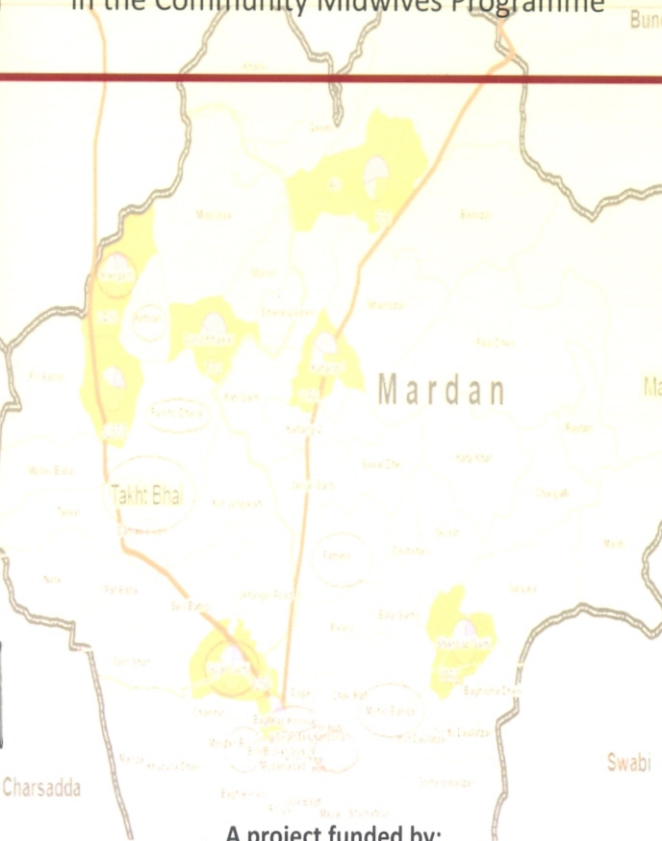


**“Community Participation-A Missing Essential from the Primary Health Care Approach in the Community Midwives Programme”**

Summary Report of a Study on Assessment of Community Participation in the Community Midwives Programme



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**Authors:****Dr. Tasleem Akhtar**

Consultant R&D,  
Khyber Medical University, Peshawar

**Ms. Samia Rauf**

Qualitative Research Consultant

**Dr. Zohaib Khan**

Assistant Director,  
Directorate of R&D  
Khyber Medical University, Peshawar

**Dr. Saleem Wazir**

Associate Professor, Department of  
Community Health Sciences  
Ayub Medical College, Abbottabad

**Dr. Shabina Raza**

Chief Health Sector Reforms Unit  
Health Department  
Government of Khyber Pakhtunkhwa

**Introduction**

The Government of Pakistan's National Maternal, Newborn and Child Health (MNCH) Programme was launched in 2006 to accelerate progress towards the achievement of Millennium Development Goals (MDGs) 4 and 5. The programme's strategic framework document pledges to ensure availability of high quality MNCH services to all, especially for the poor and the disadvantaged. The framework aims to make accessible effective MNCH services for all, particularly the poor and the disadvantaged, through the development and implementation of sustainable provincial and district programmes. Additionally the framework provides guidelines for developing advocacy campaigns and community education to create a demand for high quality MNCH services. The training and deployment of Community Midwives (CMWs) to enhance the coverage of MNCH services by skilled providers, is a key strategy of the programme.

**Study Objectives**

The research project on "Assessment of Community Participation in the Community Midwives Programme" was undertaken to study the role assigned to the community in the programme guiding documents and implementation strategies. Community participation is an essential component of the CPHC approach for achieving the HFA goal. The study aimed to determine both the recognition given to

the role of the community in the programme guiding documents and among the programme managers and advisors and the attitude, perceptions and utilisation of CMWs by the community.

### Study Methodology

The WHO definition of community participation, "A collaboration, in which the community voluntarily or because of some persuasion or incentive agrees to collaborate with an externally determined development project, often by contributing their labour and other resources for an expected benefit" was used in this study. Community participation was assessed on the indicators of community awareness, community involvement in the structures established by the programme (selection, accountability and conflict resolution committees etc.) community contribution to the programme in financial, infrastructural and security responsibility terms and finally the effective utilisation of the services provided by the CMWs. The level of participation of the poor and marginalised in the programme was also studied.

The study methodology included both quantitative and qualitative study methods. The quantitative component included interviews with a consecutive sample of women who had delivered babies in the six months period between October 1, 2010 and March 31, 2011 to document current MNCH practices in the study area, determine the factors which

influence the selection of MNCH service provider, compare the quality of services provided by different cadres of MNCH services providers and record the satisfaction of the end users with the services provided to them. The qualitative component of the study included In-depth Interviews (IDI) with programme managers and advisors, interviews with CMWs and FGDs with community groups including the poor and marginalised. Secondary data on the MNCH programme policies and strategies was collected through review of key programme documents including the Health Policy 2002, the MNCH Programme Strategic Policy and Framework Document, The Programme Combined Communication Strategy and others.

