Funded By

Human Development Research Foundation

Preference of Birthing Place:
A Mixed Methods National Study of Communities, Households, Community Midwives & MNCH Programme

February, 2012
Human Development Research Foundation

Acknowledgment

'Preference of Birthing Place: A Mixed Methods National Study of Communities, Households, Community Midwives and MNCH Programme' is a project funded by the Maternal and Newborn Health Programme Research and Advocacy Fund, and is implemented by the Human Development Research Foundation.

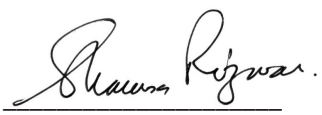
Disclaimer

This document is an output from a project funded by the UK Department for International Development (DFID) and Australian Agency for International Development (AusAID) for the benefit of developing countries.

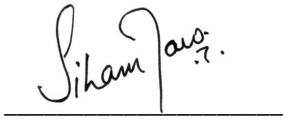
The views expressed are not necessarily those of DFID/AusAID.

Declaration

We/I have read the report titled: Preference of Birthing Place: A Mixed Methods National Study of Communities, Households, Community Midwives and MNCH Programme, and acknowledge and agree with the information, data and findings contained.



Dr. Shamsa Zafar
(Principal Investigator)



Dr. Siham Sikander
(Co-Principal Investigator)

Contents

List of Tables

List of Figures

List of Abbreviations

ANC	–	Antenatal Care
BHU	–	Basic Health Unit
CMW	–	Community Midwife
EmOC	–	Emergency Obstetric Care
FGD	–	Focus Group Discussion
IDI	–	In-Depth Interview
LHS	–	Lady Health Supervisor
LHW	–	Lady Health Worker
MNCH	–	Maternal Newborn and Child Health
PAIMAN	–	Pakistan Initiative for Mothers and New born
PC1	–	Project Commission 1
PI/Co-PI	–	Principal Investigator/Co-Principal Investigator
PNC	–	Post Natal Care
RHC	–	Rural Health Centre
SBA	–	Skilled Birth Attendant
SD	–	Standard Deviation
STATA	–	Name of a Statistical Analysis software
TBA	–	Traditional Birth Attendant
UC	–	Union Council

Executive Summary

Pakistan has a high maternal mortality ratio and a low rate of skilled birth attendance(SBAs). To address these two important issues, the Pakistan Maternal Newborn and Child Health (MNCH) Programme launched the community midwives (CMW) initiative in 2007.The success of this initiative depends upon community acceptance and a CMW placement strategy that takes on board the views of the service providers and the serviced. The purpose of this study was to document the preference for birthing placeand the associated reasons, of the community households for CMW assisted deliveries.

A mixed-methods national level study was conducted covering four provinces. The preferences of 1450 rural households, as to where they prefer the CMWs to conduct deliveries and why, were recorded using a quantitative method. The reasons behind particular preferences of women, community elders, CMWs and the MNCH Programme personnel were obtained through focus group discussions (FGDs) and in-depth interviews (IDIs).

Households were approached by trained female researchers from the rural districts selected through a multistage sampling technique. The respondents for the qualitative study were purposively selected with the help of the local lady health workers (LHWs).

The study found that a majority of the households preferred being serviced by CMWs at birthing stations (a room in the home of the CMW where delivery can take place) followed by a preference for having a flexibility between being serviced at the birthing station or at home, depending on the circumstances. The least favoured option was of having the delivery by the CMW at home. The major reason for preferring the birthing station was lack of facilities at home. Opting for flexibility between birthing stations and homes was based on the perception that during odd hours or when a complication occurs, the CMW could conduct the delivery at home. The stated motives for home-based CMW deliveries were mainly socio-cultural and related to stigma and privacy.

The preferences of women, community elders, and CMWs were similar to the household preferences. However, the views of the MNCH Programme personnel were in contrast to the opinions of the rest of the stakeholders, as they portrayed a preference for home-based deliveries.

Certain challenges were pointed out by the CMWs, including concerns about their introduction into the communities, their competition with the TBAs, procedural and financial issues, inadequate skill-set and training, and mobility and security problems.

In order for the CMW initiative to succeed, it is imperative for the MNCH Programme to align their placement policy with the actual aspirations of the community at large and those of the CMWs. The findings of this study will provide the Programme with an important insight into the perceptions of the community, the reflection of which incorporated into the MNCH Programme's policy will go a long way in achieving the important objectives of the Programme.

1 Introduction and Literature Review

Globally, 600,000 women die, every year,due to pregnancy-related complications;98% of thesedeaths occur in developing countries(The World Bank, 1999). Pakistan, with a maternal mortality of 276per 100,000 live births(PDHS, 2008) is one of the six countries that contribute to 30% of the world maternal mortality(The World Bank, 1999).

One of the major contributors to maternal mortality is a very low proportion of deliveries conducted by skilled birth attendants in the developing countries(The World Bank, 1999).A substantial number of babies (50% to 90%) are delivered by traditional birth attendants (TBAs) or un-trained family relatives in India, Bangladesh and Nepal(Sreeramareddy C T, Joshi H S, Sreekumaran B V, Giri Sabitri, & Chuni N, 2006; Osrin D et al., 2002; Kapoor R K et al., 1996; Anwar I et al., 2008; Gupta R K, 1999). The situation in Pakistan is no different as national figures show that only 39% of deliveries are conducted by skilled birth attendants (SBAs)(PDHS, 2008). Asian countries have been trying to address the high maternal and neonatal mortalities by promoting deliveries conducted by SBAs. Various projects in Pakistan (Hala and SMART Projects) have tried to increase the rate of deliveries by SBAs(Bhutta Z A et al., 2008; Arif M S, Miller P C, Munir N, & Masood I, 2006). The Maternal Newbornand Child Health (MNCH) Programmeis also trying to increase SBA deliveries by introducing community midwives (CMWs) for care before, during and after birth. The success of this initiative in preventing maternal and newborn mortality and morbidity is dependent on the acceptance of the CMWs by the communities that they serve..

In Pakistan, the high rate of home deliveries is attributed to factors such as cheaper birth attendants, lack of transport, privacy/comfort of the home, family influence, family tradition and poor socio-economic conditions(Fatima T, Afzal S, & Mehmood S, 2008; Shah N, Rohra D K, Shams H, & Khan N H, 2010). Other local studies have highlighted that women prefer to deliver at home even if a free and accessible facility is available(Jafarey S N & Korejo R, 1993). With this backdrop, the MNCH Programme clearly states in its PC1 that it will promote home-based deliveries by the CMWs(MNCH Program, 2006). The MNCH Guidelines for the Deployment of Community Midwives define a catchment area for CMW covering a population of 5000, and requireestablishing “work stations” within the homes of the CMWsequipped with an examination couch for ANC and PNC check-ups and where her medicine, equipment, supplies and delivery kits will be placed in a secure corner(MNCH Program, 2010).These work stations are not meant for deliveries.In parallel to the idea of CMW delivering women at homes , the idea of a birthing station has also been piloted by certain organisations like PAIMAN(PAIMAN, 2007). These birthing stations are essentially similar to work stations defined by the MNCH Programme where deliveries can also take place.

One of the major reasons behind home-based deliveries in Pakistan is the issue of accessibility to

health facilities and to a skilled birth attendant. It will be very interesting to see what the larger rural population would prefer if a CMW (a skilled birth attendant) is placed well within the reach and access of the communities, with an established birthing station (where deliveries can be conducted).Would they still prefer being serviced by these CMWs at theirhomes or at the birthing stations?

Birthing stations may have advantages in terms of the CMW's independence and mobility, but the experience and the perceptions of the CMWs are largely unknown. A study conducted by PAIMAN explored the opinion of CMWs as to how they could improve their acceptability in their respective communities, however, this study did not explore their own preference of place for providing services(Wajid A, Rashid Z, & Mir A M, 2010).For a sustainable, feasible and practical approach, it is important to take the opinion of both the community households and the CMWs with respect to the placement of CMWs at home or birthing stations.In addition tothis, it is also important to explore the perspectives of important stakeholders such as the community elders and the key MNCH Programme personnel regarding their preferences and challenges foreseen. The opinion of community elders, for CMW placement, is indispensable to make the initiative socio-culturally more acceptable.

The purpose of this study was to capture the preference of the above mentioned stakeholders, about the birthing place, serviced by CMW,in rural settings of all the four provinces.The decision whether the woman should deliver at home or elsewhere is a collective family decision rather than the woman's decision alone. Keeping this in mind, it washave tried to gather the household's perception regarding the place of birth, which will enable the MNCH Programme to align their placement strategy more effectively. However, in order to capture individual women's opinions and their perceptions were obtainedthrough focus group discussions.

This study highlights provincial-level findings which will provide useful insight in reviewing the current provincial deployment strategy of CMWs.It is expected that the provincial MNCH Programmes will utilise the findings from this study for CMW placement policy decisions as this will enable them to achievea higher degree of acceptance of the CMWinitiative at the community level.

1.1. Aims and Objectives

The broad aim of this study was to inform the MNCH Programme as to where the community households would prefer being serviced by CMWs, that is, at their homes and/or at birthing stations. Additionally, the study attempted to acquire a deeper understanding of the reasons, issues and challenges foreseen, related to CMW placement, by the women, CMWs, MNCH Programme, and the communities in order to enable the Programme to devise an appropriate placement strategy for CMWs.

Primary Objective

To document the proportion of community households preferring to be serviced by CMWs at a particular birthing place.

Secondary Objectives

To document:

- The households' reasons for choosing a particular place of delivery;
- The women's previous experience of birthing and accessing Emergency Obstetric Care (EmOC) services;
- The women's own perceptions and preferences, apart from the households' collective preference;
- The general community's perspective about the CMW's place of service;
- The perspective of MNCH Programme about the CMW's place of service;
- The preference of the CMWs for conducting deliveries at a particular place (homes and/or birthing stations)and their reasons for a particular preference; and
- The anticipated challenges foreseen by the CMWsin working with the communities and challenges foreseen by the MNCH Programme in placing the CMWs.

2 Methodology

2.1. Study Design

This was a cross-sectional mixed methods study.

In order to achieve the primary and secondary objectives both quantitative and qualitative methods were used. The preference of the community households, for a particular place of service by CMWs, and the reasons for this choice were captured quantitatively. However for an in-depth understanding of the views and challenges foreseen by various stakeholders, a qualitative approach was adopted.

2.2. Duration of the Study

This study was conducted from March, 2011, till February, 2012.

2.3. Study Area

This study was conducted in the Punjab, Sindh, Balochistan, and Khyber Pakhtunkhwa provinces of Pakistan. From each province, the rural districts that were selected are given in the map below (Fig.1).

Figure 1: Map of Pakistan showing the districts included in the study area

According to the 1998 census, the total population of the study area is about 8 million. The district breakdown is given in Table 1.

Table : Population data of the study districts (1998 Census)

Punjab		Balochistan		Sindh		Khyber Pakhtunkhwa	
District	Population	District	Population	District	Population	District	Population
Attock	1,274,935	*Quetta (Rural)	197,585	TandoAllahyar	514,752	Mansehra	1,152,839
Jehlum	936,957	Ziarat	33,340	Sanghar	1,421,977	Swabi	1,026,804
Layyah	1,120,951						
Note: *The district selected was Pishin but was later changed to Rural Quetta as there were no trained CMWs in Pishin.*							

2.4. Sample Population

For the quantitative part of the study, the sample population comprised the households in the districts,of four provinces, where MNCH had already deployed or was going to deploy CMWs. In these rural districts only those households were selected where married women of child bearing age (15–49years) were present.

For the qualitative part of the study, the study population comprised four levels of respondents, which are as follows:

1) Women of child bearing age;
2) The community elders;
3) The CMWs;and
4) The MNCH Programme personnel.

2.5. Sample Size

This was a mixed methods study and the sample size calculations for the quantitative and qualitative components are given separately.

Quantitative Component:

The sample sizewas calculated on the basis ofthe proportion (66%)ofhome-based deliveries in Pakistan (PDHS, 2008). Assuming this baseline, at 95% confidence level, with a relative precision of 5%, the total sample was calculated to be 1450 (inclusive of 10% attrition).

Thissample size calculation was undertaken using the World Health Organisation (WHO)Sample Size Calculator.

Qualitative Component:

Atotal oftwenty FGDs and eight in-depth interviews were proposed depending on achieving the sample saturation amongst individual types of respondents. The total qualitative contacts comprised : eight FGDs with the women; four FGDs with the community elders; eight FGDs with the CMWs; and eight IDIs with MNCH Programme personnel.

2.6. Sampling Technique

Quantitative Component:

A multi-stage sampling technique was used for the quantitative component of the study. For the first stage the sampling frame was the list of MNCH districts where CMWs were deployed or were to be deployed. Out of these, 10% districts, from each province, were selected by simple random sampling. This ensured the selection of a proportionate number of districts from each province relative to the size of the individual provinces. The second stage consisted of randomly selecting 10% of the rural union councils, from within each selected district. The last stage entailed selecting eligible households with married women of child bearing age (15 – 49years).After entering the village, the research assistants started with the first household on their right side and approached every third house to inquire whether an eligible couple lived there. In case of non-availability of an eligible couple, they moved to the next house and continued the process.

