clients emerged as a supporting factor for increasing clients. CMWs in 10/18 districts

shared that recommendations by satisfied clients resulted in bringing more women to avail their services.

Flexible Fee by the CMWs helped in conducting deliveries in 10 districts. This flexibility in charging fee ranged from conducting free deliveries to accepting whatever was offered against their services.

Other important facilitative factors

Good Experience with CMWs led women to seek CMW services. Good behaviour (3 districts), support to pregnant women in complications (4 districts), and a good experience of women in the past with the CMWs (8 districts) led women to seek their services as a birth attendant for the last delivery.

Cooperation by other health workers led to utilisation of CMW as birth attendant in some districts. Cooperation by LHW (7 districts) and referral by LHV in one district led women to seek CMW's services. A few CMWs (in 2 districts) and one woman reported cases where *dai* asked the family to call the CMW when she was unable to handle the case.

Availability of transport to the CMW helped her to reach the pregnant women. Having a family transport was mentioned in 6/18 districts. The CMW families stated that they have their own conveyance (mostly motorcycle) so they can take CMW whenever people call her.

Motivation of clients by CMWs was mentioned as a facilitating factor in 7/18 districts by the CMWs. CMWs shared that they visited women's homes and motivated the women to call them for deliveries.

Support by Family of CMWs emerged as a factor that helped in conducting deliveries in 4 districts. The family members helped the CMW by accompanying her as an attendant whenever and wherever she had to go for work. Also, family members of some CMWs belonged to health care (such as homeopathic doctor, dispenser, *dai,* etc.), so people knew the CMW from their reference and availed her services

Facilitative factors mentioned with less frequency

Bad experience with *dai*, cooperation by influentials, mobile phones with CMWs, provision of free medicines, construction of delivery room by the MNCH Programme.

Discussion and Recommendations

This study shows that CMWs have misunderstandings and misperceptions about their job descriptions, position, remuneration and support from the MNCH Programme. They perceive themselves as government employees, hence expect service grade and a reasonable salary in comparison to other cadre (such as the LHW who earns Rs. 7000 per month). Also, they have misperceptions about the programme's facilitation for establishment of a full-fledged maternity clinic for each one of them. Besides this, the programme's projection for their capacity to earn Rs. 8,000 – 10,000 per month has been misconceived as a monthly salary. These misunderstandings need to be clarified, CMWs must be made to understand that they are being given a stipend and not a salary, as a support from the government and they are not government employees. However, the programme should take early steps on priority for establishing birthing stations and providing the CMW kit (instruments, medicines and other supplies) as defined in PC-1.

***Recommendation 1*: MNCH Programme should work to remove the misunderstandings of CMWs responsible for their dissatisfactions and provide CMW Kit to all of them.**

Findings make it apparent that CMWs do not have universal access in the assigned areas and not much can be done to achieve this because of the reasons mentioned, such as geographical distances or spatial inaccessibility. However, it is important to note that the data shows that CMWs are being utilised as birth attendants only by about a quarter of the pregnant women, even in the areas that they are reaching. This is happening due to various factors such as a lack of trust in CMWs, lack of awareness about their competence and an inability to differentiate them from the *dai*. Here, the programme can play an important role by increasing the awareness of community people about the education, training of CMWs and their competence, which should compare them with *daiyan* and highlight the CMW's advantages over the *dai*. 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 (satisfied clients, LHWs, 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 about CMWs and minimize this inhibitory factor in provision of services by the CMWs.

Recommendation 2: 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

Many women have informed that CMWs charge a very high fee, up to Rs. 6,000 (in one district) for delivery, which restricts them from utilizing her services. The programme should convince the CMWs to charge less and conduct more deliveries which, in turn, would lead to higher return rather than charging more and doing fewer deliveries. The maximum fee should be agreed with mutual consultation and it should be according to the capacity of the community people. This approach will benefit both; the CMWs and community people.

Recommendation 3: Programme should advocate a maximum fee to be charged by the CMWs

Promotion of CMWs as trained birth attendants by LHWs has been reported as an important facilitative factor in some areas, as LHWs have an established rapport and reach in the communities. At the same time, it has been highlighted that LHWs have been "ordered" to refer cases directly to hospitals rather than to CMWs., This is probably occurring in districts in which a Project is monitoring LHWs by the number of referrals that they make each month to the hospital. This issue needs to be looked at and sorted out, and also, confidence of LHWs in CMWs should be built.

Recommendation 4: LHWs should be compelled to cooperate with CMWs and refer pregnant women to them

Discussions on services provided by the CMWs, shows that CMWs are popular among community women for services of ANC, family planning, PNC and treatment for general ailment. They should be encouraged to carry on these services. Their popularity among the community for obtaining family planning services should be capitalized and CMWs should be trained for inserting IUCDs also, like LHVs. However, the programme should also take note about the services that are beyond their scope of work, but are being carried out by some of them such as routinely advising ultrasound in pregnancy or conducting D&C.

Recommendation 5: The programme should encourage CMWs to provide other services for which they are trained but actively discourage those that are beyond their mandate

An important inhibitory factor in performance of their task is family restriction on their accessibility to pregnant women. These restrictions are due to multiple reasons, such as the time of delivery (night), caste of the pregnant women, religion 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 6: Increase family support to CMWs by showing role models to the CMWs' families

For further information or compete report, contact Dr Arjumand Faisel (Team Leader) at mail@aaa-pk.org