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Are community midwives competent to practise? Lessons from Pakistan

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Pakistan's Community Midwife programme trains young rural women to provide antenatal care, safe delivery, referral for emergency care and postnatal care in their local areas. Launched in 2007, the programme had enrolled 8,700 candidates and trained over 2,800 community midwives by 2010. An assessment of the quality of training has revealed several systemic barriers to the achievement of adequate competence by this new cadre of skilled birth attendants. The experience of Pakistan shows the importance of putting in place a supportive infrastructure if quality – not just quantity – is to be achieved. This will require substantial and long term investments. As Provincial governments take the lead following Devolution in 2011, this may also be an opportune moment for policy makers to address the challenges currently faced by the programme.

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1. Introduction

Reducing maternal deaths is proving to be one of the major challenges in achieving the Millennium Development Goals (MDGs). Goal 5 has a target to reduce by three quarters the maternal mortality ratio and uses as one of its indicators of progress the proportion of births attended by skilled health personnel. The indicator has been selected by the international community based on robust evidence that the presence of a skilled birth attendant (SBA) at delivery, working within a well functioning health system – with effective referral to emergency obstetric and neonatal care services when required – can have a considerable impact on reducing maternal and neonatal mortality.[1,2] Against this background, the training of SBAs is being scaled up globally.

However, rapid and successful scale up of training needs to be backed by a strong and supportive infrastructure – from adequately equipped training facilities to effective supervisory systems. In less developed countries this infrastructure is often weak and inadequately addressed. This has implications for the achievement of quality training. The key question is whether the cadres of birth attendants being trained are adequately skilled to perform the services they are expected to deliver.

Using Pakistan as a case study, this paper considers this question in the context of the training of Community Midwives (CMWs), a new cadre of skilled birth attendant. Pakistan is facing challenges as it aims to achieve high training targets with limited resources. The paper examines these challenges and suggests approaches to help overcome them.

2. Background

A skilled birth attendant is *'an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns'* (WHO, ICM and FIGO).[3]

WHO further identifies the licensed midwife as 'the prototype for a skilled attendant'.[4] However the cadres of staff defined as SBAs differ slightly from country to country, and the duration of their training varies. Recognition that lower level staff or non-professionals cannot deal with the complex decision-making required when complications occur at birth[5] has led several countries, such as Pakistan and Afghanistan, to establish a cadre of community midwife and train them in an 18 month direct entry course.

In answer to the increasingly asked question 'are skilled birth attendants really skilled?', Harvey et al[6] carried out two studies in 2002, looking at the knowledge and skills of 1,524 skilled birth attendants in five countries (Benin, Ecuador, Jamaica and Rwanda and Nicaragua). They found 'a wide gap between current evidence-based standards and provider competence to manage selected obstetric and neonatal complications'. They also noted that skills scores were generally lower than knowledge scores, leading them to conclude that 'knowledge of a procedure is no guarantee that it can be performed correctly'.

There is evidence from countries in which the maternal mortality ratio rapidly declined over a relatively short period, namely Malaysia and Sri Lanka, demonstrating that appropriate SBA training and deployment for community level staff, backed up by system wide support, can reduce maternal

[1] Global Consensus for Maternal, Newborn and Child Health (2009) http://www.who.int/pmnch/topics/maternal/consensus_12_09.pdf
[2] United Nations Secretary-General (2010) Global Strategy for Women's and Children's Health.
[3] WHO (2004) Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. The definition has been endorsed by UNFPA and the World Bank.
[4] WHO (2005) World Health Report: Make every mother and child count. Chapter 4.
[5] Ibid.
[6] S.A. Harvey et al. (2007) Are skilled birth attendants really skilled? A measurement method, some disturbing results and a potential way forward. *WHO Bulletin*, 85(10): 783–790.

deaths. Detailed studies of the training process in these countries by Pathmanatham et al[7] indicate that community level SBAs (public health midwives in Sri Lanka and community midwives in Malaysia) were trained in a well structured health system and given strong supportive supervision by highly trained staff.

However, in many countries including Pakistan, ensuring that the key elements for quality training and supervision are in place continues to be a major challenge.