This multi-stage sampling technique offers a number of advantages. Firstly, since the sampling technique employs a proportionate number of districts form each province, relative to the individual province size, the results would be representative of individual provinces in case of a variation in the results from the four provinces. Secondly, selecting only the rural union councils ensures representation of the marginalised segment of the population, which is deprived both socio-economically and from proper health care services. These are the areas where the CMW initiative will be most beneficial, therefore, the results will be more effective for policy making.

Qualitative Component:

Based on a purposive sampling technique, all the respondents were selected from the same districtsasthose of the quantitative survey.

As mentioned above, this study had four types of respondents who were identified as follows:

- **Women:** Married and pregnant women of child bearing age (15– 49 years) were identified by the local LHW and active community members.
- **Community elders:** The community elders including religious leaders, counsellors, female teachers and other important community members were identified by the local LHWs and through personal contacts with active community members.
- **CMWs:** A list of the community midwives, enlisted in the district,was obtained from the District MNCH Programme.
- **MNCH Programme personnel:** The proposed MNCH Programme personnel included one provincial and one district-level representative (13 in total). All the four provincial-level representatives were interviewed, whereas, saturation was achieved at four district-level representatives.

2.7. Instruments

Questionnaires for the quantitative component and the field guides for the qualitative component were designed in line with the statedobjectives and literature review. The quantitative questionnaire had two sections: the basic demographics like age, parity, socio-economic status, education level, employment status, family structure, etc.; section two captures the preference for the place of birth along with reasons.

For the qualitative study, the field guides were separately prepared for FGDs with women, community elders, and CMWs. For the IDIs with the MNCH Programme personnel, detailed questionnaires were prepared.

Those instruments that were to be used in the community were translated in the local language, and all the instruments were piloted prior to the start of the data collection stage (see attached inAppendix II).

2.8. Ethical Considerations

Ethical approval was obtained from the National Bioethics Committee (NBC) Pakistan–Research Ethics Committee before the start of the study (see attached in Appendix III). Written informed consent was obtained from the respondents prior to the interviews. For the FGDs as well as IDIs, verbal consent was taken from the respondents for the interviews as well as the audio recordings (see attached consent form in Appendix II).

Anonymity of the data was ensured and the data was kept confidential as only the senior research staff had access to the data. Keeping in mind the cultural sensitivity, women staff was hired to conduct the interviews.

2.9. Data Collection and Management:

The procedure for collecting the quantitative as well as the qualitative data is given separately:

Quantitative Data Collection

For the quantitative data collection, nine field research teams were hired. Each team had two women researchers who were accompanied by one male member. The research staff was recruited from the individual districts that were selected for this study, and were given two days of training on data collection by senior research staff (PI Co-PI and project coordinators).During the piloting phase, the understanding of the researchers was checked and further training was imparted. The actual data collection process was monitored and supervised by two Project Coordinators to ensure quality.

The data collected each day was scrutinised for any omissions or mistakes by the Project Coordinators prior to dispatching to the central office based in Islamabad. A copy of the original data was kept safe till the confirmation that the original data had reached the central office at which point

the copy was destroyed. At the central office, the data was computerised after cleaning the data and checking for missing values and then the hard copies were coded, filed and kept under lock and key.For verification, 25% of the manual data was randomly checked and validated against the computerised data.

Qualitative Component

The research staff who conducted IDIs and FGDs included both women and men researchers. They were specifically trained to conduct IDIs and FGDs in the community. The FGDs were supervised by the senior researchers. The audio recordings and field notes were taken and later transcribed. After coding the recordings and field notes, these were saved anonymously and only the PI and Co-PI had access to this data.

2.10. Data Analysis

For the quantitative part of the study, descriptive analysis was done. STATA version 9 was used for analysis. Results are presented in proportions of preferences and means with standard deviations of continuous variables like age, years of education, income etc.

For the qualitative data, manual analysis was undertaken and a continuous comparative method was used for generating themes/categories. This approach was used for all the four levels of respondents and then triangulation of the data was performed.

3 Results and Findings

The results of this cross-sectional mixed methods study, covering four provinces of Pakistan, will be discussed separately for quantitative results and qualitative findings.

3.1. Quantitative Results

We approached a total of 1457 eligible households to take part in this study. Seven households refused to participate in the survey (two from Province Sindh, and five from Punjab). This study had a good response rate of 99.52%.

3.1.1. Household Demographics

The basic demographics of the households are given in table 2 below:

Table 2: Household Demographics

Basic Household Demographics	Sindh (n=357)	Punjab (n=369)	Khyber Pakhtunkwa (n=365)	Balochistan (n=359)	Total (n=1450)
Women's age *Mean (SD)*	31 (6.9)	31 (6.7)	30 (7.2)	32 (7.3)	31 (7.1)
Women's education (in years) *Mean (SD)*	2 (2.9)	4 (4.8)	3 (4.3)	4 (4.1)	3 (4.1)
Husband's education (in years) *Mean (SD)*	5 (4.9)	6 (4.6)	7 (4.7)	7 (4.3)	6 (4.8)
Women's occupation *n (%)*	House wife = 298 (83%)	298 (80%)	362 (99%)	347 (97%)	1305 (90%)
	Working = 59 (17%)	71 (20%)	3 (1%)	12 (3%)	145 (10%)
Husband's employment status *n (%)*	No = 39 (11%)	17 (5%)	56 (15%)	20 (6%)	132 (9%)
	Yes = 318 (89%)	352 (95%)	309 (85%)	339 (94%)	1318 (91%)
Husband monthly income *Mean (SD)*	Rs. 4956 (2906)	Rs.8781 (6805)	Rs.11451 (10635)	Rs.8101(3697)	Rs.8280 (7073)
Family monthly income *Mean (SD)*	Rs.5346 (3092)	Rs.10467 (8005)	Rs.12705 (11363)	Rs.11784 (6041)	Rs.9980 (8230)
Family structure *n (%)*	Joint = 226 (63%)	170 (46%)	189 (52%)	238 (66%)	825 (57%)
	Nuclear = 131 (37%)	199 (54%)	174 (48%)	121 (34%)	625 (43%)
Parity *Mean (SD)*	5 (2.5)	3 (2.1)	3 (2.2)	4 (2.7)	4 (2.5)
Currently pregnant women *n (%)*	75 (21%)	59 (16%)	53 (15%)	113 (31%)	300 (21%)

3.1.2. Preference of the Household for a Birthing Place

As the objective was to capture the preference of the household rather than any individual, therefore, all the adult family married members at the time of the survey were invited to participate. The demographics of the eligible woman in the house were recorded. The household were told about the community midwives; defining them as local, educated women community workers who were trained by the MNCH Programme to conduct safe deliveries and provide post natal care. The household was then asked the question *" What would your household prefer in terms of the place of*

delivery assisted by CMWs? The respondent giving a preference of the household could have been any married member of the household; woman herself, husband or the mother in law. The options given were: 1) the respondents' home where the CMW will carry the necessary medicine, equipment, supplies and delivery kit; and 2) birthing station defined as a place within the community equipped with necessary medicine, equipment, supplies and delivery kit where deliveries can take place.

National Household Preference of a CMW Serviced Birthing Place

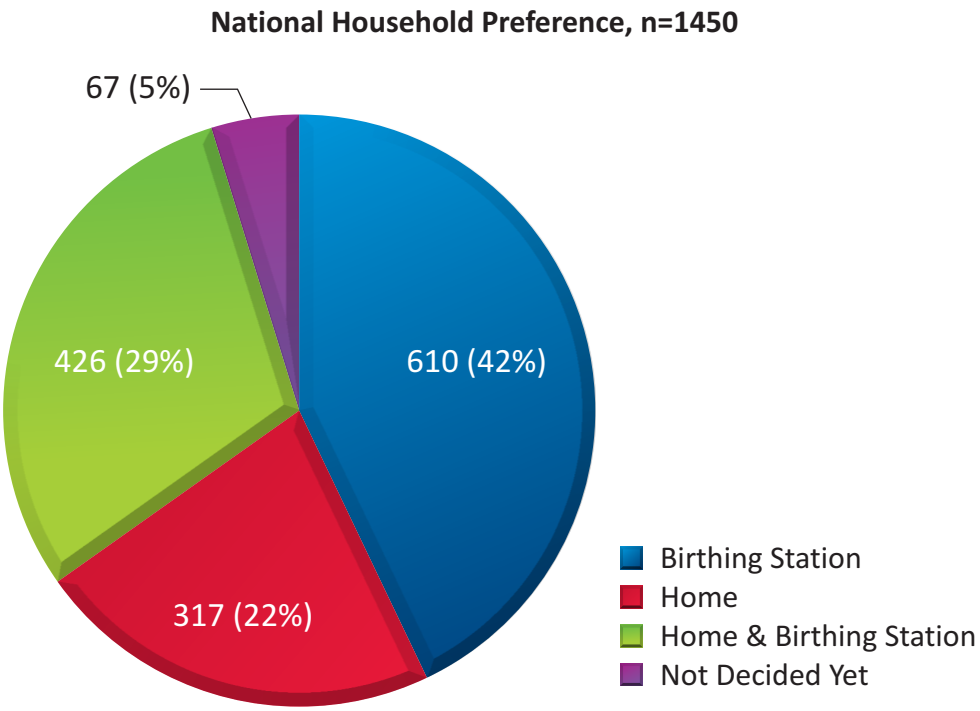


Figure 2: National Household Preference of a CMW Serviced Birthing Place

Figure 2 shows the national preference, of community households, for a birthing place. A majority of the households preferred the CMW to service them at the birthing stations. Interestingly 29% (426) households opted for having a flexibility to be serviced by the CMW either at the birthing station or at home. Less than a quarter (22%) of the households preferred that the CMW conduct the delivery at their home. Another important finding that is not depicted in the graph was that 2% (30) of the households did not want to be serviced by the CMW altogether.

Provincial Household Preference of a CMW Serviced Birthing Place

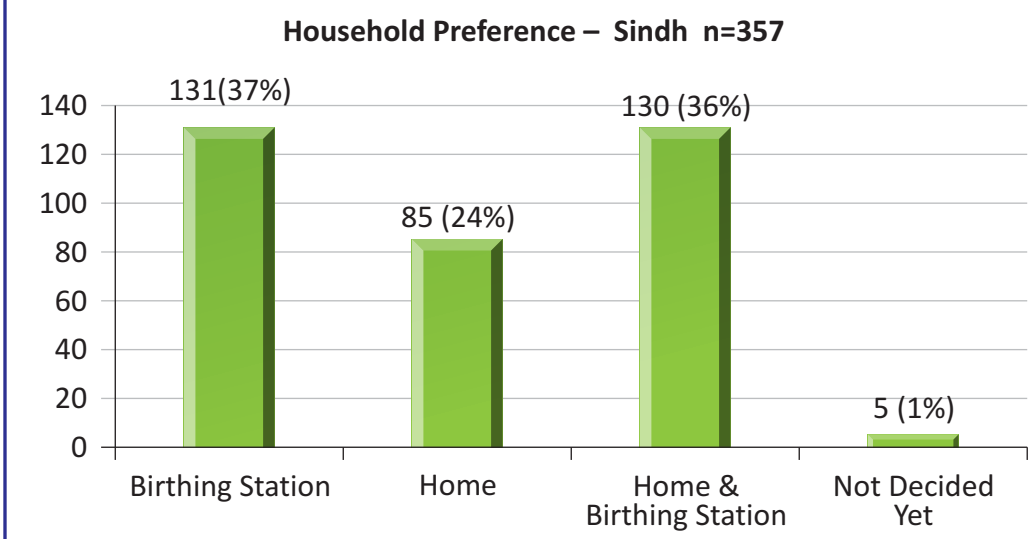


Figure 3: Provincial Household Preference of a CMW Serviced Birthing Place–Sindh

The bar chart in figure 3 illustrates the community household preference, for birthing place, in the province of Sindh. A majority of households in Sindh preferred either birthing station or having a flexibility of both birthing stations and home. Home deliveries were preferred by fewer households.

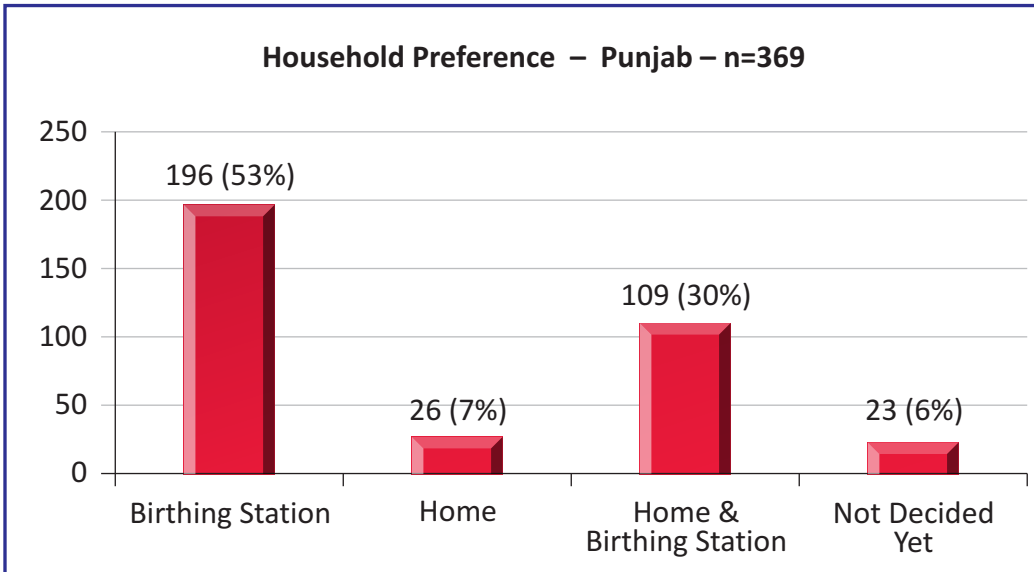


Figure 3: Provincial Household Preference of a CMW Serviced Birthing Place–Sindh

Figure 4 shows the household preference in the province of Punjab. Here, more than half the households are opting for the birthing station as the place of birth rather than the home, which is greater than the national preference.

