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Exploring operational barriers encountered by community midwives when delivering services in two provinces of Pakistan: A qualitative study

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ABSTRACT

Objectives: to explore barriers experienced by community midwives (CMWs) when delivering services, from their own and their managers' perspectives, at provincial and district level in the context of organisational factors, and to determine other factors linked with the poor performance of CMWs in the delivery of maternal, neonatal and child health (MNCH)-related services within their communities.
Design: qualitative study design using in-depth interviews (IDIs) and focus group discussions (FGDs).
Setting: two districts in Khyber Pakhtunkhwa and Punjab provinces in Pakistan.
Participants: 41 participants were interviewed in depth; they included CMWs, lady health supervisors and managerial staff of the MNCH programme.
Measurements: participants were interviewed about administrative issues including financial and policy areas, training and deployment in the community, functioning in the community, and supervision and referral for emergency cases.
Findings: CMWs reported financial constraints, training needs and difficulty with building relationships in the community. They required support in terms of logistics, essential supplies, and mechanisms for referral of complicated cases to higher-level health facilities.
Conclusions: CMWs working in developing countries face many challenges; starting from their training, deployment in the field and delivery of services in their respective communities. Facilitating their work and efforts through improved programming of the CMW's services can overcome these challenges.
Implications for practice: the MNCH programme, provincial government and other stakeholders need to take ownership of the CMW programme and implement it comprehensively. Long-term adequate resource allocation is needed to sustain the programme so that improvements in maternal and child health are visible.

Introduction

Worldwide, over 300 million women suffer from birth-related illnesses, and approximately 358,000 mothers die during childbirth each year (WHO, UNICEF, UNFPA, World Bank, 2010). While the resources for maternal health remain unequally distributed, the developing countries share 99% of the global burden of maternal deaths (UNFPA, 2004; WHO, 2005). Despite global and national efforts, achievement of Millennium Development Goal 5 (MDG 5) by 2015 remains unlikely (Campbell and Graham, 2006; UNICEF, 2008; WHO, 2008). Additionally, slow progress has been reported on MDG 4 and 5 for many developing countries for which achievement of these MDGs was set as a priority (Bhutta et al., 2008; Countdown Coverage Writing Group, 2008).

Maternal health in Pakistan has had a dismal outlook for decades. The last demographic and health survey in Pakistan reported a maternal mortality rate of 276 deaths per 100,000 livebirths (NIPS Pakistan, 2008). However, this number is the

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national average, and the country suffers from gross inequities with regard to the burden of maternal deaths, as many rural areas have maternal mortality rates as high as 500 deaths, or even more, per 100,000 livebirths (Planning Commission of Pakistan, 2002; WHO, 2006; NIPS Pakistan, 2008; UNICEF, 2008).

Facility-based obstetric care by skilled health workers is considered to be the best practice for safe motherhood (UNFPA, 2004; Campbell and Graham, 2006; Bhutta et al., 2008; Kidney et al., 2009). However, increasing coverage to all pregnant women is a huge challenge globally (Kidney et al., 2009). High-quality maternal health services remain inaccessible to many women in developing countries because of cost, cultural practices and geographical distances (Thaddeus and Maine, 1994; Barnes et al., 1998; Say and Raine, 2007; Gabrysch and Campbell, 2009). In resource-poor settings, a fragmented health system affects the availability and utilisation of facility-based skilled births (Thaddeus and Maine, 1994; Barnes et al., 1998; Gabrysch and Campbell, 2009).

Recent evidence in support of facility-based deliveries (Bhutta et al., 2008) has indicated the need for community-based strategies for safe and uneventful births (Kidney et al., 2009). Evidence from Asia suggests that births attended by CMWs, with standby referral linkages, can improve maternal health outcomes remarkably (Wajid et al., 2010b). Such models of CMW-led births have shown success in Indonesia (Hatt et al., 2007) and rural Bangladesh (Fauveau et al., 1991; Ronsmans et al., 1997).

