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CAREER LADDERS FOR MIDWIVES IN PAKISTAN

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Executive Summary

Career Ladders

Career ladders provide both employers and the employees with a rational understanding of the requirements and opportunities for career advancement. It is not possible or desirable for all employees to reach the most senior levels of employment. Some will enter and leave an organization at the same level. This scenario avoids a top-heavy organization with too many managers and too few doers. Those employees with potential to work at the higher levels, however, need to be identified and developed. In this way, career ladders help employees to progress in such a way that their ambitions are satisfied. At the same time, career ladders help employers who need to assure access to high quality services by having suitably trained and experienced staff in place.

Pakistan, as with most developing countries, is encountering a severe shortage of healthcare providers of all kinds, including midwives, especially in rural and remote areas. In an exhaustive literature review (600 articles considered) of what impacts rural retention of healthcare providers in developing countries, Lehman et al (2008)¹ listed career advancement opportunities as one of the three most important factors. (Physical working environment and living conditions were the other two.) In a separate study in Pakistan², the TACMIL project confirmed these findings: midwives that participated in focus group discussions mentioned cessation of career advancement as one of the most important reasons for either not taking, or leaving rural and remote postings. Career ladders provide a transparent method for recognizing experience and qualification, helping reduce turnover and vacancies in rural and remote areas.

Background

In Pakistan the rates of mothers and babies dying at birth is unacceptably high³. Emphasis is being placed on ensuring that trained health providers are present at delivery. Approximately 2/3 of all babies are delivered at home. Of those, only 8% are attended by a doctor or a trained midwife. There needs to be a significant increase in the presence of midwives working in both facilities and in the communities. The Maternal Newborn Child Health (MNCH) Program is currently training 12,000 community midwives to operate independently as private providers outside Government of Pakistan (GoP) civil service or the Ministry of Health (MoH). There are also a variety of cadres of midwives working within the MoH. These women are paid on a variety of pay scales depending on their qualifications. The lowest paid are registered midwives, who are trained exclusively as midwives for one year. The highest are registered nurse/midwives who have an additional three year diploma in nursing. In between are lady health visitors who undertake one year of public health training and one year of midwifery training. All these women have at least one year of training as midwives and all meet ICM definitions of a midwife and the WHO definition of skilled birth attendant.

¹ Lehman, Dielman, and Martineau. *Staffing remote rural areas in middle- and low-income countries: A literature review of attraction and retention*. BMC Health Services Research, 2008.

² Luoma and White. *Financial and Non-Financial Incentives to Improve Midwife Retention in Pakistan*. USAID TACMIL project, December, 2009.

³ Demographic and Health Survey, 2008, MEASURE DHS (USAID)

Methodology

At the time of this writing (December, 2009) an exhaustive HRH assessment is underway in Pakistan, but currently there are very few data on midwives available. Consequently, this document is based on a review of documents available on the nursing and midwifery cadres in Pakistan, interviews with key informants in Islamabad and Karachi, and data collected on the career histories of sixteen senior nurses. As some data were available on registered nurses/midwives, analysis was conducted on them in order to produce a potential career ladder. While information on nurses was somewhat more complete than that for midwives, it was still insufficient to enable precision in recommendations. This career ladder can therefore only be regarded as indicative. However it does provide a background for proposing career ladders for the various cadres of midwives.

Findings

Registered midwives (also known as pupil midwives) have been overlooked in their development, and there was no evidence that any had advanced beyond this position. The same was not true of Lady Health Visitors. Quite a few matrons and instructors are former LHVs, but it would appear that, with a few exceptions, any progress they have made is by their own initiatives. There is no standardized career ladder for LHVs. Registered Nurse/Midwives do have career ladders, but it appears that very few are delivering midwifery services.

Recommendations

Those registered midwives with potential and a desire to operate as community midwives should be offered the opportunity to attend an abridged course. This would be based on the knowledge and experience they are currently lacking and not be the full eighteen months that the inexperienced entrants currently undergo.

Capable Lady Health Visitors with potential should have clearly defined ladders open to them, either to progress to instructor or to supervisor for those maintaining a role in delivering midwifery services overall. A few should be identified and enabled to transition into the RN/RM program in order to provide the strategic management and leadership offered by those in BPS 18 and above. Capable Lady Health *Workers* with the capacity should be considered for future training as LHVs or community midwives (CMWs).

The community midwives are being trained to operate independently as private providers within communities and as such are responsible for their own businesses and advancement and therefore should not have a ladder developed for them by the government.