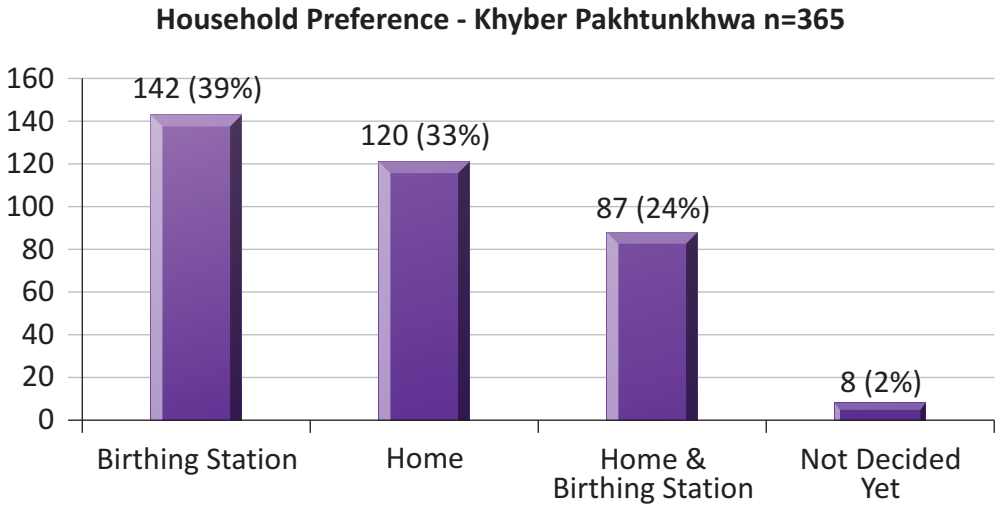


Figure 5: Provincial Household Preference of a CMW Serviced Birthing Place – Khyber Pakhtunkhwa

Figure 5 depicts the household preference in the province of Khyber Pakhtunkhwa. Here too, the choice of birthing station stands as the foremost choice. However, unlike other provinces the second choice is home delivery. Having flexibility between the two places has been opted as the third choice.

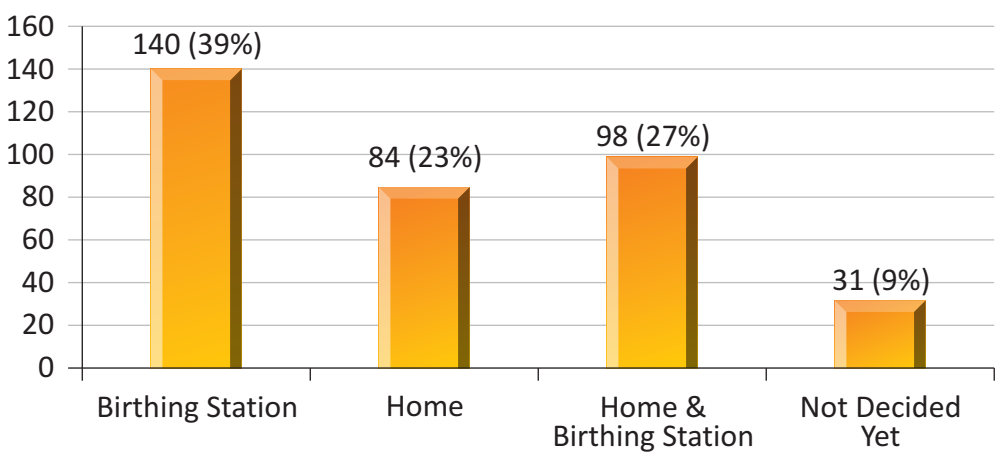


Figure 6: Provincial Household Preference of a CMW Serviced Birthing Place – Balochistan

Figure 6 illustrates the household preference in the province of Balochistan, which is just like the overall national preference.

3.1.3. Reasons for Choosing a Particular Preference

The households that opted for the birthing stations as the place of delivery (610) were asked about the reasons for this choice and the responses reported are shown in Table 3. We have noted down the responses as they were reported hence there might be some similarity in the reasons. The foremost reasons for choosing the birthing station was that the birthing station would still be better equipped compared to the facilities at home. Almost all the responses refer to the lack of available facilities at home.

An important finding is that Province Khyber Pakhtunkhwa has reported the lack of space for delivery within the home as a reason more often than the rest of the provinces. The households in the Province who have opted for the birthing station are those who lack facilities at home and will avail services at the birthing station if in the vicinity.

Table 3: Reasons for choosing Birthing Station as the place of delivery

Reported reasons for choosing Birthing Station	Sindh n=131	Punjab n=196	Khyber Pakhtunkhwa n=142	Balochistan n=140	National Total n=610
Complete facilities at birthing station	107 (82%)	170 (87%)	142(100%)	132 (94%)	551 (90%)
No amenities at home	36 (27%)	132 (67%)	134 (94%)	69 (49%)	371 (61%)
Lack of private space for delivery at home	7 (6%)	81 (41%)	126 (89%)	39 (27%)	253 (42%)
Station better equipped for emergencies	7 (6%)	125 (64%)	126 (89%)	58 (41%)	316 (52%)
Proximity of the birthing station	5 (4%)	118 (60%)	125 (88%)	90 (64%)	338 (56%)
Other reasons	0 (0.0%)	71 (36%)	1 (0.7%)	6 (04%)	78 (13%)

Note: *Individual households had more than one reason for choosing a particular preference, therefore, the total percentage is more than 100.*

The households that preferred home-based deliveries by the CMW had various reasons for this preference which are given in Table 4. The majority perceived that the deliveries at the birthing station would involve some extra financial cost in the form of medicine, possible fee, and if the birthing station is at some distance from the home then cost and availability of transportation will be another issue. The local customs seem to play a major role in making this choice. Another very important reason for choosing home as the birthing place was the stigma associated with women going out of the home, and the issues of shyness and privacy.

The majority of the households in Khyber Pakhtunkhwa who are preferring home-based deliveries state that there is good family support and help available at home, which they may not get outside the home.

Table 3: Reasons for choosing Birthing Station as the place of delivery

Reported reasons for choosing Birthing Station	Sindh n=85	Punjab n=26	Khyber Pakhtunkhwa n=120	Balochistan n=84	National Total n=317
Lack of Finances	59 (69%)	18 (69%)	90 (75%)	65 (77%)	233 (74%)
Non-availability of timely transportation	23 (27%)	18 (69%)	82 (68%)	35 (41%)	159 (50%)
Family custom	39 (46%)	12 (46%)	31 (26%)	48 (57%)	128 (41%)
Birthing station expensive option (costly medicine and higher fee)	24 (28%)	17 (65%)	96 (80%)	64 (76%)	204 (64%)
Stigma	1 (1.2%)	3 (11%)	46 (38%)	23 (27%)	73 (23%)
Privacy	2 (2.4%)	16 (62%)	81 (68%)	45 (53%)	144 (46%)
Family Support and help available at home	1 (1.2%)	11 (42%)	91 (76%)	40 (47%)	143 (48%)
Other reasons	3 (3.5%)	6 (23%)	0 (0.0%)	11 (13%)	20 (06%)

Note: *Individual households had more than one reason for choosing a particular preference, therefore, the total percentage is more than 100.*

The households that prefer to have flexibility so that they can choose between home or birthing station give two main reasons (Table 5). The nature of the delivery (complicated/uncomplicated) and their financial circumstances at the time of the delivery will dictate their decision. So, the households want to have both options available.

Table 5: Reasons for having flexibility between both Home & Birthing Station as the place of delivery

Reported reasons for choosing Birthing Station	Sindh n=130	Punjab n=109	Khyber Pakhtunkhwa n=87	Balochistan n=98	National Total n=424
Nature of delivery (emergency)	77 (59%)	103 (94%)	84 (97%)	97 (99%)	365 (85%)
Financial condition at the time	102 (78%)	52 (48%)	51 (59%)	79 (80%)	286 (67%)
Other reasons	4 (3%)	30 (28%)	3 (3.5%)	4 (04%)	42 (10%)

Note: *Individual households had more than one reason for choosing a particular preference, therefore, the total percentage is more than 100.*

3.1.4. Previous Birthing Experience and Accessing Emergency Obstetric Care (EmOC) Services

Table 6 shows the proportion of women who faced complications in their previous deliveries and availed emergency obstetric services. In Sindh 48% (171/357) of the women faced obstetric complications during a previous delivery. Out of these, only 25% (45/171) availed EmOC services. Likewise, the figures from the other provinces are following a similar pattern. Amongst the provinces, Punjab has the highest proportion of EmOC services availed (76%).

Table 6: Previous Birthing Experience and Accessing Emergency Obstetric Care (EmOC) Services

Women's Previous Obstetric Experience & Availing of EmOC Services	Sindh n=357	Punjab n=369	Khyber Pakhtunkhwa n=365	Balochistan n=359	National Total n=1450
Previous obstetric complications n (%)	171 (48%)	181 (50%)	131 (38%)	238 (72%)	721 (49%)
EmOC Services availed n (%)	45 (25%)	137 (76%)	61 (46%)	82 (34%)	325 (45%)

Note: *Individual households had more than one reason for choosing a particular preference, therefore, the total percentage is more than 100.*

3.2. Qualitative Findings

The qualitative data was obtained from a total of 196 respondents. The breakdown of FGDs and IDIs is given below (Table 7). Amongst the respondents, there were 72 women with a mean age of 31.8 (SD 9.1) years and mean years of education of 4.4 (SD 4.1). The community elders had a mean age of 52.1 (SD 11.1) years and mean years of education of 9.5 (SD 4.2). The CMWs had a mean age of 25.8 (SD 4.4) and mean years of education is 12.1 (SD 1.6). Out of the 68 CMWs, 26 (38%) were married whereas 42 (62%) were unmarried. Only 24 (35%) CMWs had been deployed into their respective communities, and 44 (65%) had yet to be deployed. The community was however unaware of the presence of the CMWs even in the communities where they were already deployed.

Table 7: Breakdown of IDIs and FGDs

Qualitative contacts	Sindh	Punjab	Khyber Pakhtunkhwa	Balochistan	Total IDIs/FGDs	Total number of respondents
FGD with women	2	2	2	2	8	72
FGD with community elders	1	1	1	1	4	48
FGD with CMW	2	2	2	2	8	68
IDI with MNCH personnel	2	2	2	2	8	8

Note: *Individual households had more than one reason for choosing a particular preference, therefore, the total percentage is more than 100.*

This section presents the findings under three broader categories, namely:

- **The preferences for a particular birthing place;**
- **Reasons for a particular preference; and**
- **Challenges foreseen.**

3.2.1. Preferences for a Particular Birthing Place

The quantitative data captures the preferences of the households, but in order to include the opinions of other important stakeholders in the community including women, community elders, CMWs and the MNCH Programme personnel, FGDs and IDIs were undertaken with these stakeholders.

The notion of having CMWs based in the communities was welcomed by women and elders across all the provinces. The need for skilled birth attendants was considered very important. There was an instant and a very strong sense of ownership expressed from all the women respondents about this initiative, which was expressed as, *"We will welcome the CMWs into our communities as they will come here to provide a much needed service for us".*

The overwhelmingly positive response of women to CMW initiative can be appreciated by the quote, of a woman respondent, below.

> *"We will help them by providing rooms in our houses for them. In fact, we will even stitch their clothes and their bags, for carrying their instruments, as they will come here to provide a much needed service for us".*

Women's Preference: Birthing Stations or Flexibility of Having CMWs at Birthing Station or Home:

During the FGDs a majority of women expressed that they would prefer the CMW providing delivery services at birthing stations. One of the women in the focus group discussions stated, *"We want to be serviced by the CMW at the birthing station for our deliveries".* Another preference that was reported by the women in all the focus group discussions was having the flexibility of being serviced, by the CMW, at either the birthing station or at their homes. They expressed that this flexibility would allow the CMW to visit their homes and conduct the delivery in case there is an emergency or the delivery takes place in the evening/night.

> *"We would prefer a flexible option that if we cannot go to the birthing station, for some reason or the other, the CMW should be able to come to our homes to provide delivery services",* stated a woman during the FGD.

However, some of the women preferred only homes for CMWs to provide delivery services and in Balochistan some women strongly voiced out that they should be serviced by CMWs at their homes because it is considered odd for women to go out of their houses. One of the women in Balochistan stated, *"I am not allowed out of the home even if I am dying".*

In summary, three types of preferences for birthing place, serviced by CMWs came out from the FGDs of women: birthing stations; home; and the flexibility of having services by the CMWs either at the birthing station or at their homes.

Community Elders Preferred Birthing Stations for CMW Services

The community elders not only welcomed the idea of CMWs, but also expressed their preference for a birthing station in their community.

