Exploring community midwives' perceptions of their work experience after deployment in the rural areas of Chitral, Pakistan

Abstract

Aims: To explore the perceptions of community midwives about their work experiences after deployment in the rural settings of Chitral, Khyber Pakhtunkhwa, Pakistan.

Methods: A qualitative descriptive approach was used, conducting in-depth semi-structured interviews with 13 community midwives.

Findings: The three major themes that emerged from the analysis of the data were: (1) rural community midwives' perceptions of their role and competencies, (2) factors facilitating and hindering the rural community midwives' ability to function, and (3) continuation of community midwives' services in the future.

Conclusions: The study findings highlighted the factors that empower and obstruct community midwives in providing services in rural areas. The majority of the community midwives felt empowered because of their increased earning capacity and enhanced competencies in performing their roles. However, some of them shared challenges in terms of socio-cultural and financial constraints. These findings have important implications for midwives working in rural areas.

Keywords

Community midwives | Midwifery care | Perceptions | Experiences |

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Globally, the maternal mortality rate and neonatal mortality rate remain persistently high (World Bank, 2015). Globally, there are 216 maternal deaths per 10 000 live births every year. In South Asia, this rate is estimated as 180 maternal deaths per 100 000 live births, whereas in Pakistan maternal mortality rate estimates are 178 maternal deaths per 100 000 live births. Globally, the neonatal mortality rate is estimated as 19 deaths per 1000 live births, whereas in Pakistan it is estimated to be 46 deaths per 1000 live births (World Health Organization (WHO), 2015). The Sustainable Development Goals for 2016–2030 highlight the urgent need to work in economic, social and environmental dimensions, with 17 goals and 169 targets. The Sustainable Development Goals are hoped to be achieved over the next 15 years to tackle pressing challenges around the world (United Nations, 2015). According to Sustainable Development Goal 3, by 2030 the global maternal mortality rate should be reduced to less than 70 per 100 000 live births and the neonatal mortality rate to 12 per 1000 live births (United Nations, 2015).

According to *Midwives' voices, midwives' realities report 2016* (WHO, 2016), midwifery is defined as 'skilled, knowledgeable, and compassionate care of childbearing women, newborn infants, from pre-pregnancy, pregnancy, post-partum and early weeks of life'. In this article, midwives are considered professional skilled birth attendants when they have acquired midwifery training from the local midwifery board to provide care throughout the birthing process (Koblinsky et al, 2006). According to the WHO (2015), global coverage of skilled attendants during childbirth was reported to be 62% in 2000 and 73% in 2013. Women living in at rural areas preferred trained birth attendants as they are easily available and cost less than skilled birth attendants (Ali et al, 2008; Khan et al, 2009). The limited percentage of skilled birth attendants in South Asia means that there is a need to train midwives, especially in the rural areas,

to reduce maternal and neonatal mortality rates. In the past 10 years, use of maternity services has increased substantially and now 75% of women worldwide give birth accompanied by a skilled birth attendant (WHO, 2015). However, millions of women still receive delayed, inadequate or unnecessary maternal services (Campbell et al, 2016; Miller et al, 2016).

Rural midwives are trained professionals and have the skills to improve the physical, psychological, spiritual and social wellbeing of women and their families throughout womens' childbearing cycles (Sarfraz and Hamid, 2014). Today, practising midwifery in rural areas involves independent management of women's health, focusing mainly on common primary care issues, family planning, gynaecological needs, pregnancy, childbirth, the postpartum period, and care of the newborn (Faisel et al, 2012). Training enables certified midwives to use their skills and judgment in the provision of primary health services, in accordance with the standards of midwifery practice.

Several researchers have described a wide range of attributes of good midwives, including good communication skills, being compassionate, kind, knowledgeable, competent, organised, logical, skilful, and supportive to women, along with providing perinatal care (Nicholls and Webb, 2006; Halldorsdottir and Karlsdottir, 2011; Turkmani and Gohar, 2015). However, some of the barriers illustrated in the literature to practicing midwifery services autonomously include a lack of recognition, lack of confidence, poor working conditions, complicated infrastructure, inadequate transport facilities, deterrant socio-cultural norms, cost of services and financial constraints (Koblinsky et al, 2006; Kornelson, 2009; Dhakal et al, 2011; Faisel et al, 2012; Sarfraz and Hamid, 2014).

