Children First

RAF
Working Towards Millennium Development Goals
Research & Advocacy Fund

How far can I go? Social Mobility of Community Midwives in Azad kashmir

A project funded by the Maternal and Newborn Health Programme Research and Advocacy Fund and Implemented by Children Frirst

February 2012

Summary Report

ACKNOWLEDGEMENT

*"**How far can I go? Social Mobility of CMWs in AJK**"* is a project funded by the Maternal and Newborn Health Programme Research and Advocacy Fund, and is implemented by Children First. We would like to acknowledge the continuous support of Department of Health AJK and the Directorate of MNCH AJK. We also thank Dr Qurban Mir and Dr Sardar Mehmood and their team for their tremendous support and guidance in this research.

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 have read the report titled ***"How far can I go? Social Mobility of CMWs in AJK"*** and acknowledge and agree with the information, data and findings contained.

THE RESEARCH TEAM

Principal Investigator: Shahzad Ali Khan

Co-Investigators: Tabinda Zaman; Bushra Shams; Majid Shehzad; Aashifa Yaqoob

Research Associates: Ghulam Hussain, Naila Khalil, Sabine Khan, Adnan Qureshi

Administrative Support: Asif Hayat, Akhtar Hussain, Raja Omar, Saad Gillani

INTRODUCTION

An estimated 25,000 mothers die in Pakistan because of the complications of pregnancy and child birth - most of these deaths are preventable by improving access to quality services at all levels. Maternal Mortality Ratio (MMR) is 276 per 100,000 live births in Pakistan, in urban areas it is 175, and 319 in rural settings; in Azad Jammu and Kashmir (AJK) the MMR is 210 per 100,000 live births. Both lack of antenatal care and skilled birth attendance are significantly associated with maternal mortality. A majority of the deaths are of women who do not receive antenatal care or have not been delivered by a skilled birth attendant. A clear risk factors for maternal mortality, in rural clusters is the lack of transport facility and a distance of 40 kilometres or more to any health facility i.e. primary health facility or referral hospital. are The average distance to a reproductive health facility in rural areas is almost four times the distance in urban areas, making access to services for rural women without transportation or funds extremely difficult.

Many countries like Sri Lanka, Malaysia, Bangladesh, Indonesia, Nepal and Bolivia have introduced targeted community-based interventions such as training and deployment of midwives to provide skilled care, imparting health knowledge and promoting appropriate health seeking behaviours, as a complement to facility-based service delivery. These midwives were backed by a team of highly skilled obstetricians in tertiary care hospitals. Despite many challenges in community based midwifery services these countries successfully lowered their MMR by increasing uptake of skilled care services at birth through improved human resource.

The National Maternal, New-born and Child Health (NMNCH) Programme was launched in Pakistan in 2006. An important component of NMNCH Programme was to train and deploy 12,000 Community Midwives (CMWs) in the country till 2012 to ensure safer deliveries by adequately trained and skilled birth attendants. Of the targeted 12,000 CMWs, more than 4,700 had been trained by December 2011 by NMNCH Programme and other development partners including PAIMAN, UNICEF and UNFPA.

OBJECTIVES

This research was conducted to identify the social mobility and barriers in accessibility of CMWs in rural population of AJK. Specifically, it attempted to map the coverage of CMWs outreach; determine the barriers in acceptability and functionality of CMWs and how CMWs interact with other care providers.

STUDY DESIGN AND METHODOLOGY

The study was conducted in all 10 districts of Azad Jammu and Kashmir. It was a mixed method research; both qualitative and quantitative research methods were used in this study.

Qualitative research comprised of In-depth Interviews (IDIs) and Focus Group Discussions (FGDs). Six FGDs and ten IDI were done in each of study district. Thus, in total 60 FGDs and 100 IDIs were completed. The main theme of FGDs and IDIs were social mobility and acceptability of the CMWs in terms of geographical, economical, gender and social aspects. The interviews and FGDs were recorded for accuracy and transcribed and translated into English language. Guidelines for data collection were prepared and used for training of research team, and team had it as a ready reference while conducting IDIs and FGDs.