> *A male community elder said, "The way we all want our children to get best of education, so we send them to the best of schools; similarly if we have CMWs and birthing Stations in our communities we would have our children born at the best possible place. We have seen a lot of mothers and children die at the hands of TBAs and it is time to change this".*

The majority of the community elders preferred birthing stations as the place of delivery; some of the elders went on to suggest, *"The CMW should either set up the birthing station at her own home or at the Basic Health Unit, which is easily accessible by the community at large".*

However, a few of the elders preferred home-based deliveries because they viewed this as culturally more appropriate. One of the elders stated, *"CMWs should provide services for deliveries at homes; homes are the best place for such matters".*

Thus, the community elders preferred either the birthing station or home for CMWs provision of delivery services. It was interesting to note that none of the elders strongly opted for having the flexibility of services delivered by CMWs either at birthing stations or homes, as was preferred by the women.

CMWs Preferred Birthing Stations as the Place for Providing Services to the Communities:

The community midwives were also asked about their preference for a birthing place, and all of them were hoping to set up birthing stations instead of conducting deliveries at women's homes. This overwhelming preference of birthing stations by the CMWs was recorded in all the provinces. However, they did suggest that they should visit the homes of the women initially to introduce themselves, and to spread awareness. One of the CMWs stated, *"At the start of our work of course we would have to go around visiting homes in order to properly introduce ourselves to the communities, but we would like to conduct deliveries at our own birthing stations".* They also preferred that the birthing stations be set up at their own homes for the sake of their convenience as this could in turn ensure a 24-hour availability of services for the community.

> *"Our personal residence is better because we would have all the instruments at home and we can set one room of our house as birthing station. This will increase our worth in the community as well",* a CMW stated.

Therefore, having birthing stations as the first and the only preference by the CMWs is similar to the foremost preference of the women and the community elders. Additionally, the CMWs also view having birthing stations in their own homes as convenient and as a means of providing stature to them in the communities where they will eventually serve.

MCNH Programme Personnel Preferred Homes as the Birthing Place

Last but not the least, views and opinions of the MNCH Programme personnel were taken to ascertain what their current thinking was regarding placement of CMWs. The majority of the MNCH Programme personnel were of the opinion that CMWs should be conducting deliveries at the women's homes.

> One of the district Coordinators said, *"CMWs should go to homes for conducting deliveries".*

One of the district coordinators recognised that in certain places the community households may not have a proper place for conducting deliveries at home and suggested, *"CMWs should have a mobile cabin made of wood or plastic so that they can adjust that into the courtyard of houses because many houses in Balochistan and Khyber Pakhtunkhwa do not have surplus rooms".*

The initial strategy or policy of the MNCH Programme was to have CMWs conduct home-based deliveries and gradually replace the TBAs. However, one of the MNCH Programme Personnel had a different view, *"CMWs should have a birthing station within her own house; we would want her to conduct deliveries there. This will help the CMWs as it will be very convenient for her. We are thinking of establishing birthing stations for them".*

In summary, from findings of all the four types of respondents, it is interesting to note that divergent views have been captured regarding the preference for a birthing place. The majority of the women, community elders and all the CMWs preferred birthing stations for conducting deliveries. On the other hand, the MNCH Programme categorically stated that the deliveries by CMWs have to be home-based. However, there seemed to be a hint of re-thinking/re-assessing by the MNCH Programme on this decision of having just home-based deliveries conducted by CMWs. In order for the CMW initiative to become successful, the MNCH Programme will have to be receptive to the preference of the community households and the CMWs.

3.2.2. Reasons for a Particular Preference

We inquired about the reasons for the preference from all groups of respondents. Following are the reasons that the respondents stated for the three main preferences: birthing stations; homes; and of

having the flexibility to be serviced by CMWs either at the birthing stations or homes.

Reasons for Preferring Birthing Stations for Service by CMWs:

The reasons for preferring birthing stations were reported to be:

- **Availability of better facilities at the birthing station**

  Across all the provinces, the major reason for choosing birthing stations serviced by CMWs, where deliveries could take place, was the perception of having better facilities compared to homes. This was despite the fact that it was explained to the respondents that CMWs will have same set of instruments when she provides delivery services at homes, but they still felt that the birthing stations would be better equipped to handle unforeseen issues. One of the women in a FGD stated, *"At the birthing station the CMW would have proper instruments like medicines, oxygen, emergency kit and injections".* It seems that birthing stations of CMWs gave some sense of extra security to the respondents.

- **Better cooling and heating at Birthing Stations**

  An interesting perception was reported by some women, in terms of having an optimum temperature during deliveries, which was considered very important for the health of the mother and the new born. Many a times houses are not properly equipped to control the temperature of the room where the delivery is being conducted, whereas, birthing stations may have this facility.

> *Voiced by the women, "Our houses get very hot in summers and very cold in winters. We have no way of keeping the temperature suitable for the delivering mother and the new born; it is very important for the health of the mother and child that the room temperature is just right. This would not be a problem at the birthing stations".*

- **Birthing Stations will have a separate delivery room**

  Having a separate room or space to have a delivery was raised as an important consideration in opting for the birthing stations of CMWs. Many a times households do not have a room to spare at the time of delivery, and since birthing stations would be catering for deliveries they would not have this issue.

> *Stated by a woman, "Many houses do not have a separate room to have deliveries and it gets very difficult. As a result the women then opt to get delivered at their parent's homes and that too is not always possible".*

- **Birthing station will ensure better privacy**

  Linked to having a separate space for deliveries was the issue of having privacy during deliveries. A lot of women raised the issue of being shy and embarrassed at the time of their previous deliveries. They felt especially embarrassed by the male folk being present at home while they were delivering. This concern of embarrassment and shyness was more in Province Punjab compared to other provinces.

> *Some of the women said, "The birthing station is better because to deliver at home in the presence of male members and children looks odd and embarrassing. Sometimes the woman starts crying which does not look good and children make fun of it afterwards".*

Therefore many women preferred being delivered at birthing stations by CMWs just for this reason.

- **Birthing station will help CMWs conduct better services**

  The women and the community elders were very welcoming about the notion of having CMWs servicing their communities and had shown a sense of ownership on their part towards the CMWs. Linked to this was another interesting finding that women and community elders were linking CMW's levels of confidence and her self-worth directly to her skills. To ensure that she feels confident at what she does (conduct deliveries), they were of the opinion that CMWs will feel most comfortable at their birthing stations rather than at other people's homes. A lot of women were also conscious about the psychological satisfaction and confidence level of the CMWs.

> *The elders and women said, "Mental satisfaction of the CMW is also important while conducting deliveries and she will feel better at her own place".*

Women believed that along with experience, practical knowledge, skills and better instruments, confidence level and psychological comfort of the CMWs will also ease the process of conducting deliveries for them.

Some elder people were also of the view that setting a birthing station will increase the worth of CMW in the community and stated, *"When she will roam around in the village and visit every house, who will respect her? But if she will have a birthing station then she will receive more respect from the community and this will, in turn, help her do a better job".*

Reasons for Preferring Home-Based Deliveries:

Some women and community elders preferred that CMWs provide delivery services at homes instead of her birthing station. The reasons of this were found to be:

- **Home ensures better privacy and is in line with cultural values**

  For some women and community elders homes were the most appropriate place for having deliveries conducted by CMWs. This was mainly due to cultural reasons, so women in Balochistan preferred homes as the birthing place due the privacy issue and cultural norms. In their context having to go out and get delivered at birthing stations would be considered culturally inappropriate and odd.

> *A few of the women said, "Home is a better option because we observe veil/parda and according to our cultural values, activities of woman outside the home are considered bad".*

  Similar views were also shared by community elders and some of them stated, "Delivery is a private and sensitive matter, so why make it public. It is not our practice to have our sisters and daughters go out for such matters. Homes are the most suitable place to be delivered even by a CMW".

- **Elder women (mothers-in-law) would favour home-based deliveries:**

  Many a times the women do not have the autonomy or the decision making power when it comes to their own health and especially reproductive health. It is usually the elder women or the men-folk who decide about such matters. Similarly, the decision about where to have the delivery would also lie with elder women especially the mothers-in-law. One of the reasons reported by women in opting for home-based deliveries, conducted by CMWs, was because their mothers-in-law are the ones who decide the place of delivery, and even the male members usually do not interfere in this decision.

> One of the women stated that, *"Mothers-in-law decides where to deliver, males do not know anything about it, and they have nothing to do with it".*

  Mothers-in-law were reported to be very influential; to the extent that if women required consulting lady doctors or to have ultra sounds, in most cases mothers-in-law would not permit this. Some women reported that *"our mothers-in-law say that we ourselves also gave birth to children but we never went outside or got an ultra sound done. Why waste 200 or 300 rupees for an ultrasound, you may take milk for yourself with this money".*

  Therefore, many women just because they felt that their mothers-in-law are the key decision makers, preferred their homes for being serviced by CMWs.

Preference of Having Flexibility in Being Serviced by CMWs at Either Birthing Stations or at Homes:

Many women and a few community elders opted for having a flexibility of being serviced by CMWs either at the birthing stations or at the homes. Many respondents wished that the CMW should also visit their homes in case of an emergency or in some situations when they themselves cannot go to the birthing stations. For example, women expressed that under the circumstances when the delivery takes place late at night and proper transportation may not be available to reach the birthing stations, CMW can visit the home.

> One of the women stated, *"Having the birthing station that is easily accessible is good, but there may be circumstances in which I may not be able to go there. In such cases the CMW should then come to my home. So sometimes I can go to her birthing station and at other times she can come to my home".*

Similarly a few community elders voiced that *"the CMW should establish a birthing station in the community but she should also visit homes if needed".*

Although birthing station was the major preference of community elders and women but it was also found in discussions that people wanted to have flexibility in receiving services from the CMW.

3.2.3. Challenges

One of the objectives of this study was to explore potential challenges CMWs may face once they start providing services to their respective communities. Following are the main challenges reported by the respondents:

Lack of Awareness in the Community about Community Midwives

Majority of the respondents (women and community elders) were not aware about the CMWs, their nature of work and their deployment in the area. In Punjab, CMWs were deployed but people did not know about their nature of work because they were not actually working in the field. In most of the qualitative contacts with women, it was reported that they had not heard of CMWs, while some claimed that they knew about CMWs deployment in other villages.

> One of the women said, "I do not know of any CMWs working in the area".

Similar remarks were stated by many community elders. Many of the CMWs themselves and the community elders gave suggestions to help improve the awareness of the community regarding CMWs. Many CMWs suggested that *"Our programme should use media to introduce us to the communities and have a launching ceremony at least at the district-level which may also help in better awareness among the communities".* The community elders however gave the suggestion of *"having announcements made in the communities through mosques to help raise awareness in the communities".*

Competition with Traditional Birth Attendants (TBAs)

Traditional birth attendants are a reality in the community. They have been there, providing services, far before the CMWs. The CMWs are to replace the existing TBAs, however, this will not be easy.

> One of the CMWs said, *"The TBAs in my catchment area know that I have been trained which is causing them to feel threatened that I will eventually take over their clientele. Out of this insecurity, the TBAs go around saying that I am a novice, inexperienced, and an unmarried person compared to her who is an experienced, trusted and a well-tested birth attendant".*

This competition will naturally be faced by all the CMWs. However, if the TBAs are turned into allies, this challenge might get addressed. For example, another CMW said, "In one situation, the TBA could not deal with one complication during a delivery, so she referred the case to me because of which there was a positive introduction into the community for me by the trusted TBA".

This transition or replacement of TBAs will not happen overnight. All that needs to be done is that the communities, the TBAs, as well as the LHWs should be aware of the presence of the CMWs and the services that a skilled birth attendant can offer. This was raised by many CMWs who stated "If the LHWs and Lady Health Supervisors (LHS) help introduce us to their clients, we may have a smoother entry into the communities". While some other CMWs were also of the opinion that "If TBAs are helpful and know that a skilled attendant is available to help her in deliveries this may help us too".

Delay in Deployment and Certification of CMWs

Majority of the CMWs were of view that people will accept them provided they were given certificates after their trainings and necessary instruments to start conducting deliveries in the community. This delay in handing out the certificates to CMWs posed as a challenge. Many CMWs stated, "we still await our certification and people say if we have not as yet gotten the certificates from the Programme, then this indicates that we have failed our training and are not certified to serve the communities".

Similarly awaiting deployment was raising certain issues for the CMWs. Many reported that, "since we have not been formally deployed and given a go ahead from our Programme this is casting doubts in the minds of the communities and they are thinking that the CMWs have been abandoned by the Programme". This delay in deployment, apart from raising concerns at the community-level, was also causing a delay in practically applying what the CMWs had learnt. This was leading to a weakening of their skill-sets, which was highlighted by the CMWs.

> *"We are forgetting what we have studied because training had taken place three years ago and we will need to refresh our skill-set before we start serving the community",* stated by a CMW.

These delays on the part of the Programme are causing demotivation and the plummeting of confidence levels as well as tarnishing the image of the CMWs in the community. This can be avoided provided that the Programme addresses its procedural delays. This aspect came up in the discussions and the group of already deployed CMWs reported that *"Women in the community observe the way deliveries are conducted (by CMWs wearing gloves, having safe delivery kit) which is not in practice of the TBAs. This practice was appreciated by the community and will enhance the trust level of the community in the future".* This quote is self-explanatory since the main competition for the CMW is the TBA, therefore, in order to make the CMW widely acceptable within the community her creditability has to be reinforced.