### Study Results:

The key findings of the study are:

1. The MNCH programme guiding documents have not adequately conceptualised the comprehensive PHC approach to achieve its objectives and the MDGs.
2. The programme's guiding documents failed to recognise the role of other stakeholders in the achievement of its objectives. Especially missing are the role of the community and other sectors. The community role has been reduced to that of, at best, an aware consumer. Inter-sectoral

collaboration and cooperation is mostly ignored.

3. The programme managers and advisors were generally satisfied with the programme conceptualisation and strategies. They pointed out management and implementation issues and noncompliance with the Programme PC-I.
4. Twenty two out of the thirty CMWs deployed in the Mardan district were not working in their assigned areas and had taken employment elsewhere.
5. The main reason for leaving their assigned areas was non-payment of remuneration to them.
6. Other programme activities in the field like awareness creation and social mobilisation and the activities of the Lady Health Supervisors (LHS) were also at a standstill owing to non-availability of funds.
7. Respondents of the study reported political influence on the selection of CMWs. This was mainly because of the stipend being paid to trainee CMWs.
8. The quantitative data generated shows that over 50% of deliveries were attended by TBAs and relatives, 15% did not get any antenatal care,

25% had 2 or less antenatal checkups and 40% had no postnatal checkups.

9. Factors that influence the selection of birth attendant include education of respondent and their husbands, income and type of housing and number of living children.
10. Poverty and illiteracy are significant factors responsible for marginalisation in the context of MNCH services utilisation.
11. An incidental finding of the study is that 42.5% had 4 or more children and 11.6% had 7 or more children. This indicates a big gap in the performance of the over 20 years duration National Programme for Primary Health Care and Family Planning.

## Conclusions

From the study findings, it is concluded that:

- The MNCH Programme PHC approach to achieving its objectives is incomplete and similar to previous such programmes and therefore may end up similarly with limited success. The programme guiding documents do not conceptualise PHC adequately;
- The programme's guiding documents do not recognize the roles of different stakeholders; hence both community

participation and inter-sectoral collaboration are missing from the programme strategies;

- There is a disconnect between the programme guiding policies and strategies. There is lack of clarity of thinking regarding current approaches to the conceptualisation, strategies development and implementation of PHC programmes. Managerial capacity for programme implementation also appears to be inadequate;
- The programme's guiding documents and perceptions of its managers and advisors indicate that there is as yet little thinking as regards the incorporation of the CPHC approach in the programme as is being recommended by leaders and researchers in the field. Community participation is limited to awareness creation about the services being provided.
- Undue political influence is undermining the recruitment of CMWs as per laid down criteria in the PC-I document of the programme. Some observations of the participants of focus groups indicate that political interference is also preventing the appointment of knowledgeable and competent programme managers.
- The integration of MNCH services in the community is being challenged by

the emergence of rivalries between the services providers. The LHVs and LHWs' own interest in providing obstetric services prevent them from fulfilling their role in the programme.

- The poor and the illiterate are the highest non-utilisers of MNCH services. They are also the highest utilisers of TBA services. Poverty and illiteracy are therefore responsible for marginalisation of women in the context of utilisation of MNCH services.
- Financial resources availability is already a challenge to the sustainability of the programme as indicated by the lack of payment of remuneration to the deployed CMWs and the stoppage of the field operations of the programme.

**Recommendations:**

1. Review the MNCH/CMWs programme to remove gaps and deficiencies and align policies with strategies and implementation plans.
2. Incorporate the CPHC approach in the programme to achieve effective community participation.
3. To deal more effectively with governance issues and to enhance management capacity, institutionalize health systems research and continuing education in the health care system.
4. Review the job descriptions of LHVs, LHWs and CMWs and remove the overlapping of functions.
5. Study and test models for financial viability of CMWs in order to identify socio-culturally compatible and sustainable models for the different communities of Pakistan.

**For further Information  
please contact:**

**Directorate of Research &  
Development,  
Khyber Medical University**  
PDA Building, Phase V  
Hayatabad, Peshawar.  
+92 91 9217258  
+92 321 9009167  
dr.zohaibkhan@kmu.edu.pk



The Printman Printers & Publishers  
printman96@yahoo.com

## KHYBER MEDICAL UNIVERSITY

Block-IV, PDA Building Phase-V Hayatabad, Peshawar.  
Email: [drzohaibkhan@kmu.edu.pk](mailto:drzohaibkhan@kmu.edu.pk)  
Ph: 091-9217703 Fax: 091-9217704, 9217258  
Website: [www.kmu.edu.pk](http://www.kmu.edu.pk)