For the quantitative part, a population-based cross sectional survey was conducted in all 10 districts of AJK. The total sample used in each district was 400 (300 females and 100 males); and thus it was 3000 females and 1000 males for 10 districts in AJK. From each district 20 villages were randomly selected as Primary sampling Units (PSUs). Within these randomly selected 20 villages, 20 households were selected from each village using systematic selection technique in order to complete the sample of 400 per district.

GIS Mapping was done to get information about working outreach of CMWs. The key variables included in the mapping were existing CMWs working in area, household distance from CMW's house and other MNH care providers and health facilities in the area.

Data collection for the survey was done by district level teams comprising of one District team leader and research associates, both male and female. A questionnaire was used for face to face interviews after describing the purpose of research and taking an informed consent. The completed questionnaires were entered into an MS Access database and analysis was done using SPSS version 18.

KEY RESULTS:

GIS Mapping: Results of the GIS Mapping showed variation in availability of CMWs in different districts of AJK. For example, Mirpur, Neelum and Hattian Bala were the districts with very low number of CMWs. Other districts like Sudhnoti, Muzaffarabad and Kotli were having relatively higher number than other districts, at the time of GIS Mapping.

The GIS mapping also pointed out the outreach of the CMWs and different districts have different outreach area of CMWs. A few districts have availability of CMWs in dispersed manner with little overlap of outreach. But in most districts there were areas non-covered by CMWs and in some cases, there was overlap of CMWs outreach due to placement of two or more CMWs in proximity. District Sudhnoti with the highest number of CMWs had well dispersed CMWs and little overlap of CMWs outreach. But some union-councils were without availability of CMWs.

Results of qualitative research methods showed less social mobility of CMWs due to many issues like title – 'CMW', selection and training issues, lack of referral system from LHW to CMWs and problems in referral cases of CMWs to higher level health facilities. There are problems in practical skills of CMWs, low acceptability by community, poor ownership by health department and lack of linkage with other providers in the area. There are issues of perceived cost of services, as being supported by government MNCH Department, community midwife thinks she should provide free services and must not charge her patients. Similarly there are issues of sustainability of the CMW initiative due to drop out of CMWs from training, deployment and retention when their stipend may be stopped by the MNCH Department after two years.

The quantitative survey showed lack of awareness about availability of CMWs in their area and very low utilisation of CMW services. 90% of the respondents were unaware of the presence of CMWs in the area this maybe attributed to a deficient communication strategy and non-involvement of community at the time of deployment of CMWs. It was found that population using CMWs belonged to poor and less educated groups as compared to those who are not using her services. This finding is encouraging as it provides evidence that even if the coverage is very low, the CMWs are serving poor and marginalised population groups in AJK. Most respondents in community are not aware of the user fees of CMWs and perceived cost of CMW services was very high. The perceived high cost of CMWs was stated as reason for not using CMWs.

Significant differences in age, education, distance and income were noticed among the respondents who visited and those who never visited CMWs. There was a significant difference in age groups, with extreme ages not going to CMWs; women with less education visiting CMWs and more educated women not visiting CMWs. Extremes of income groups were not visiting, while those needing a travel time of more than 30 minutes to reach CMWs house also tend not to visit CMWs. Only people a living within close proximity i.e. at a walking distance from CMW's residence were using CMW services,.

The most intricate finding emerging out of the comparison between users and non-users of CMWs was health expenditure in last six months. Expenditures in all categories were much higher for the respondents which never visited the CMWs. The health expenditure of respondents which visited CMWs was lower for consultation fees, medicines and delivery charges; signifying an assumption that those visiting CMWs were probably poorer and have less affordability than those who never visited CMWs. Although the difference was statistically significant for all expenses, except medicines, the difference was greatest in consultation fees; where median fee paid to CMW was rupees 20 as compared to the median fee rupees 750 paid by the group that never visited CMWs. This finding has a significant implication and provides insight into the importance of CMWs for provision of skilled birth attendance to poor families.