Inadequate Skill-set of CMWs

Another important factor of note is related to the training of the CMWs. Many of the CMWs reported that they did not feel ready in terms of knowledge and skill-set to start servicing the communities. This was conveyed in the discussion by them.

> *"We did not get a chance to practically conduct deliveries in the supervision of doctors due to which we are hesitant in going out and conducting deliveries",* the remarks of a trained CMW.

Furthermore, commenting on a lack of communication skills, one of the CMWs stated, *"We CMWs should be given training on presentation and communication skills that can be beneficial when visiting households. This will help us in introducing ourselves and engaging with the families in a more confident manner".*

Inadequate Remuneration of CMW Services

Another challenge contributing to the demotivation and low self-esteem of CMWs was related to insufficient remuneration of CMW services. One of the CMWs, stated in an FGD, *"Currently, I am being paid a stipend of Rs. 2,000 per month, whereas, an LHW who is not a skilled professional gets paid Rs. 7,000 per month. This is undermining my stature and credibility as people draw comparisons and believe that since LHWs are getting more, they must be more skilled".* Apart from this inadequate stipend, there are often delays in the release of the payment which further adds to this challenge. So, one of the CMWs stated, *"We do not get our stipend on a timely basis due to which we end up spending money from our pockets to go attend meetings. As a result of this, I have often thought of quitting".*

> One of the MNCH Programme personnel reported, *"We have had cases where CMWs, due to our financial constraints, have left the Programme and joined other organisations that were paying better".*

This is one of the serious challenges faced by the Programme because, on the one hand, it is causing demotivation at the level of the CMWs and, on the other hand, it is posing a problem for the Programme in terms of retention of the trained CMWs.

Issues Related to the Mobility of the CMWs in the Communities

The catchment area allocated to the CMWs currently stands at a population of 5000 people. This, however, can vary in terms of geographical area covered as the population density may vary across different provinces, for example, in Balochistan the CMW will have to cover a larger area as compared to a more densely populated province. This challenge was raised and reported during the discussions with the CMWs.

> One CMW stated, *"My catchment area is spread over a large area which I find extremely difficult to cover".*

Related to this, another challenge raised was the lack of transportation available to reach out to the community. This was voiced by a CMW, who said, *"transport is a big issue in rural areas; Government should provide us a van, to make our job easier".* This particular challenge was also acknowledged by the MNCH Programme personnel who stated, *"CMWs should have vans allocated to them to help with the issue of mobility in reaching the far-flung areas".*

Another challenge linked with the issue of mobility, raised by the CMWs, was security while travelling, particularly at night. One of the CMWs stated, *"I find it very difficult to go out into the community in the evenings or at night, to perform deliveries at homes. It is a worrying concern for me regarding my security since all sorts of good or bad people do exist".*

Mobility, therefore, seems to be a major concern and challenge for the CMWs.

Young Age and Marital Status of the CMWs

Another challenge faced by the unmarried CMWs, especially those who are young, was that the communities did not reckon a young and inexperienced CMW capable of conducting deliveries.

A CMW said, *"My community feels that since I am unmarried and have not gone through a pregnancy or have had a child of my own, how will I related to the pregnant woman who will be my client".* Linked to this personal lack of self-experience, another challenge is posed where the community feels that it is inappropriate for an unmarried woman to be talking about pregnancy related issues and conducting deliveries. This was voice by one of the CMWs as, *"My community thinks of me as a bad person with bad morals as I am talking confidently about such issues without being married myself".*

This particular challenge is adding to the difficulties faced by the CMWs working in the communities. Interestingly, one of the CMWs who was facing this challenge and eventually got married and had a child reported,

> "After I had a child, I saw a remarkable change in the community regarding my stature and acceptability, and the ease with which my clients could now relate with me".

4 Discussion and Conclusion

The CMW initiative of MNCH Programme in Pakistan is aiming to reduce a high national maternal mortality by increasing SBA deliveries. For the success of this very important initiative, the deployment strategy of CMWs has to be in line with the wishes of the community and the requirements of the CMWs. The challenge of the acceptance and the accessibility of CMWs largely depend upon this alignment. As this is a one-time chance to get it right, the Programme would want to put the right foot forward after careful planning and thoughtful deliberation. To help the Programme achieve this objective, this first of its kind national study was undertaken to get informed about the preferences of various stakeholders about where they would like the CMWs to conduct deliveries.

This mixed methods study not only inquired about the preferences but also explored the reasons behind these preferences in four provinces of Pakistan. The representative provincial data emerging from this study is particularly useful for the Programme in the post-devolution scenario.

It is important to note that at the time of the study, majority of CMWs were waiting to be deployed after having received their trainings. Therefore, seeking preference of households meant posing them with a hypothetical scenario to pick a preference in the absence of working CMWs. To address this, the operational definitions of "work stations" and "catchment area" was used as given in the PC1 document of the MNCH Programme (MNCH Program, 2006). It was clarified to the respondents that the "birthing stations" are essentially "work stations" with the added facility for deliveries. Apart from this it was also explicitly clarified to the respondents that this "person" who is a CMW will be a trained and a skilled birth attendant who shall be based within their community to provide services. Further clarification was given that CMWs were different from the Lady Health Workers and the Lady Health Supervisors who service the communities or the Lady Health Visitors that are stationed at government facilities like BHUs and RHCs.

The major finding of this study is that the majority of the households nation-wide opted for birthing stations, rather than homes, as the preferred birthing place where they would be serviced by the CMWs. This preference is followed by the demand for a flexibility to have either of the options available, however, a minority is still opting for home-based deliveries by the CMWs.

There is ample evidence suggesting that a majority of women in Pakistan deliver at home (PDHS, 2008). The reason behind this is not solely a preference, but is perhaps due to the fact that TBAs are the only available, affordable, accessible and community-based option. Other related evidence points to non-utilisation of health facilities for deliveries due to several reasons including financial, logistical, fear of operations, etc. For this reason, this is perceived as a tilt towards home-based deliveries that is erroneously misconstrued as the household preference. Since now the households have a choice of a skilled birth attendant within their community, their preference for a place of delivery has unfolded.

This finding of the preference of birthing stations, nationally as well as provincially, was because of the perception of the community that homes lack the necessary facilities, for example, a separate place, temperature control, emergency equipment, privacy from family members, etc. The lack of amenities at home is also pointed out by other studies (Wagle R, Sabroe S, & Nielsen B, 2004). Various studies have indicated that economic and physical accessibility are key factors that contribute to choice of the place of birth (Thaddeus S & Maine D, 1994; Say L & Raine R, 2007; Mayhem M et al., 2008). Our results are also in line with these findings as many of the households have expressed that proximity of the proposed birthing station was a main reason for selecting the birthing station as the preferred choice.

The preference for the mixed model where the CMW would provide delivery services both at home and at the birthing station is not a new concept. Some countries have programmes that are practicing the mixed model for the community midwives (Currie S & Fowler R, 2007). A large majority of households from all the four provinces have actually suggested a mixed model approach where they have a flexibility of choice. The underlying reasons given for this preference are understandable as women may prefer to be delivered by the CMW in their homes at odd hours or when a complication or non-availability of transport restricts mobility of the woman.

Compared to this study, previous studies have indicated high proportions of home based deliveries (PDHS, 2008; PDHS, 1992; Safdar S, Inam S, Omair A, & Ahmed S, 2002; Fatima T et al., 2008; Jafarey S N & Korejo R, 1993). Our study has revealed that nationally less than a quarter (22%) of the households would explicitly prefer home-based deliveries. The Province Khyber Pakhtunkhwa had a little higher percentage of households (33%) preferring home births probably due to local traditions of the Province. The major reasons stated for this preference were similar to those stated in previous studies, such as, privacy, stigma, financial considerations, lack of transportation and proximity of the health facility (Fatima T et al., 2008; Shah N et al., 2010).

It is heartening to note that the community overwhelmingly welcomes the idea of a trained birth attendant in their locality. This is an excellent opportunity where the wishes of the community, families, women, as well as the CMWs are aligned in terms of preference for the birthing place. Now it is up to the Programme to capitalise on this opportunity and address the challenges foreseen by the stakeholders. The community midwives are the key stakeholders who will carry this initiative forward provided that their motivation and commitment is ensured. This can be done by valuing their opinions regarding their placement and working, and by addressing the challenges foreseen by them. The various challenges pointed out by the CMWs during the discussions are: the lack of awareness about them in the community; competition with the TBAs; procedural delays; inadequate skill-set; inadequate remuneration; mobility and security; and perceptions about their young age and marital status.

An important finding about the perception of the MNCH Programme personnel, with respect to the place where the CMWs will provide service, is based on the historical view of home-based deliveries. They are viewing the CMWs as substitutes for TBAs, who only deliver at home. This positioning is in contrast to the opinions expressed by the community stakeholders. The wholehearted efforts of the Programme in achieving its objectives may be hampered by the divergent views of the policy makers and the important community stakeholders.

4.1. Recommendations/Implications

The results of this study have important implications for provincial MNCH Programmes as the study provides insights in to community preferences and provides evidence for the Programmes to align their placement policy with the aspirations of the community and the midwives. The key recommendations for the Programmes are:

1) The MNCH Programme should revisit their approach towards home-based deliveries through CMWs. The envisaged work stations can be converted into a facility where deliveries can take place as well. This will have minimal additional cost implications.

2) A flexible mixed model approach would be ideal to cater for the preferences of the majority. Under this model the CMW would be placed in a birthing station but when required she would conduct home-based deliveries as well.

3) A well thought out strategy for launching and introducing the CMWs into their communities should be undertaken with the assistance of media, and the existing community-based agents like the LHWs and LHSs.

4) It is necessary to ensure that the CMWs acquire a high standard of skill-set, with a sound practical experience. Better communication skills which will help the CMWs to engage with the communities in more confident manner.

5) The Programme needs to ensure a highly motivated CMW work-force and this can be achieved by resolving procedural delays such as timely distribution of certificates as well resolving their financial considerations.

Reference List

Anwar I, Sami M, Akhtar N, Chowdhury M E, Salma U, Rahman M et al. (2008). Inequity in maternal health-care services: evidence from home-based skilled-birth-attendant programmes in Bangladesh. *Bull World Health Organ,* 86, 241-320.

Arif M S, Miller P C, Munir N, & Masood I (2006). S*afe Motherhood Applied Research & Training Project SMART* (Rep. No. 3). Islamabad, Pakistan: Population Council.

Bhutta Z A, Memon Z, Soofi S, Salat S M, Cousensb S, & Martinsec J (2008). Implementing community-based perinatal care: results from a pilot study in rural Pakistan. *Bull World Health Organ,* 86, 459.

Currie S & Fowler R (2007). A bold new beginning for midwifery in Afghanistan. *Midwifery,* 23, 226-234.

Fatima T, Afzal S, & Mehmood S (2008). Psychosocial determinants of preferring home births. *Biomedica,* 24, 85-88.

Gupta R K (1999). Institutional and non-institutional deliveries in some Slum areas of Delhi: factor analysis. *Indian Journal of Community Medicine,* 24, 147-149.

Jafarey S N & Korejo R (1993). Mothers brought dead: An inquiry into causes of delay. *Social Science & Medicine*, 36, 372.

Kapoor R K, Srivastava A K, Misra P K, Sharma B, Thakur S, Srivastava K L et al. (1996). Perinatal mortality in urban slums in Lucknow. *Indian Pediatrics,* 33, 19-23.

Mayhem M, Hansen P, Peters D, Edward A, Singh L, Dwivedi V et al. (2008). Determinants of Skilled Birth Attendant Utilization in Afghanistan: A Cross-Sectional Study. *Am J Public Health,* 98, 1849-1856.

MNCH Program (2006). *National Maternal Newborn and Child Health (MNCH) Program: PC-1* Government of Pakistan, Ministry of Health.

MNCH Program (2010). *Guidelines for the Deployment of Community Midwives (Revised 2011)* Government of Pakistan, Ministery of Helath.

Osrin D, Tumbahagphe K M, Shrestha D, Mesko N, Shrestha B, Manandhar M K et al. (2002). Cross sectional, community based study of care of newborn infants in Nepal. *BMJ,* 325.

PAIMAN (2007). *Annual Report* Pakistan Initiative for Mothers and Newborns (PAIMAN).

PDHS (1992). *Pakistan Demographic and Health Survey 1990 - 1991* National Institute of Population Studies & IRD/Macro International.

PDHS (2008). *Pakistan Demographic and Health Survey 2006-07* National Institute of Population Studies Islamabad, Pakistan: Macro International Inc. Calverton, Maryland USA.

Safdar S, Inam S, Omair A, & Ahmed S (2002). Maternal Health Care in a rural area of Pakistan. *JPMA,* 52.

Say L & Raine R (2007). A Systematic Review of Inequalities in the Use of Maternal Health Care in Developing Countries: Examining the Scale of the Problem and the Importance of Context. *Bull World Health Organ,* 85, 812-819.

Shah N, Rohra D K, Shams H, & Khan N H (2010). Home deliveries: reasons and adverse outcomes in women presenting to a tertiary care hospital. *JPMA,* 60.

Sreeramareddy C T, Joshi H S, Sreekumaran B V, Giri Sabitri, & Chuni N (2006). Home delivery and newborn care practices among urban women in western Nepal: a questionnaire survey. *BMC Pregnancy Childbirth,* 6.