Background

Types of health workers offering maternity services

In Pakistan, babies are delivered with the assistance of a wide array of individuals. Over 50% of all deliveries are conducted by *Dais* (TBAs), with two thirds of all deliveries in the home⁴. Only 11% of deliveries are conducted at public sector health facilities and a further 23% at private sector facilities. Overall, doctors deliver 33% of babies, and the combined cadres of lady health visitor, registered midwife, registered nurse/midwife conduct less than 6% of deliveries. Relatives or friends are present at most of the remaining deliveries. Only 4% of all deliveries away from health facilities are performed by doctors; the same proportion is delivered by nurse/midwives, LHV's and midwives combined. Ninety-two percent of home deliveries are carried out by a relative, friend, or TBA.

The current pay scales of the different skilled birth attendants vary tremendously, even though the non-doctors all have similar lengths of training *in midwifery* prior to working.

Cadre	Qualification / training	Entry level pay scale – BPS
Doctors	MBBS – 4 years	17
Registered Nurse Midwife (RN/RM)	Diploma RN training 3 years + RM training 1 year	16 – promotions up to 20 possible
Lady Health Visitors (LHV)	Diploma 2 years: 1 public health + 1 midwifery	9 – very limited promotion opportunities
Registered Midwife (RM) (aka Pupil Midwife)	Diploma RM training 1 year	5 – no promotion opportunities
Community Midwife (CMW)	18 months	Not civil service (but provided with training and material support)

The Ministry of Health's MNCH Program, initiated in 2005, is training CMWs with the intention to replace *dais* as the primary birth attendants in communities, as it is accepted that most deliveries are conducted in the household. The first output is between 1400 and 1500 new CMWs, and there are a further 3000 to 3500 in training. The target is to produce 12,000 CMWs, and there is currently a basic requirement for 50,000 of these deliverers⁵.

The RM training program is still active but it is scheduled to end in three years. RMs will continue in the public service until the last one retires, possible in as long as 25 years.

The LHV's continue to be trained.

⁴ Demographic and Health Survey, 2008, MEASURE DHS (USAID)

⁵ Information gained during interviews with MNCH National program manager and technical staff.

Data on the number of LHVs, RMs, and CMWs, their locations, and their experience levels is sparse. The opportunity for these three cadres to be promoted is extremely limited. In order to assess potential career ladders for them, the career experiences of Pakistani nurses will be considered.

At the time of writing (December, 2009) an exhaustive HRH assessment is underway in Pakistan. The assessment is being undertaken by the MOH with support from WHO/Pakistan, the WHO Global Health Workforce Alliance, and the USAID TACMIL project. The results of this assessment will provide substantive quantitative information about the numbers and distribution of the various healthcare worker cadres in Pakistan. Results are expected to be published in early 2010.

Methodology

A desk review was completed considering all available publications, MOH documents, training materials, and project reports, and key informant interviews were conducted with Government officials who help set and apply employment policy for midwives in Pakistan and with other knowledgeable parties such as the Pakistan Nursing Council.

Data

Because there is currently a dearth of hard data on midwives, the data were collected on senior nurses who have come through the registered nurse midwife route. In particular, the careers of 16 senior nurses who have achieved the BPS 18 or higher were examined to serve as a case study of the career ladder for nurses. Understanding their career ladders enabled potential career ladders to be recommended for the Registered Midwives, the Lady Health Visitors and the Community Midwives. Possible linkages with Lady Health Workers are also discussed.

Key informant interviews

These key informant interviews sought information about current employment prospects for the various categories of midwives, and the strengths and weaknesses of the present practices.

Interviewees included officials from

- Ministry of Health
 - Director of Health Services
 - MNCH Program Director and staff
 - Additional Secretary of Health (Planning)
 - Executive Director, Federal Government Services Hospital
- Pakistan Nursing Council
- Midwifery Association of Pakistan
- Public Service Commission
- GTZ

The following additional documentation was considered.

- The requirements specified in the Ministry of Health's National Consultation Nursing and Midwifery, 2007
- The draft of the National Commission on Career Structures for Health Professionals, 2008
- Information from a variety of background documents concerning nursing and midwifery in Pakistan.

Findings

Current Career Ladders for Registered Midwives (aka Pupil Midwives)

From document reviews and key informant interviews, it is clear that the current registered midwives do not have a ladder for progression at the present time. It would appear they have been trained to do a specific job without any option of progression through additional training. Almost all will leave the service at the same level, either through retirement or quitting. RM's can become LHV's or RN/RM's, but there is currently no allowance for their education or experience, and they would need to start training for these advanced positions from the beginning.