3. Pakistan's strategy for increasing SBA coverage

The Community Midwife programme was set up in 2007 as part of Pakistan's National Maternal Newborn and Child Health (MNCH) Programme, prior to Pakistan's devolution process which transferred health and other responsibilities to Provincial governments in 2011. Aiming to reach poor and marginalised women and children, and accelerate progress towards achieving MDGs 4 and 5, the programme seeks to provide a continuum of care from pre-pregnancy through delivery and postnatal care, delivered though services which range from skilled birth attendance (in this case community midwives) to comprehensive Emergency Obstetric and Neonatal Care (EmONC). Through the Community Midwife component, young rural women are trained to provide antenatal care, safe delivery, referral for emergency care and postnatal care in their local areas, with the intention of providing a skilled workforce replacing traditional birth attendants. At the same time, the MNCH programme envisages strengthening district health systems to create a supportive system (e.g. in terms of management and supervision, referral arrangements, and supplies of equipment and medicines) in which the community midwives can effectively provide services.

By 2010 the programme had enrolled 8,700 candidates and trained over 2,800 CMWs, although at the time graduates were still awaiting formal deployment in their district communities.

Assessment of the quality of training

In 2010 the MNCH programme requested an assessment of the quality of CMW training. This was triggered by anecdotal evidence that newly qualified CMWs lacked the degree of skill and competence to fully provide the services required of them in the community. The programme proposed that the recommendations generated through the assessment could be strategically applied for further strengthening of training. This was seen as a very positive step towards addressing any initial shortcomings.

The assessment was conducted by a team recruited through the Technical Resource Facility in Islamabad with support from HLSP, and funded by the UK Department for International Development (DFID) and the Australian Agency for International Development (AusAID).

Methodology
The assessment looked at several areas, including:

(i) the selection of CMWs;
(ii) teaching and training approaches;
(iii) the availability of required resources; and
(iv) the competencies of CMWs.[8]

The assessment team visited 13 CMW schools across the country, together with their respective clinical training institutes (representing approximately 10% of the 138 schools nationally). These included schools managed by the MNCH programme and development partners. The methodology included observation, structured and semi structured interviews of stakeholders, knowledge and skills assessment of tutors and clinical trainers, and knowledge assessment/objectively structured clinical examination (OSCE) of CMW graduates.

[7] Indra Pathmanatham et al. (2003) Investing in maternal health: learning from Malaysia and Sri Lanka. World Bank.
[8] New training manuals for community midwives, developed for Pakistan with support from UNFPA, were used as the competency standard. The manuals draw on WHO (2007) Managing complications in pregnancy and childbirth: a guide for midwives and doctors.

Key programme achievements

The achievements of the CMW training programme following 30 months of implementation are significant. Uptake has been good and enthusiasm for the programme by students is high, although misconceptions regarding their role persist. The programme prepares a new professional cadre among rural women and provides them with employment to serve their communities through addressing the needs of the more vulnerable women who often do not deliver in health facilities.

4. Discussion

Emerging challenges

The main challenges identified by the assessment are related to systemic issues which hamper programme implementation, rather than to the programme's concept.

Recruitment
The CMW programme has struggled with recruitment. While the selection criteria for CMW candidates are clearly set out – married (preferably) rural women, 18 to 35 years old, with a minimum of ten years of schooling – it has proved challenging to find suitable candidates, particularly in remote rural areas such as Baluchistan where education achievement is low. As a result selection committees (responsible for identification of students at district level) recruited up to 30% of women from urban areas to meet their targets. However these women are reluctant to relocate to rural communities and the programme requested that this practice stop.

Recruitment will continue to remain a challenge. The programme may need to look to the experience of Afghanistan where a similar issue is being addressed through the addition of modules such as basic science to the CMW training. This in itself points to the issue of whether more education is required overall. In Sri Lanka the entry requirement for training as a village based midwife was initially eight years of schooling, but as the course was developed further it was raised to 11 years and finally to 13 years in 2003.

Clinical skills
The CMW curriculum clearly sets out a theory to practice ratio of 25:75 with regard to time spent. However theoretical teaching has ended up becoming the dominant element of the CMW course, limiting clinical learning and the achievement of clinical competence by the students. There are several systemic reasons for this:

- The CMW programme is managed vertically by the MNCH programme and is not well understood outside it, for example in hospital and clinic settings. Although CMW schools are often in close proximity to the hospital facilities where the clinical training takes place, there is little joint planning between the two, resulting in a disconnect between theoretical and practical learning.
- Other cadres of students (e.g. medical students and nurse/midwives) compete for clinical learning, and CMW learners tend to be sidelined. For example, sometimes they are sent to non-maternity units to fill in gaps in understaffed departments.
- Often tutors based in CMW schools have not maintained their competence in midwifery practice, and are therefore unable to support students during clinical placements.
- The clinical trainers are medical officers, nurse midwives and lady health visitors on duty in maternity units. They are given no orientation to the CMW programme or incentives for teaching CMW students, and therefore feel no real ownership of this cadre.
- The current CMW curriculum is not based on a system of 'block teaching', which allows for continual stretches of clinical practice. In many schools, clinical experience takes place following morning theory sessions and therefore becomes fragmented, limiting the students' ability to follow through on individual case management.
- Inadequate accommodation means that the residential nature of the course cannot currently be enforced and night rotations are subsequently missed.

Critical analysis and synthesis of knowledge
The evaluation found inadequacies in the ability of CMWs to apply theoretical knowledge to a clinical scenario. The schooling system in Pakistan is based on traditional learning processes, and this methodology also tends to be used in CMW training schools. Many tutors require more thorough training in methods of adult teaching to help students develop analytical skills and the ability to synthesise and apply knowledge. The training of trainer course which contains the adult learning module was donor funded. Since the initial training, no refresher courses have been run, meaning that new teaching methods are not well institutionalised. Concepts that were difficult for tutors to grasp (such as designing academic calendars and lesson plans) were poorly adopted. Nurse tutors who have been more recently enlisted to take on growing numbers of CMW students, often lack this training. Without analytical skills, once placed in the community CMWs will find it extremely difficult to respond with proficiency to clinical cases.

Community experience
For this community based cadre, the well structured organisation of community placements during training is essential. During their community rotation, CMWs should gain the practical experience which prepares them to work in their respective communities. However the training of CMWs was initiated rapidly and deployment guidelines were not formalised. As a result CMW schools did not develop any formal plan for community rotation, and the potential of placements to provide good orientation for the CMWs' future role was not achieved. In addition, understaffing and low utilisation of primary level facilities prevents students from gaining the clinical experience they need in their own community – and lack of accommodation elsewhere means they cannot gain this experience away from home.

Supervision
Mentorship and preceptorship, whereby a student has a dedicated clinical supervisor, are not part of the established training system in Pakistan. Student clinical log books, which should serve to verify their achievement of clinical competence, are signed by theory tutors who in fact do not witness their work. It is still to be seen how well supportive supervision is implemented once graduates are formally deployed. The public sector is under-resourced both in terms of finance and human resources, but the necessary development of CMW skills can only take place in an environment of supportive supervision by trained health providers within the community and/or through internships at district level hospitals.

Other issues
More broadly, CMWs are hindered in their work by the fact that efforts to strengthen the district health system are lagging behind the implementation of the training programme. Some hospitals do not meet minimal training requirements (with staff shortages, lack of equipment, and low case loads). In addition, at inception of training, some CMW schools lacked adequate numbers of fully competent tutors, which remains an ongoing issue.

These challenges are not exclusive to the CMW programme, but are reflected in the wider literature on experiences in Pakistan and other settings. Studies conducted in Pakistan between 2008 and 2009 on aspects of the training process point to the same systemic bottlenecks.[9] Similarly the WHO World Health Report 2005 draws attention to the areas that commonly need strengthening: tutor skills, the organisational aspects of basic training, supervision and team building.

The primary challenge is therefore to ensure that key government and institutional stakeholders are strongly aware of this evidence, and coordinate partner inputs to address the issues systematically. Their understanding may lead them to redefine training targets so that *quality* is given priority over *quantity*. International partners must also take responsibility for strong collaboration in building local capacity based on a clearly defined strategy.

[9] Population Council (2010) Assessing the potential acceptability of a new cadre of community midwives for pregnancy and delivery related care in rural Pakistan. The study was conducted in 2008-2009; Population Council (2010) Initial assessment of community midwives in rural Pakistan. The study was conducted in 2008.

Recommendations from the 2010 assessment

The 2010 assessment of quality of training led to a series of key recommendations and an action plan to address the key challenges described earlier. Recommendations include, among others:

- **Raising awareness at Provincial and district level on the elements required to ensure quality outcomes, and on the need for robust accreditation and regulatory processes to maintain these**. The Pakistan Nursing Council (PNC) requires support to ensure that the relevant regulations are adhered to. These guarantee that CMW schools a) meet the criteria to provide quality standardised CMW training, and b) plan student numbers according to their capacity to provide such training.