Thaddeus S & Maine D (1994). Too Far To Walk: Maternal Mortality in Context. *Soc Sci Med*, 38, 1091-1110.

The World Bank (1999). *Safe motherhood and The World Bank: lessons from ten years of experience.* Washington, DC: The World Bank.

Wagle R, Sabroe S, & Nielsen B (2004). Socioeconomic and physical distance to the maternity hospital as predictors for place of delivery: an observation study from Nepal. *BMC Pregnancy Childbirth,* 4.

Wajid A, Rashid Z, & Mir A M (2010). *Initial Assessment of Community Midwives in Rural Pakistan* Islamabad, Pakistan: Population Council.

Appendices

Appendix I– Geographical Location (Maps of the Area Highlighting Project Districts)

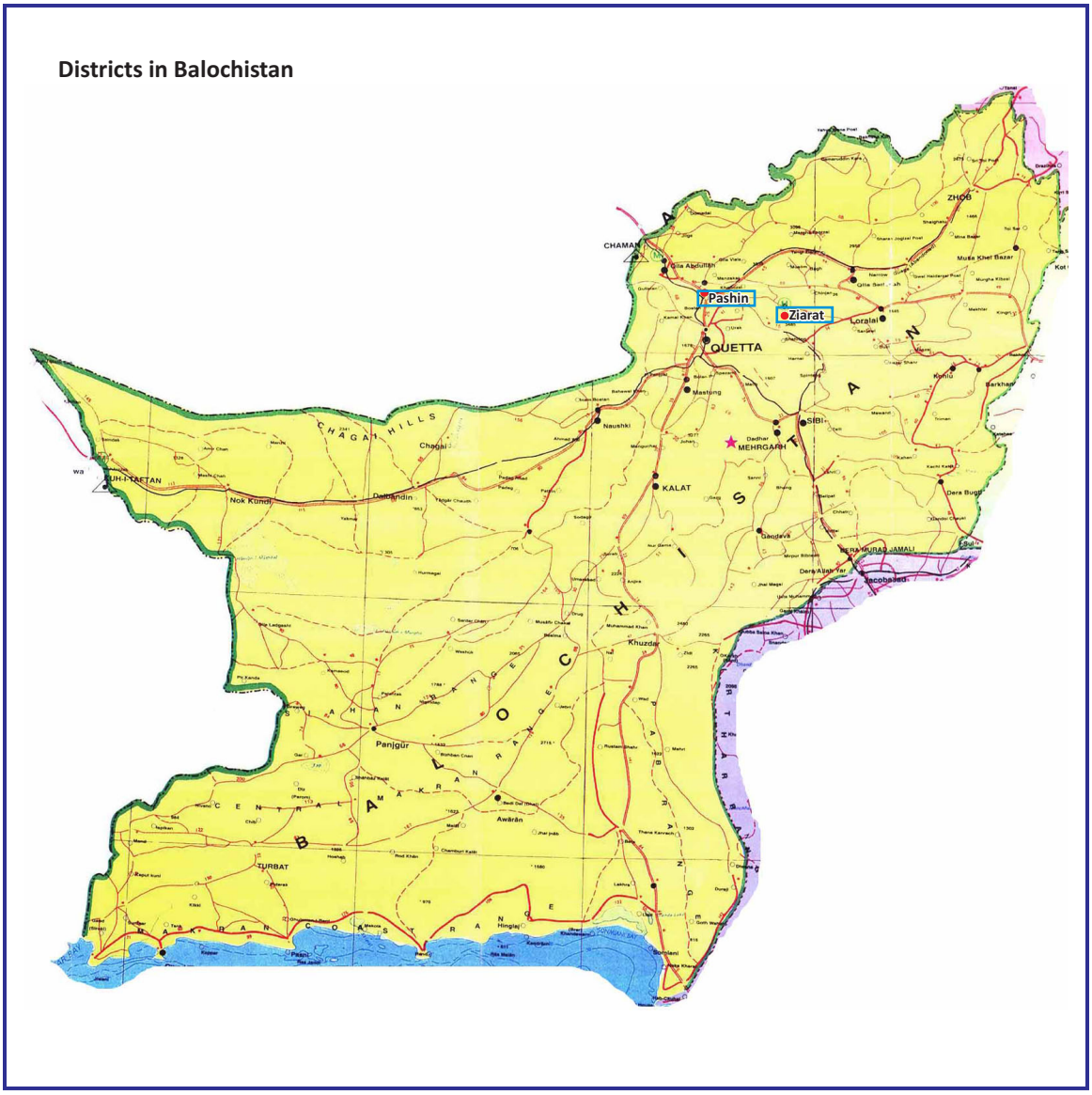


Figure 7: Map of Province Balochistan

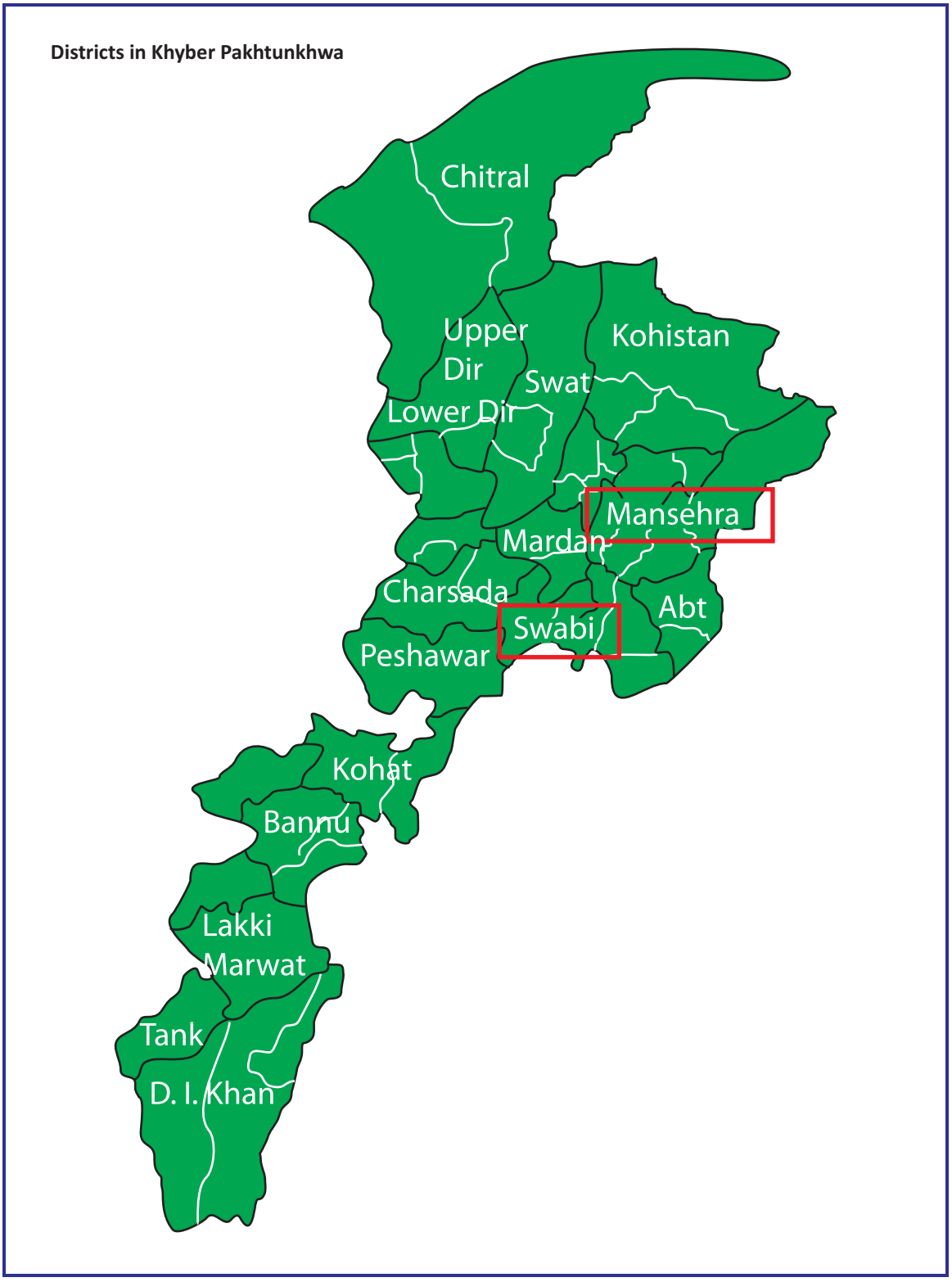


Figure 8: Map of Province Khyber Pakhtunkhwa

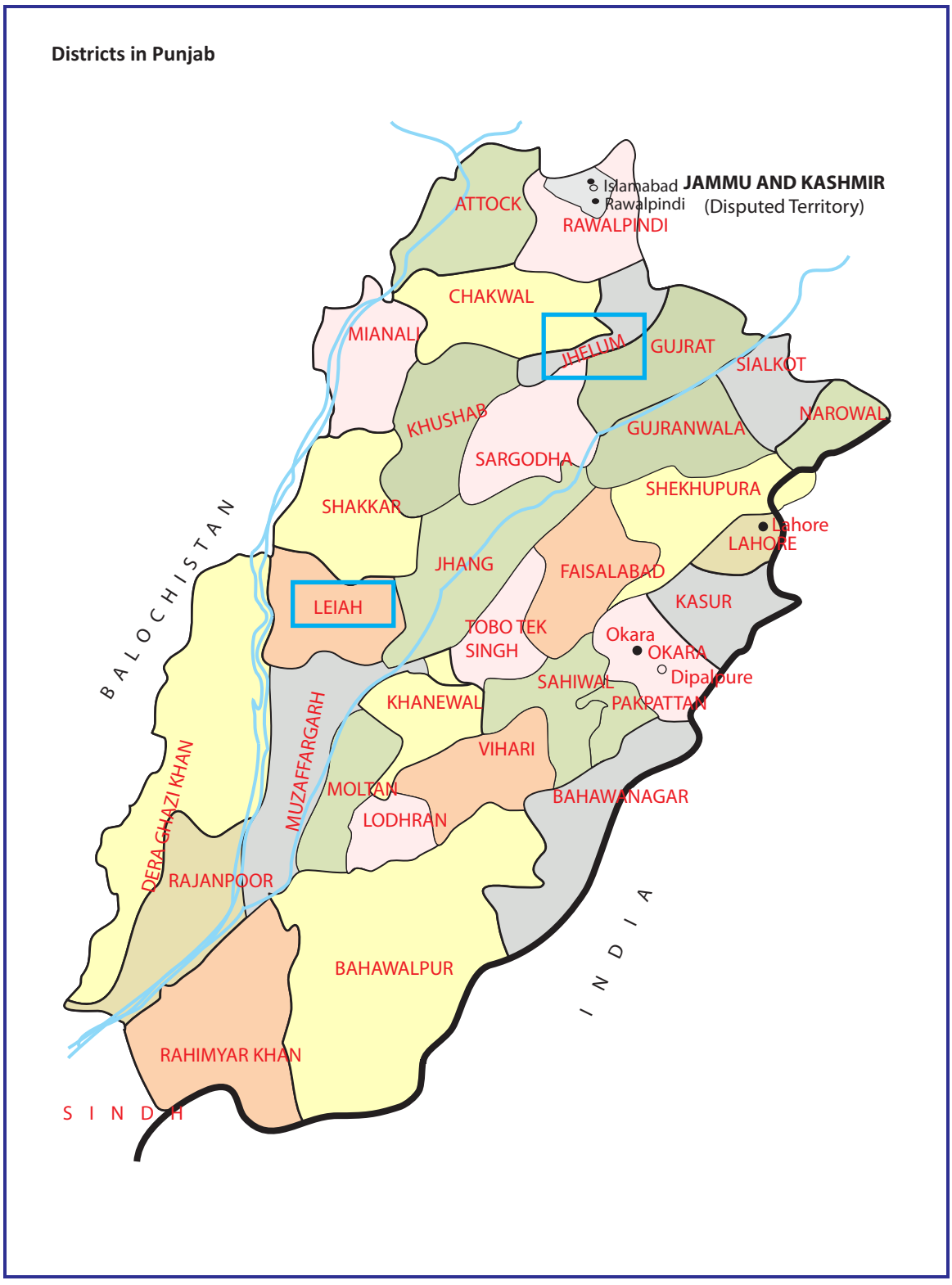


Figure 9: Map of Province Punjab

Districts in Sindh

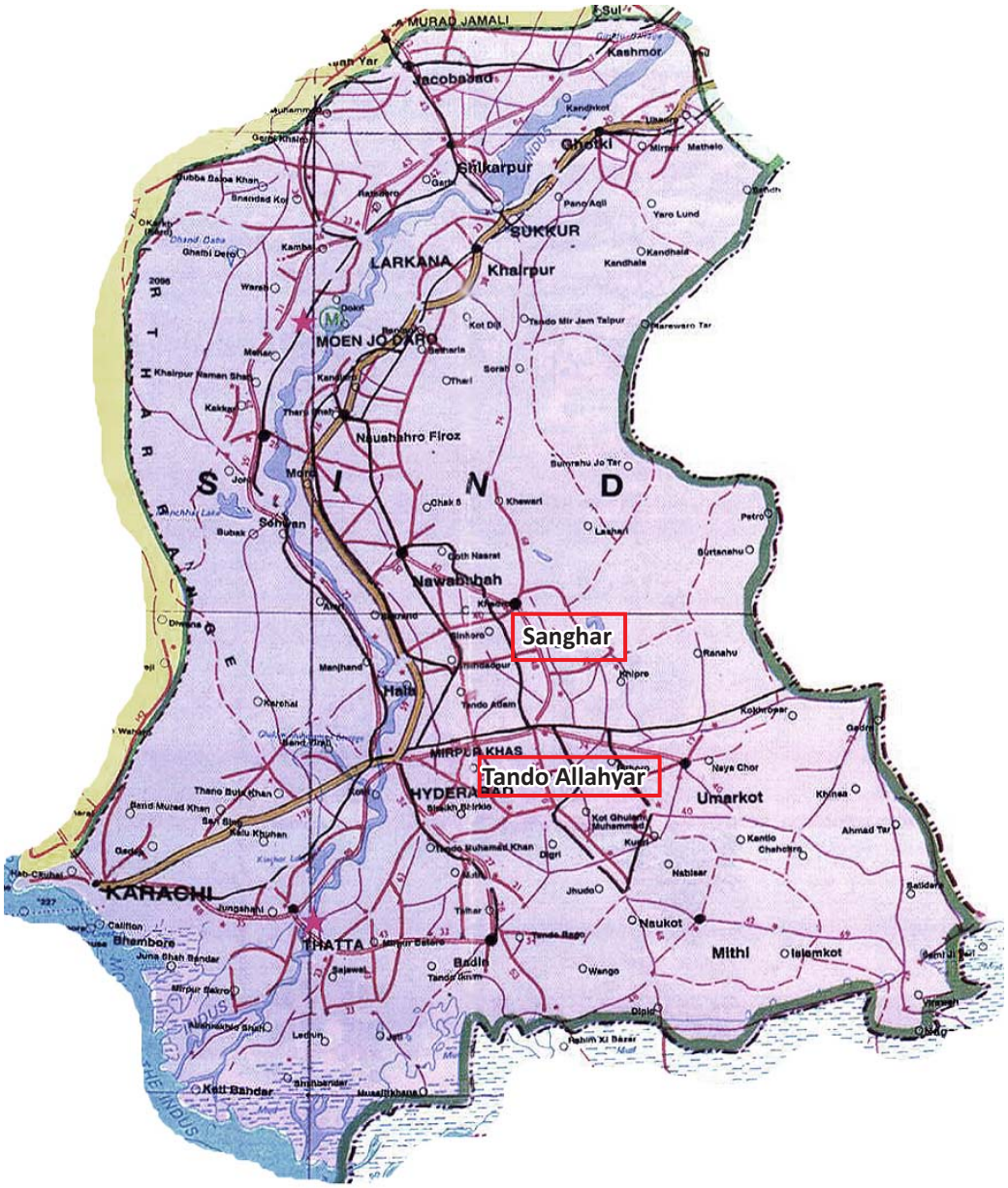


Figure 10: Map of Province Sindh

Appendices II – Research tools (Questionnaires, etc.)

Informed Consent Form

پراجیکٹ انفارمیشن

Project Tilte: Preference of Birthing Place, A Mix Method National Study of Communities, Households, Community Midwives & MNCH Program	**Project No:**
ERC Ref No:	**Sponsor:** RAF
Principal Investigator: Dr. Shamsa Rizwan Dr. Siham Sikander	**Organization:** Human Development Research Foundation(HDRF)
Location: I-8/3, Islamabad	**Phone:** 051-4864249
Other Investigators: Mr. Ikhlaq Ahmad Dr Mansoor Ahmad	**Organization:** Human Development Research Foundation(HDRF)
Location: I-8/3, Islamabad	**Phone:** 051-4864249

تحقیق میں شمولیت کی دعوت:۔

آپ کو ایک تحقیق میں شرکت کی دعوت دی جارہی ہے۔اس سے پہلے کہ آپ کوئی فیصلہ کریں آپ کا یہ جاننا ضروری ہے کہ یہ تحقیق کیوں کی جارہی ہے اور اس میں کیا ہوگا۔ برائے مہربانی نیچے دی گئی معلومات کو غور سے پڑھیں اور اگر آپ چاہیں تو کسی دوسرے سے مشورہ بھی کر سکتے ہیں اگر آپ کو کوئی چیز سمجھ نہیں آرہی یا آپ مزید معلومات چاہتے ہیں تو آپ ہم سے بات کر سکتے ہیں۔آپ فیصلہ کرنے میں وقت لے سکتے ہیں کہ آپ اس تحقیق میں شامل ہونا چاہتے ہیں یا نہیں۔

اس تحقیق کا مقصد کیا ہے؟

اس تحقیق کا بنیادی مقصد یہ معلوم کرنا ہے کہ CMW's کے ذریعے زچگی کرانے کے حوالے سے گھرانوں کی کی کیا ترجیح ہے اور اس ترجیح کی وجہ کیا ہے؟ CMW's خود کہاں زچگی کرنا چاہتی ہیں اور اس ترجیح کی وجہ کیا ہے؟ CMW's کے خیال میں ان کے کام کرنے کی جگہ سے متعلق کیا دشواریاں ہوسکتی ہیں اور کمیونٹی اس کو کیسے قبول کرے گی۔ MNCH کے لوگوں کا نقطہ نظر کہ CMW's اپنی خدمات کہاں سرانجام دیں (گھر پر یا زچگی سنٹر پر) اور اس پروگرام کو شروع کرنے میں درپیش مشکلات کیا ہوسکتی ہیں۔

طریقہ کار:۔

اگر آپ اس تحقیق میں شامل ہونے پر رضامند ہیں تو آپ کو CMW's کے کام کے حوالے سے کچھ سوالات کے جواب دینے کے لئے مدعو کیا جائے گا۔آپ کیا چاہتے ہیں کہ وہ آپ کے علاقے میں اپنی خدمات کیسے سرانجام دے آپ کو ایک گروپ کی صورت میں گفتگو کے لئے کیا جائے گا یا آپ سے فرداً فرداً بات چیت کی جائے گی۔

ممکنہ تحفظات:۔

آپ جو بھی معلومات مہیا کریں گے اس کو انتہائی صیغہ راز میں رکھا جائے گا اور صرف اور صرف اس تحقیق کے مقصد کے لئے استعمال کیا جائے گا۔آپ کے اس تحقیق میں شامل ہونے سے کوئی نقصان نہ ہوگا۔

ممکنہ فوائد:۔

فی الوقت تو اس تحقیق سے شاید آپ کو کوئی براہ راست فائدہ نہ ہو لیکن یہ معلومات آپ کے علاقے میں ماں اور بچے کی صحت کے حوالے سے سہولیات کو بہتر کرنے میں مددگار ثابت ہوں گی۔

مالی معاونت:۔

اس تحقیق میں آپ کی شمولیت رضا کارانہ ہے اور اس کے لئے آپ کو کوئی مالی معاونت نہیں کی جائے گی۔

رازداری:۔