DISCUSSION

The results of GIS mapping highlight CMW outreach and placement of CMWs in most districts of AJK. GIS mapping can be used for identification of areas where MNH care providers are not available to the community and help in selection of eligible candidates from the areas with the most need.

The results also pointed out the paucity of skills and capacity of CMWs to tackle issues of maternity care in remote rural setting. The class room training component was not of good quality, the practical aspect almost lacking and a complete absence of refreshers or continuous professional development strategy. The reason cited by most community respondents for seeking maternity care was provider's skill and training. But as many CMWs lacked this aspect, very little utilisation was found with limited clientele. This has been a problem at the initial stage of launching community based health workers in many developing countries. Selection and training of community worker is crucial as well

as very challenging. It has been seen to improve gradually through proper training programme and skill development.

There was limited linkage of CMWs with LHWs, and with the health facilities. This is can be crucial in case of need for referrals during maternal complications.. The lack of availability of 24/7 maternal care services can also make referrals difficult for CMWs in critical situations .

Given the level of illiteracy and social taboos related to pregnancy and child birth, it ischallenging for CMWs in remote and rural community settings to make women understand certain important signs of maternal and new-born care. This is especially challenging if the CMWs have poor interpersonal communication skills. Also this puts them in lower position as compared to the other experienced traditional providers like TBAs that have long term relationships with their communities. In some research studies on community based workers, the social mobility has been linked to individual level attributes of workers, but this is also affected by the system in which they are working

CONCLUSION

Substantial evidence exists to conclude that selection, training and deployment process of CMWs needs further improvement. Owing to the novelty of programme, there were many delays in sequencing of activities starting from selection of candidates, initiation of trainings, examinations, certifications and most importantly deployment of CMWs in the field in AJK. Although awareness level about presence of CMWs in the area was very low, the perceived cost of service of CMW was very high thus limiting the accessibility. There were also problems of linkage of CMWs with the LHW and the health facilities in their areas.

RECOMMENDATIONS

The specific recommendations are as follows;

1. During selection of women for CMW training, priority must be given to those villages where none or limited options are available for maternal health care.
2. There is a need to involve community representatives in selection of women for CMW trainings. This will help build ownership of community and may also ensure that selected and trained CMWs will stay in their area and perform their work in a favourable environment.

3. MNCH Programme should consider renaming the title CMW in consultation with the CMWs in order to improve their value in community and increase their motivation.
4. The training of CMWs needs revision and must be made more practical and skill based rather than theoretical. There is clear need of incorporating interpersonal communication skills in the CMWs curriculum so that they are able to interact with the clients in a better way and make their services more valued. There is also a need for refreshers and continuous training of CMWs to maintain and update their skills.
5. Delays in selection and training and between completion of training and examination must be avoided; and deployment must be immediate after passing the exams as delays cause frustration and lack of interest and mistrust on the part of CMWs.
6. The deployment must be done in a more formal manner with involvement of community elders/notables and proper communication of the benefits of CMWs to the community. This dissemination and launching ceremony must be followed by continuous monitoring and support of the CMW work.
7. CMWs must be linked with 24/7 health facilities so that they can refer the cases when ever needed and there are services available to support their work. This referral link may start from LHWs to secondary level health facilities but will definitely require more integration at programmatic level, as MNCH and LHW programme are managed at separate level in district as well as provincial level.
8. As most of the CMWs were hesitant in asking fees from poor clients, there must be a window of adjusting those who cannot afford to pay, through Zakat or Bait-ul-Mal, and Social Welfare Department. The BIS scheme can also be tapped for the funds for poor women.
9. Mechanism should exist to recognise good performance by a CMWS through financial or any other incentives so that the good performing CMWs can maintain the good work while others are motivated for putting more efforts in their work.
10. As TBA has been identified a common service provider for maternity care in rural population in AJK, their position in the community should be leveraged upon for the support of CMWs. This research witnessed close collaboration between TBAs and CMWs in two districts. The MNCH Programme can integrate between these two providers at village level in order to develop collaboration instead of competition.

For more Information on this Research Contact:

Dr. Shahzad Ali Khan

Email:shahzadk67@gmail.com

Telephone: +92-343-5252522