In remote areas of Pakistan, topography is a major problem. Mountainous terrain makes it difficult and expensive to transport sick clients from one place to another (Rasool, 2010; Anwar, 2012; Singh et al, 2012; Sarfraz and Hamid, 2014). Therefore, the priority of midwifery services in the rural areas is to maximise the safety of home deliveries, since health facilities may be too distant or costly for women to access (Newburn, 2012; Homer et al, 2014; ten Hoope-Bender et al, 2014; Van Lerberghe et al, 2014). The 2016–2030 Sustainable Development Goals also aim to provide access to safe, affordable, accessible and sustainable transport systems by improving road safety.

The Chitral Child Survival Programme is another positive step towards reducing the global burden of neonatal and maternal mortality. The objectives of the Chitral Child Survival Programme were to improve uptake of the community midwife services, to foster sustainability over time, and to develop a model that enhanced the use of the community midwife services in Chitral.

Purpose

This study explored the community midwives' perceptions of their work experiences after their deployment in the rural areas of Chitral, Khyber Pakhtunkhwa, Pakistan.

Methods

Study design

The study had a qualitative descriptive design to obtain the perspectives of community midwives who had been deployed in the rural areas of Chitral by the Chitral Child Survival Programme, were presently working at their stations in their village and have an active license issued by the Pakistan Nursing Council (PNC). The study was conducted in Chitral, which is the largest district and located towards the north in the Khyber Pakhtunkhwa province of Pakistan. Purposive sampling was used, and 13 of 28 community midwives were recruited. At the tenth participant data saturation was achieved, but three more interviews were conducted to ensure that no new information was emerging.

The data were collected through an open-ended questionnaire, which was pilot-tested on 6 community midwives during the first phase of the study. No changes were made to the tool as a result of pilot testing.

Ethical approval

The study was approved by the ethical review committee of the Aga Khan University. Before each interview, the participant's written consent was obtained and demographic information was noted (*Table 1*). Confidentiality and anonymity were maintained by using code numbers for the participants.

Data collection and analysis

The data were collected through an open-ended questionnaire, which was administered on a one-to-one basis in Urdu. Data analysis, in which the researcher referred repeatedly to the data to find meaning and to develop a deeper understanding of the findings, was done concurrently with the data collection process (Creswell, 2013). Interviews were read and re-read by primary investigator, Mehtab Jaffer (MJ) and co-investigators Rafat Jan (RJ) and Arusa Lakhani (AL)to gain familiarity with the data. Simultaneously, member checking was carried out by MJ, RJ and AL face-to-face with the study participants, by visiting them at their workplace.

Results

The participants' demographic data were analysed and are presented in *Table 1*.

After an in-depth analysis of the participants' interviews, three major themes emerged from the data. These are illustrated in *Figure 1*.

Table 1. Demographic characteristics of the participants (*n*=13)

Participants' ID number	Age	Academic qualification
1	24 years	Bachelors of Arts
2	24 years	Matric[1]
3	23 years	Bachelors of Arts
4	30 years	Bachelors of Arts
5	22 years	Matric[1]
6	23 years	Matric[1]
7	23 years	Bachelors of Arts
8	23 years	Bachelors in Science (BSc)
9	22 years	Intermediate[2]
10	25 years	Intermediate[2]
11	25 years	Matric[1]
12	25 years	Intermediate[2]
13	25 years	Bachelors of Arts