اگر آپ اس تحقیق میں حصہ لینے پر رضامند ہیں تو آپ سے لی گئی کوئی بھی معلومات ریسرچر صرف تحقیق کے نتائج اخذ کرنے کے لئے استعمال کریں گے۔ اگر آپ چاہیں گے تو آپ کا اصلی نام استعمال نہیں کیا جائے گا۔ تحقیق کے دوران لی گئی تمام معلومات کو انتہائی صیغہ راز میں رکھا جائے گا۔

تحقیق سے اخراج:۔

کسی بھی سطح پر اور حتٰی کہ دوران انٹرویو گفتگو آپ تحقیق کو چھوڑ کر جا سکتے ہیں، اس سے آپ کو کوئی نقصان نہیں ہوگا۔ اور آپ ان تمام تر سہولیات کے حقدار ہیں جو آپ کو عام حالات میں ملتی ہیں۔

معلومات کے ذرائع:۔

تحقیق سے متعلق سوالات کے لئے

ڈاکٹر منصور احمد اور اخلاق احمد

فون نمبر۔ 051-4864849۔

اجازت:۔

میں نے یہ فارم پڑھ اور سمجھ لیا ہے اور میں رضا کارانہ طور پر اس تحقیق میں شامل ہوتا ہوں۔ میں جانتا ہوں کہ مجھے اس فارم کی ایک کاپی دی جائے گی۔ میں نے رضا کارانہ طور پر اس تحقیق میں شمولیت کا فیصلہ کیا ہے لیکن میں جانتا ہوں کہ اس رضامندی سے کسی کی کوئی غفلت یا غلطی کی وجہ سے میرے قانونی حقوق پر کوئی اثر نہیں پڑے گا۔ میں جانتا ہوں کہ اس رضامندی فارم میں کسی ریاستی یا مقامی قانون سے کوئی چیز متصادم نہیں ہے۔

شامل ہونے والے کا نام _____

تاریخ _____

شامل ہونے والے کے دستخط _____

تاریخ _____

پرنسپل انوسٹیگیٹر کے دستخط _____

تاریخ _____

رضامندی لینے والے کے دستخط _____

تاریخ _____

Household Survey Form

ID No	_____	_____ 001
Name of key Respondent	_____	_____ 002
Relation with Eligible Woman	_____	_____ 003
Name of Eligible woman	_____	_____ 004
Name of husband of eligible woman	_____	_____ 005
Age / DOB of eligible woman	_____	_____ 006
Province	_____	_____ 007
District	_____	_____ 008
UC/Village	_____	_____ 009
Date Interview	_____DD/MM/YY	_____ 010

SECTION 1. PERSONAL INFORMATION QUESTIONNAIRE (PIQ) OF ELIGIBLE WOMAN

اب میں آپ اور آپ کے گھرانے کے بارے میں کچھ سوالات کروں گی

1. آپ کی تعلیم کتنی ہے۔
(سالوں میں) _____ 011

2. آپ کے خاوند کی تعلیم کتنی ہے۔
(سالوں میں) _____ 012

3. کیا آپ گھریلو خاتون ہیں یا ملازمت پیشہ خاتون ہیں؟
.1 گھریلو خاتون
.2 ملازمت پیشہ خاتون _____ 013

4. اگر آپ ملازمت پیشہ ہیں تو آپ کی ملازمت کا پیشہ کیا ہے۔
.1 فیکٹری ملازمت/مزدوری وغیرہ
.2 دفتری ملازمت (ٹیچر وغیرہ) _____ 014
.9 لاگو نہیں ہوتا۔

5. آپ کی اوسطاً ماہانہ آمدنی کیا ہے۔
.9 لاگو نہیں ہوتا۔ _____ 015

6. کیا آپ کا خاوند کام کرتا ہے؟

.0 نہیں

.1 ہاں

.9 لاگو نہیں ہوتا ——— 016

7. آپ کے خاوند کا پیشہ کیا ہے۔

.1 فیکٹری ملازمت/مزدوری وغیرہ

.2 دفتری ملازمت (ٹیچر وغیرہ)

.9 لاگو نہیں ہوتا۔ ——— 017

8. آپ کے خاوند کی ماہانہ آمدنی کیا ہے۔

.9 لاگو نہیں ہوتا۔ ——— 018

9. وہ اپنی ملازمت کے سلسلے میں گھر سے کتنا عرصہ دور رہتا ہے؟

.0 بالکل نہیں

.1 تین ماہ سے کم

.2 تین سے چار ماہ

.3 چھ ماہ سے زیادہ

.9 لاگو نہیں ہوتا۔ ——— 019

10. آپ کے خاندان کے لوگ کیسے رہ رہے ہیں؟

.1 اکٹھا خاندان

.2 صرف میاں بیوی ——— 020

11. آپ کے کتنے بچے ہیں۔

.1 کل تعداد ——— 021

.2 لڑکیاں ——— 022

.3 لڑکے ——— 023

12. آپ کے گھرانے کی کل ماہانہ آمدنی کتنی ہے۔

.9 لاگو نہیں ہوتا۔ ——— 024

13. کیا آپ حمل سے ہیں؟

.0 نہیں

.1 ہاں ——— 025

14. حمل کی کل تعداد (موجودہ حمل کو ملا کر) ——— 026

15. کیا آپ کے کسی گزشتہ حمل میں کوئی پیچیدگی ہوئی؟

0. نہیں
1. ہاں

027

اگر ہاں تو کیا؟

1. کیا حمل کے دوران کوئی مسئلہ ہوا۔

0. نہیں
1. ہاں

028

2. کیا زچگی کے دوران کوئی مسئلہ ہوا۔

0. نہیں
1. ہاں

029

3. کیا زچگی کے بعد یا چھلے میں کوئی مسئلہ ہوا۔

0. نہیں
1. ہاں

030

16. پیچیدگی کی صورت میں آپ نے کس سے مشورہ کیا تھا؟

1. گھر میں کسی سیانی عورت سے
2. لیڈی ہیلتھ ورکر سے
3. لیڈی ہیلتھ وزیٹر/ڈاکٹر سے
4. کسی اور سے

031

17. پیچیدگی کی صورت میں آپ نے کیا کیا؟

1. گھریلو ٹوٹکا استعمال کیا
2. دوائی وغیرہ

032

18. آپ کے گھرانے میں اس سے پہلے بچوں کی پیدائش کہاں ہوئی۔

1. گھر میں کسی سیانی عورت سے
2. گھر میں دائی سے
3. سرکاری ہسپتال
4. پرائیویٹ ہسپتال
5. کچھ کی گھر پر اور کچھ کی ہسپتال (اگر ہاں تو کیا وجہ تھی کے کچھ کی پیدائش گھر پر ہوئی اور باقیوں کی نہیں)