- **Building capacity to ensure effective implementation of the midwifery curriculum**.[10] The curriculum is currently under revision and is being cross referenced to the approved PNC training manual. Its full comprehension by faculty members must be ensured through regular reviews.

- **Training of trainers should be a rolling programme**. This will help institutionalise the use of adult learning methods and competency-based teaching methods to facilitate learning, and increase the skills of tutors in lesson planning and assessment.

- **Improving the organisational aspects of training**. Training coordination teams should be established to help ensure shared ownership of this programme by both CMW schools and training hospitals, and improve planning and supervision of students training, understanding of CMW deployment arrangements and planned internships as part of continuous professional development.

- **The examination system must be more robust**. Students who do not achieve skills competency in clinical placements should not be allowed to sit final examinations. The student log books must provide accurate verification of this achievement.

Outstanding issues

A key issue is that both government and some development partners have continued to focus on the *number* of CMWs without due attention to their specific role within the overall health system, which requires functional EmONC and referral systems to make an impact on maternal mortality.

Another major issue relates to devolution. The 18th Constitutional Amendment has transferred to Provincial governments many of the functions and resources formerly in the remit of the federal Ministry of Health. At the time of writing the health sector in Pakistan is undergoing major change, and it is still unclear how this will affect the CMW programme. For sustainability and success, in the newly devolved context, it is essential that the CMW strategy is fully developed and owned by Provincial governments. Devolution may provide the opportunity for the Provinces to prioritise the coordination and funding of key elements of the MNCH programme to reach the desired results. An example would be placing equal emphasis on strengthening the district health system, and on scaling up EmONC and referral services in parallel with the CMW initiative.

It may not be possible for some time for many of Pakistan's CMW training schools to meet certain criteria, such as tutors who are competent clinical midwifery practitioners with up-to-date knowledge. However there is a need to take immediate steps to address those systemic issues that are within reach, so that Pakistan can move towards the intended outcomes of the CMW intervention. Feasible solutions are needed. For example, CMWs who graduated some time before their deployment or with limited clinical practice in some areas may need periods of internship with dedicated preceptors until full competency is achieved. The need for graduate internships has already been identified in Punjab, and this experience could provide useful lessons for other provinces.

[10] The International Confederation of Midwives also makes this recommendation for midwifery training in its Statement of Belief (2008).

Devolution is also an opportunity for developing integrated arrangements for programmes that are currently managed vertically. This will potentially improve the alignment of the CMW initiative with the Lady Health Worker Programme. Lady health workers are also community based and responsible for primary health care and reproductive health services such as family planning. Although they are considered a non-professional cadre, they are well established and accepted in the community, and their scope of work is expanding. It is important that the work of these two cadres is mutually supportive. Secondly, effective supervision can be ensured when the CMW programme is solidly linked to the primary health care (PHC) system. Until this happens there may be a tendency for PHC health staff to view it as an isolated programme.

5. Conclusions

Efforts to accelerate progress towards MDG 5 may drive interventions around training of SBAs ahead of capacity to achieve the desired result.

The training challenges encountered in Pakistan illustrate the substantial and long term investments that are required to achieve 'competent' practitioners. If government plans dictate that training should continue without the supportive systems fully in place, there may be a need to reduce new training targets and find immediate interim solutions to improve quality. Meanwhile, investment should continue to be made in the resources and institutions to ensure that good quality basic training will be provided in future years.

Short term improvements can be made to the quality of CMW training, but the value of this should be determined by the commitment and preparedness to address larger and longer term issues – such as the need to establish regular refresher course for all clinical trainers and to build hostel accommodation so that residential courses can meet standard criteria.

The MNCH programme and Pakistan Nursing Council have been responsive to the recommendations made by the assessment of training and have jointly agreed to an action plan to strengthen the training and deployment processes. The PNC is taking an active lead on the revision of the CMW curriculum. DFID is supporting implementation of the action plan through the Technical Resource Facility in Islamabad. With this commitment, it is expected that some of the bottlenecks within the training process can be overcome.

This paper is based on work carried out by the Technical Resource Facility (TRF) in 2010.

The TRF is a five year technical assistance project managed by HLSP and funded by UK Department for International Development and AusAID to help the government of Pakistan achieve its goal of improving people's access to quality health care services. Its focus is on poor people and marginalised groups and with special emphasis on helping to achieve MDGs 4 and 5.

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