[1] Secondary education; [2] Higher education

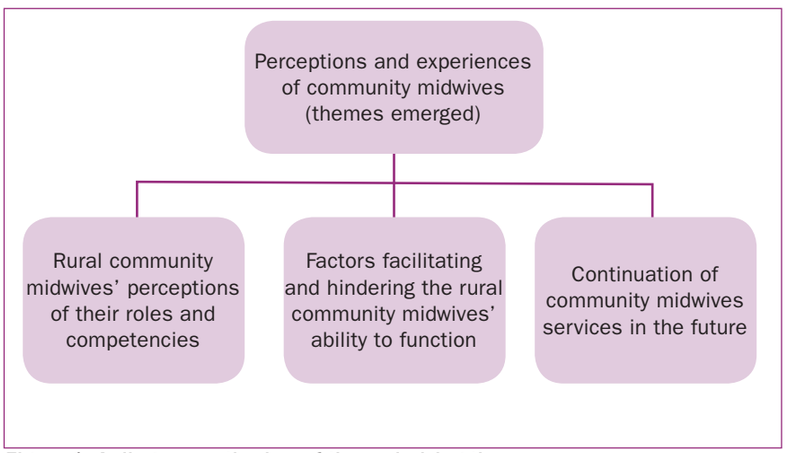

Figure 1. A diagrammatic view of the underlying themes

Theme 1: Rural community midwives' perceptions of their roles and competencies

Most of the participants described their roles as rural midwives and considered themselves as trained professionals who are able to provide several kinds of care in their community, including antenatal, intranatal, postnatal and newborn care. One of the participants said:

> ***'I take complete antenatal history, check the vital signs, weight, height, take pregnancy test, do urine dipstick and perform blood grouping.' (P13)***

Another participant highlighted the importance of providing newborn care, education and safe practices during and after the delivery. She stated:

> ***'Immediately after the newborn delivery, I wipe the newborns, keep them in a warm temperature, and check the umbilical cord, and instruct mothers about the importance of breastfeeding. Also I provide health education to mothers regarding balanced diet.' (P4)***

In addition, the participants were able to clarify some of the misconceptions regarding postnatal diet patterns in their community. One participant said:

> ***'There is a myth in our village that whenever a newborn dies, the mother should refrain from eating red meat and eggs, as this would harm the next pregnancy. I teach the community that this practice is not right.' (P8)***

The participants compared the differences between delivery practices in the past and the present. In the past, most deliveries were conducted by untrained providers, who were unable to maintain aseptic techniques. The participants had all the essential instruments to provide safe and clean deliveries, something which the traditional birth attendants lacked. In this regard, one participant stated:

> ***'Previously TBAs [traditional birth attendants] used to cut the umbilical cord with dirty blades, but at my clinic all the equipment is sterilised now.' (P11)***

Theme 2: Factors that facilitated or hindered a community midwife's ability to function

The second theme that emerged was the factors that facilitated and hindered the community midwives' ability to function in their respective communities.

> ***'In the beginning, I have faced lots of problems in my community; they were even not ready for consultation with me, but now my relationship is very good with them, people respect me and ask about their health condition, because they are satisfied with the services I deliver.' (P2)***

Interestingly, a few participants said that their community members showed concern if the community midwives did not reach or visit their work centres. This was obvious in one of the participant's response:

> ***'If, for instance, one day I didn't visit my work centre because of some personal reason at home, then the community people would visit my home to ask,***

"What happened to our daughter? Why has she not visited her clinic today?"' (P5)

Some of the participants felt that because of their families encouragement and support they can easily perform their midwife role in the community. One respondent expressed her feeling:

'Whenever I have to visit the community women's homes, my husband takes care of our 1 year old baby.' (P10)

Participants also shared some factors which hindered their work, right from the beginning of their deployment. These hindrances were physical, financial and social in nature. Almost all participants emphasised the geographical location of the Chitral district—one participant said:

'Chitral is located in a mountainous area and the terrain of our area is too tough. Making home visits in the community is not an easy task. Many times, I have to walk one or two hours away from my home, just to reach the women's homes.' (P7)

One community midwife shared that problem faced while providing postnatal care to the women.

'At times it is difficult for women to visit for their postnatal check up as they live very far from the community midwife work station so can't turned back at stations for their postnatal checkups.' (P2)

Another major physical challenge faced by the community midwives was the snowfall in the Chitral district. One respondent expressed her anxiety by saying:

'We face a lot of weather-related issues, especially in winter, like snowfall, in which roads get completely blocked and covered with snow. We face difficulties walking on the snow.' (P7)

The participants stated that they charged a very small amount of money for the services that they provided to the community. This money was generally used for transportation and for buying medication for the patient. One participant shared her exasperation:

'I take Rs 10 to Rs 25 (£0.07–£0.18) for the antenatal services and between Rs 500 to Rs 1500 (£3.691–£11.07) for conducting deliveries at my place. There are times when the community members are unable to pay me for my services, because of poverty…' (P12)

Theme 3: Continuation of community midwives' services in the future

The third and the most important theme that emerged from the analysis of the data was the community midwives' attitudes to continuing their services after the closure of the funded project and the end of financial support for the community midwives. One participant [looking anxious] said:

'Presently, the project is providing me the income of Rs 5000 (£36.91), but if this stipend money will stop, then it would be difficult for me to manage. If I get enough financial benefits, then only I will be able to continue my work, otherwise I will discontinue it.' (P3)

One participant was very disappointed with her community's attitude and was not ready to work for a single day after the closure of the project. She said:

'It is very difficult to work in the community. People call me to utilise my services, get treatment from me, and then when I ask them to pay for my services, they refuse.' (P1)

However, other participants felt positive and motivated to continue their services even after the funded project ends. One participant shared:

'I am working alone in my village and whatever issues I have in my community, my community trusts me. I can work as they have regard for me.' (P4).