033

ریسرچ اسسٹنٹ کے لئے ہدایات:۔

حکومت پاکستان نے ایک پروگرام ماں اور نوزائدہ بچے کی صحت کے لئے (MNCH) شروع کیا ہوا ہے جس کے تحت آپ کے ہی علاقے کی ایک پڑھی لکھی عورت کو زچگی کرنے اور زچگی کے بعد دیکھ بھال اور اس سے متعلقہ مسائل سے نمٹنے کی تربیت دی گئی ہے اور اب حکومت پاکستان ان تربیت یافتہ خواتین جن کو کمیونٹی مڈوائفز (CMWs) کا نام دیا گیا ہے آپ کے قریب دیہی علاقوں میں تعینات کرنا چاہتی ہے اس سے متعلق آپ کی رائے معلوم کرنا چاہتے ہیں کہ اگر یہ آپ کے علاقے میں ہی ایک سینٹر بنالیں جو آپکے گھر سے زیادہ دور نہ ہو، وہاں پر زچگی کریں یا یہ آپ کے گھر پر آکر زچگی کریں. آپ کی اس رائے کی روشنی میں ہم حکومت پاکستان کے اس پروگرام کو مشورہ دیں گے۔

کیا آپ کے علاقے میں کسی CMW نے کام شروع کیا ہے۔ (ریسرچ اسسٹنٹ کنفرم کرے کہ یہ CMW ہے یا LHV,LHW ہے)

.0 نہیں
.1 ہاں

034

اگر ہاں تو پوچھیں CMW زچگی کہاں کر رہی ہے

.1 اپنے سنٹر/کلینک پر
.2 گھروں میں جا کر

035

کیا آپ اس کے کام کرنے کے طریقے سے مطمئن ہیں؟

.0 نہیں
.1 ہاں

036

اگر نہیں تو کیوں مطمئن نہیں ہیں؟

آپ کیا چاہتے ہیں کہ CMW کہاں پر زچگی کرے۔

.1 آپ کے علاقے میں اپنے سنٹر/کلینک پر
.2 آپ کے گھر آکر
.3 دونوں جگہوں پر ہوسکتا ہے
.4 CMW سے ڈیلیوری کروانی ہی نہیں (اگر نہیں کروانی تو پھر کس سے کروانی ہے)
.5 ابھی فیصلہ نہیں کیا

037

نوٹ:۔ اگر مندرجہ بالا 1 سے 4 تک جو ترجیح منتخب ہوئی ہے اس سے متعلقہ سیکشن میں چلے جائیں۔ جواب ہاں یا نہیں میں دیجئے

سیکشن 1 0 نہیں 1 ہاں

آپ کے علاقے میں اپنے سنٹر/کلینک پر ترجیح کی وجوہات کیا ہیں؟

038 _____ .1 کمیونٹی ٹرینڈ ورکرز تربیت یافتہ ہیں۔

039 _____ .2 سروس سنٹر پر سہولیات زیادہ ہیں۔

040 _____ .3 گھر میں سہولیات نہیں ہیں۔

041 _____ .4 گھر میں علیحدہ جگہ نہیں ہے۔

042 _____ .5 ایمرجنسی کی صورت میں سروس سنٹر پر سہولیات کا ہونا۔

043 _____ .6 سروس سنٹر کا نزدیک ہونا

044 _____ .7 کوئی اور وجہ _____

سیکشن 2 0 نہیں 1 ہاں

آپ کے گھر آ کر ترجیح کی وجوہات کیا ہیں؟

045 _____ .1 پیسوں کی کمی

046 _____ .2 بروقت گاڑی کا نہ ملنا

047 _____ .3 خاندانی رسم و رواج

048 _____ .4 فیس اور دوائیاں بہت مہنگی ہیں

049 _____ .5 لوگ باتیں کریں گے/مذاق اڑائیں گے (stigma)

050 _____ .6 پردہ داری/پردے کا انتظام

051 _____ .7 رشتہ داروں کی توجہ

052 _____ .8 گھر میں زیادہ سہولت ہے

053 _____ .9 عورتوں کا گھر سے باہر نکلنا معیوب سمجھا جاتا ہے

054 _____ .10 کوئی اور وجہ _____

سیکشن 3 0 نہیں 1 ہاں

دونوں جگہوں پر ہو سکتا ہے۔ ترجیح کی وجوہات کیا ہیں؟

055 _____ .1 زچگی کی نوعیت (ایمرجنسی کی صورت میں)

056 _____ .2 زچگی کے وقت پیسوں کا ہونا یا نہ ہونا اس وقت فیصلہ کریں گے۔

057 _____ .3 کوئی اور وجہ _____

سیکشن 4 0 نہیں 1 ہاں

CMW سے زچگی کروانی ہی نہیں تو مندرجہ ذیل وجوہات میں سے کون سی وجہ ہے؟

058 _____ .1 صلاحیت پر بھروسہ نہیں ہے۔

059 _____ .2 شناسائی نہیں ہے۔

060 _____ .3 فیس زیادہ ہے۔

061 _____ .4 یا کوئی اور وجہ _____

FGD/IDI Qualitative Material – Intro Form

Location/Place _____	Date _____
Note taker _____	Interviewer/Facilitator _____
	_____

▪ Thanks	I want to thank you for taking time to meet with me/us today.
▪ Intro	We are _____ and would like to talk to you about CMWs initiative.
▪ Purpose	To discuss about birthing place preference of community of CMW.
▪ Confidentiality	All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.
▪ Duration	The interview should take less than an hour.
▪ Tape/Notes	We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done. Since we are recording this interview, I would request all to speak loudly so that we don't miss your comments.
▪ Clarifications	Are there any questions about what I have just explained?
▪ Consent	Are you willing to participate in this interview?

FGD/IDI Qualitative Material – Demographics Forms
(To be recorded prior to the interview)

For Community Elders

Sr. #	Names	Gender	Age	Education (in yrs).	Marital Status	Occupation	# 0f yrs. of living in this community

For Community Midwives

Sr. #	Names	Age	Education (in yrs).	Marital Status	Midwifery Training received from (PAIMAN, MNCH etc)	Current status (deployed/not waiting to be deployed)

For Women

Sr. #	Names	Age	Education (in yrs).	# of children	Education of Husband (in yrs.)	Husband's Employment Status

FGD/IDI Qualitative Material – Interview Guides

For Community Elders

RQ: Explore views about the choice of birthing place, reasons for a particular option and about the role of CMWs and suggestions to make this initiative acceptable to the larger community			
No	**Questions**	**Probes/exploring points**	**Responses**
1	**Where do women in your community generally deliver their children?**	1.Deliveries at homes 2.At BHUs 3.Private hospitals 4.By TBA 5.By Daii 6.By elder women 7.Explore reasons for a particular option 8.How are emergencies dealt with (EmOC)	
2	**Have your heard about the CMW initiative? (if yes explore)**	1.About CMWs services? 2.About their deployment? 3.Are CMWs deployed in your area and where are they providing services.	
3	**How would your community feel about this initiative in terms of availing CMW services?**	1.Antenatal and Postnatal care? 2.Deliveries 3.Referrals to and by CMWs	
4	**What would be the likely barriers for women to avail these services?**	1.New initiative without credibility 2.Set practices of households 3.Traditional ways – especially Dais being trustworthy	
5	**What would be the likely barriers for CMWs in providing these services?**	1.Mobility of CMWs 2.Dias being a competition	
6	**Where would you, as community elders, prefer CMWs should provide their services?**	1.Explore reasons for a particular preference.	
7	**What would you suggest to make CMW initiative more acceptable for the community?**	1.Explore reasons for a particular preference.	

For Community Midwives

RQ: Where would CMWs prefer providing the services? Reasons for their preferences. What are the challenges CMWs foresee (challenges in placement, competition with TBAs, community acceptance etc). How can the acceptability of communities be established for CMWs?			
No	**Questions**	**Probes/exploring points**	**Responses**
1	**Describe the main responsibilities of CMW s?**	1.Services to community 2.Birth attending 3.Antenatal and post natal care 4.Any other task assigned to you. 5.Where do you provide services (birthing stations or households) 6.Have you received any instructions from MNCH regarding your place of servicing?	
2	**What would you prefer in terms of the place for conducting deliveries?**	1.Birthing stations 2.Homes 3.Why the particular option? 4.Why not the alternative option?	
3	**What are the challenges you are facing or foresee in carrying out your responsibilities in the community?**	1.Transportation 2.Security and mobility issues 3.Time constraints 4.TBAs 5.Your supervision 6.Referrals	
4	**How do you think these issues/challenges that you have mentioned can be addressed?**	1.By program 2.By community	
5	**How does the community feel about CMWs?**		
6	**Any suggestions to help the acceptability of CMWs in the community?**	1.How to improve service uptake of community by CMWs	

For Women

RQ: Explore women's choice of birthing place & whether it differs from the household's preference. Explore the reason if a difference of preference exists.			
No	**Questions**	**Probes/exploring points**	**Responses**
1	**Where do women in your community generally deliver their children?**	1.Deliveries at homes 2.At BHUs 3.Private hospitals 4.By TBA 5.By Daii 6.By elder women 7.Explore reasons for a particular option 8.How are emergencies dealt with (EmOC)	
2	**Have you heard about the CMW initiative?**	1.Are there any CMWs placed in your village? 2.If yes, where do they provide their services? 3.What are the main services provided by CMWs	
3	**What is or would be the opinion of your households about this CMW initiative?**	1. Place of service (homes or birthing stations) 2. Would they prefer CMWs over other service providers	
4	**What will you think Women will do if they have these services available to them?**	1.Would women's choice differ from their household's choice 2.How is this difference of choice resolved	
5	**What are the main challenges that you face as a woman in the decision making regarding deliveries?**		
6	**What would you suggest that CMWs become successful in your community?**		

For MNCH Programme Personnel (IDI)

RQ: Explore views about the potential challenges foreseen in implementing the initiative, MNCH personnel's preference of a birthing place, reasons for a particular choice and how they plan to help the CMWs acceptability in the larger community			
No	**Questions**	**Probes/exploring points**	**Responses**
1	**Tell us something about CMW initiative?**	1.Previous h/o similar initiatives? 2.Learning from international /regional experiences?	
2	**In your views, what are the main objectives of this program?**	3.What will be the scope of this service?	
3	**In your opinion what would be the most appropriate strategy for placing the CMWs in their respective communities?**	1.Birthing stations or Homes 2.Why a particular option? 3.Why not the alternative option?	
4	**What sort of challenges do you foresee in the implementation of the program regarding placement strategy of CMWs?**	1.Acceptance at community level? 2.Problems-CMWs 3.Problems in the mobility of CMWs	
5	**What could be the remedial measures for the challenges you foresee?**	1.Provision of facilities to CMWs. 2.How to enhance the acceptance of CMWs at community level?	

Appendix III – Ethical Approval

28-FEB-2012 14:04 FROM TO Nazia Tariq P.001/001

National Bioethics Committee (NBC) Pakistan

Ref: No.4-87/11/NBC-60/RDC/ 32-15 Date: January 26 2011

Patrons
Federal Minister Health
Federal Secretary Health

Chairman
Director General Health

Secretariat
Pakistan Medical Research Council

Members Ex-Officio
President
College of Physicians and surgeons of Pakistan
President
Pakistan Medical and Dental Council
Executive Director
Pakistan Medical Research Council (Member/Secretary)
WHO Country Representative
President
Supreme Court Bar Association
Nominee
Surgeon General Pakistan Army

Members
Prof. Dr. Zulfiqar A. Bhutta (Chairman REC)
Prof. Dr. Aasim Ahmad
Prof. Dr. Anis Ahmed
Dr. Anwar Nasim
Prof. Dr. Mohammad M. Amin
Prof. Dr. Farhat Moazzam
Dr. Maqbool H. Jafary
Dr. (Mrs) Anwar Aziz
Dr. Shaukat Ali Jawaid
Dr. Asmatullah
Prof Dr. S. Haroon Ahmad
Dr. Farid Khan
Prof. Dr. Baqi Darrani
Dr. Muhammad Zaheen

Mr James Cowan Coventry
Interim Team Leader
Research & Advocacy Fund (RAF)
H. # 9, Street 64
Sector F-8/4,
Islamabad

Subject: **Preference of Birthing Place: A mixed methods study of Communities, Households, Community Midwives & MNCH Program (NBC-60)**

Dear Mr. Coventry,

I am pleased to inform you that the above mentioned project has been cleared by "Research Ethics Committee of National Bioethics Committee".

Kindly keep the National Bioethics Committee Secretariat updated with the progress of the project and submit the formal final report on completion.

Yours sincerely

(Dr. Zulfiqar Bhutta)
Chairman
Research Ethics Committee

NBC Secretariat:
Pakistan Medical Research Council, Shahrah-e-Jamhuriat, Off Constitution Avenue, Sector G-5/2, Islamabad.
www.pmrc.org.pk, e-mail: pmrc@isb.comsats.net.pk . Tel: 92-51- 8207386, 9216793, 9205480, Fax 9216774, 9204559

RECEIVED 28 JAN 2011

TOTAL P.001