Lack of evidence that traditional birth attendants (TBAs) can reduce maternal mortality led to a shift of focus on skilled care providers (Maine, 1993; Starrs, 1998; Bergstrom and Goodburn, 2001). However, in rural Pakistan, TBAs or 'Dais' continue to attend childbirths at home, with only 37% of childbirths conducted by skilled birth attendants (SBAs) (NIPS Pakistan, 2008). Poverty and living in a rural area are two important reasons why women do not have an SBA present during childbirth. In 2007, only 25% of women in rural areas had an SBA present during childbirth, compared with 56% of women in urban areas, and 74% of women in the highest wealth quintile had an SBA present during childbirth, compared with 12% of women in the lowest wealth quintile (NIPS Pakistan, 2008).

In 2004, the Ministry of Health in Pakistan, realising the need to focus on maternal and child health, launched the maternal, neonatal and child health (MNCH) programme (Ministry of Health Pakistan, 2004). One of the key strategies of the MNCH programme is to make skilled birth services accessible to communities on their door steps by introducing CMWs. The aim of the MNCH programme was to train 12,000 midwives in the first 5-year phase (Ministry of Health Pakistan, 2004). By February 2010, more than 4500 midwives had been trained by the national MNCH programme and other government partners including USAID, UNICEF and UNFPA (Global Health Technical Assistance Project, 2010; Ministry of Health Pakistan, 2011). With the approval and implementation of the 18th Constitutional Amendment in 2010, the programme was devolved to provinces. The four provinces are now responsible for administrative, operational and financial oversight of the MNCH programme.

In the MNCH programme, CMWs are inducted for training by a committee appointed by district health authorities through a standard recruitment procedure. The criteria requires women to be local to the district, female, aged 18–40 years, preferably married, have previous work experience in the community, and have at least a 10th-grade education in science subjects (Ministry of Health Pakistan, 2011). After completion of course work, two years of practical training and passing a midwifery examination, a CMW is deployed in her community with a population of approximately 10,000. CMWs are eligible to provide basic obstetric, reproductive and child health care services to the community, and are allowed to charge clients a nominal fee. Lady health workers (LHWs) of the national programme for family planning (FP) and primary health care (PHC) from the same community are required to refer clients to CMWs. Lady health visitors (female nurses who specialise in midwifery at static health facilities) and women medical officers (WMOs) from the nearby basic or rural health centres are responsible for technical supervision of CMWs in the community. Lady health supervisors (LHSs) of the national programme for FP and PHC are expected to monitor and supervise CMWs (Ministry of Health Pakistan, 2011).

This study aimed to identify potential operational barriers to the services provided by CMWs in Khyber Pakhtunkhwa and Punjab provinces, Pakistan. Very few studies have been undertaken regarding the scope and problems faced by CMWs in delivery of services at district level, and how the managers of health programmes perceive and respond to the challenges. In this study, it was assumed that provincial and district managers represent the organisational level, and CMWs, LHSs and lady health visitors represent the community level.

Methods

A qualitative design was used to understand the concepts, definitions, characteristics and descriptions of operational barriers to CMW services from the perspectives of CMWs, supervisors and managers. In addition, the study determined interprofessional interactions, relationships and dynamics between CMWs, clients, supervisors and programme managers.

Conceptual framework

A conceptual framework was developed to investigate potential barriers highlighted from previous research in Pakistan and elsewhere. Important themes included: practical and field training of CMWs; barriers related to logistical systems, stock and supplies; financial system for CMWs; supervision and monitoring mechanisms and related barriers; barriers related to reporting mechanisms; and barriers related to referral mechanisms.

Study setting and population

The study was conducted in two districts of Punjab province (Kasur and Okara) and two districts of Khyber Pakhtunkhwa province (Swat and Mardan) from May to August 2011. The study population included any CMWs who had been trained and deployed by the MNCH programme in the four districts. Other participants included district managers, LHSs, WMOs and lady health visitors.

Selection criteria for districts

The study districts were selected if any CMWs had been working there for at least one year. Only two districts in Khyber Pakhtunkhwa province fulfilled this criterion. In Punjab province, over a dozen districts were eligible, but two of the most rural districts were selected.

Selection criteria for participants

Any CMW working in her community was eligible for inclusion in the study. LHSs who had been supervising CMWs for at least three months, provincial and district co-ordinators of MNCH programme WMOs, and superintendents of CMW training hospitals were also eligible for inclusion in the study.