Two participants felt proud that their community had accepted them, hence they would continue to work as community midwives. One proudly said:

'I am the only trained professional in my community, my community is ready to pay me according to my services; I am very much satisfied.' (P13)

Two participants appreciated and acknowledged their supervisors' efforts to facilitate their personal and professional growth. They stated that they would need their supervisors' support, irrespective of whether they received any project money in the future. While appreciating the supervisor's efforts, one participant stated:

'If, in the near future, this project will discontinue, then the only thing which I will need would be supportive supervision from my supervisors.' (P10)

Another participant stated:

'In future, I will run my own big clinic independently as a community midwife so that I can treat other minor and major health illness of my community.' (P13)

Discussion

The community midwives showed that they were performing their roles seriously by providing vigilant monitoring and giving physiological and psychological support to the mothers and babies throughout the pregnancy and in the postnatal period. In other studies community midwives have been trained in pregnancy-related monitoring (blood pressure, presence of oedema, weight gain) and are capable of referring complicated cases to other facilities (Hughes and Fraser, 2011; Mohammad et al, 2015). Moreover, the community midwives reported their responsibility in providing postnatal care in areas such as checking vital signs, watching for bleeding, maintaining personal hygiene, teaching postnatal exercises, checking haemoglobin status, and instructing the women to maintain a balanced diet. Other studies indicated that health professionals were able to develop competence and confidence in providing essential care and to identify complications that may occur during the post-partum period so that prompt treatment can be administered (Baqui et al, 2008; Titaley et al, 2008).

Some women lived far from health facilities and could not reach the community midwife for postnatal examinations. In those cases, the community midwife stayed at the woman's home to provide postnatal care. This finding is congruent with three other studies in which the researchers found that midwives had to spend quality time with the women during the postnatal period (Whelan and Lupton, 1998; Morrell et al, 2000; Lugina et al, 2002). A series of articles in the *Lancet* concluded that midwives were recognised as the main backbone of maternal and child health services, and were considered to be a cost-effective strategy which could prevent maternal and neonatal mortality (ten Hoope-Bender et al, 2014;Ven Lerberghe et al, 2014).

Another aspect which empowered the community midwives was their earning capacity, which gave them financial independence and stability. Previously, these women had been working in the community as housemaids, where they were not respected. However, after their deployment, they were considered respectable members of the community which helped them feel liberated and gave them a sense of self-respect. They had developed greater self-worth and were motivated to continue working in the future as they took pride in their own earning capabilities. Getting a stable income from work and receiving continuing education were also paramount motivating factors for rural health workers in Vietnam (Dieleman et al, 2003; Prytherch et al, 2012; Mohammad et al, 2015).

The participants had faced challenges regarding the community's acceptance. However, as time went by the community started accepting them and gained confidence in their competency, so the community midwives did not want to lose this trust and support. The community's acceptance resulted in encouragement, motivation, a sense of accomplishment, and achievement for the community midwives and enabled them to continue their services, regardless of the challenges. Going forward, a few community midwives were planning to start their own midwifery clinics, which would further empower them to manage women-related issues in their respective communities. Rasool (2010) conducted a study in Baluchistan, Pakistan in which the community midwives expressed their readiness to serve in communities independently because of their community's cooperation.

Reflecting on the experience, the participants also provided insight into the factors that constrained community midwives while providing midwifery services in the rural areas. The major constraint highlighted by the study participants was the geographical location and terrain, weather, and infrastructure in the Chitral district. The topography of Chitral comprises bare rocks, barren ground and snow-clad mountains. Winter blizzards and summer floods disrupt communication and transportation both within and outside the community (NWFP and IUCN Pakistan, 2004). As a result, the community midwives faced problems while walking on difficult roads, often taking up to 2 hours just to reach the women's homes. Unsurprisingly, studies have found that poor and harsh field conditions create challenging situations for community midwives (Faisel et al, 2012; Sarfraz and Hamid, 2014). Therefore, it has been suggested that community midwives stay at the pregnant women's home if there is the risk to the maternal and neonatal health or they can communicate via phone with the women and refer them to the nearest health care center for the birth.

Community midwives were concerned about their financial support, as they would not receive their monthly stipend after the closure of the Chitral Child Survival Programme. The study findings revealed that some community members had a very low income and could not afford to pay the community midwives so the community midwives provided free services to them, but this meant that the community midwives were paying for medications, transportation, and other logistical expenses themselves. This finding is consistent with the findings of other studies in Pakistan, which indicated that the community midwives were not willing to work for their community because of the limited resources and the

community's inability to pay for their services (Rasool, 2010; Faisel et al, 2012;Van Lerberghe et al, 2014; Sarfraz and Hamid, 2014).

Another constraint shared by the participants was that some communities repeatedly used the services of the community midwives but did not pay them, as they considered community midwives to be the daughters of the community and daughters were not supposed to receive any financial incentives from their families. This attitude created a sense of disappointment in the community midwives because they were not getting any payment for their hard work (Sarfraz and Hamid, 2014).

A few participants reflected that although their family members seemed happy to support them in managing housework and childcare when they left to deliver home services, the same family members may not be supportive in the future if adequate financial benefits were not forthcoming. This issue was very distressing and challenging for most of the participants, and such a situation was likely to lead to retention challenges in the future. The retention of providers, especially in poorer countries, is a major concern in remote and rural areas. In South Asia, the reasons for this concern are inadequate income, low prestige, poor rural infrastructure and social isolation. Failure to overcome these deprivations leads to lower coverage of health services (Koblinsky et al, 2006; Titaley et al, 2010; Ith et al, 2013). The study findings were consistent with those of *Midwives' voices, midwives' realities report 2016* (WHO, 2016). The WHO collaboration with the International Confederation of Midwives demonstrated the analytical framework which discussed the barriers to quality of care by midwifery personnel: social, economic and professional.

Strengths

This study was an initiative to explore the roles of community midwifery services by the community women in the rural areas of Chitral, Pakistan. It helped to identify the supporting and constraining factors that affected the provision of services by the community midwives in their respective villages in the rural areas of Pakistan.

Implications

This study has major implications for rural midwifery policy-making, such as the need to develop strategies to recruit and retain midwives in isolated rural areas. Moreover, government stakeholders and employers need to arrange continuing educational programmes at the community level to increase awareness of the community midwives' role and to enhance community trust in their professional roles.

At the practice level, there is a need to collaborate with other donor agencies to help community midwives with financial and administrative aspects. Such support would increase the retention of the community midwives' services in their deployed villages, which will ultimately reduce costs and improve outcomes. There is also a need to reinstate the stipend support programme for the community midwives, as this would lead to more viable and independent operational programmes. The study also has direct implications for providing supportive supervision to rural community midwives. Supportive supervision is helpful for community midwives in providing evidenced-based practice to the women of the community; it is a form of continuing education, specific to their circumstances.

Key points

- Community midwives play an important role in providing care to childbearing women of all ages at rural areas
- There is an urgent need to train and recruit community midwives especially in rural areas in order to reduce maternal and neonatal mortality and morbidity
- There remains a lack of awareness among the community about the role of community midwives and there is a need to improve their use over traditional birth assistants

Recommendations

Recommendations from this study include various strategies, such as ongoing refresher training courses for community midwives, continuous appreciation of community midwives' work performance by publicising their work through the media, for example organising an event on International Midwives' Day. Moreover, there is a need to conduct studies to explore the level of women's satisfaction with the role of community midwives in the rural areas.

Conclusions

This study was a part of a larger project which explored the perceptions of the community midwives about their work experience after deployment in the rural areas of Chitral, Pakistan. The study findings substantiated the factors that empower and obstruct community midwives in providing services in the rural areas of Chitral. Financial independence, competencies and knowledge, community acceptance and trust, the family members' support, and supportive supervision were the major empowering factors for rural midwives, whereas socio-cultural and geographical constraints and future financial challenges were the major obstructions. BJM

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