Current Career Ladder for Lady Health Visitors

Much the same can be said of the Lady Health Visitors, as no career ladder has been thought through for potential promotion of these workers.. In the 16 case-study careers that were examined, at least one LHV succeeded in progressing to the most senior nursing grades, but she was unable accomplish this progression while still practicing midwifery: once she moved to nursing, she ceased clinical midwifery practice.

Current Career Ladder for Registered Nurse Midwife

To form a case study of nursing careers, the project gathered the curricula vitae of 16 very senior nurses. The complexity of various job titles and changing pay scales for the same jobs undertaken by these women throughout their careers was simplified as follows.

- The entry point is charge nurse, currently BPS 16, but previously BPS 14, BPS 11 and BPS 9.
- These charge nurses can progress to a variety of jobs, all currently either BPS 16 or 17. These are positions such as head nurse, nursing supervisor and assistant nursing superintendent.
- They then may progress to the management, leadership, stewardship positions in grades 18 and above.
- Periods of training were also noted.

The experiences of these senior nurses are summarized in the table below.

Table 1. Illustrative case studies of the careers of 16 senior nurses: years of service in each position.

Nurse	Length of career →							
	Education	RN/RM Charge Nurse	Education	Supervisor	Instructor	Education	Management (18+)	Years in career
1	5	4	3	3	10	2	3	27
2	6	6			5	3	7	37
3	6	9	3	3	12		8	38
4	5	2	2	2	4	2	16	31
5	4	3			13		3	27
6	4	6			19	3	2	34
7	3	13	3	3	10		2	31
8	5	4	2	2	7	2	4	24
9	6	5			15		3	31
10	5	12				3	3	25
11	7	12	3	3	6		3	35
12	4	4	5	5	1		3	17
13	5	7	2	2	11		17	42
14	4	6			12		4	29
15	3	5	2	2	16	2	5	33
16	4	5	2	2	13	5		29
Avg.	4.8	6.4	1.7	1.7	9.6	1.4	5.2	30.6

Examination of the career histories of the sixteen senior nurses revealed the following.

1. Based on our investigations and discussions, RMs or LHVs in Pakistan currently have no opportunities to progress up a career ladder. One exception is a former LHV who undertook the RN/RM program and, subsequent to that qualification, she ceased to practice clinical midwifery.
2. The RN/RMs have had opportunities to develop. Amongst the non doctor cadres delivering babies, only individuals who are RN/RM qualified have progressed into any supervisory or management roles in any numbers.
3. On average they spent about six and a half years of clinical nursing before moving onto some more senior role, interspersed with training.
4. All but one of the sixteen have had instruction roles during their careers: only one nurse went directly from supervision to management without being an instructor.
5. These nurses spent the longest periods of time in their careers as instructors
6. Only one senior nurse expressly said she had worked as a midwife, for a total of six months. As the sixteen had received a total of 16 years of training in the midwifery field, this would appear to be a poor investment.
7. After their initial qualification, these 16 senior nurses received an average of three years of additional study. One nurse had as many as seven years of additional training, but three did not record any training beyond their basic qualifications. The information available suggests that the in-service training content was of a clinical, rather than management, nature.

The paper *The National Consultation on Nursing and Midwifery: Nursing and Midwifery in Pakistan: Partners in Pursuit of Global Goals* (March 2007), principally authored by Dr Iftikhar Naru, includes a breakdown of current and projected future requirements for nurses by level,

much as described above, and by province. This breakdown shows the needs of the health sector for the various cadres of nurses and midwives. The breakdown states that there is a need for 17,212 charge nurses, 1,940 middle-level (supervisory) nurses, and 369 senior nurses, including those not overseeing operations but providing the leadership and stewardship roles. This rational structure suggests that, on average each supervising nurse is overseeing 9 charge nurses, and that there is then one senior nurse at BPS 18 or higher overseeing 5 supervising nurses.

The National Commission for Career Structures document, produced by the Pakistan Medical Research Council (PMRC), on the other hand, has concentrated on drawing up career ladders to satisfy nurses' expectations. It proposes structures where only half of the nurses are working as charge nurses, and the other half are in supervisory or management roles. This demonstrates the dilemma of trying to promote as many people as possible to satisfy their expectations, and the need of an organization to have sufficient numbers of people delivering services. These competing conceptualizations of nurse promotion are depicted in the figures below.

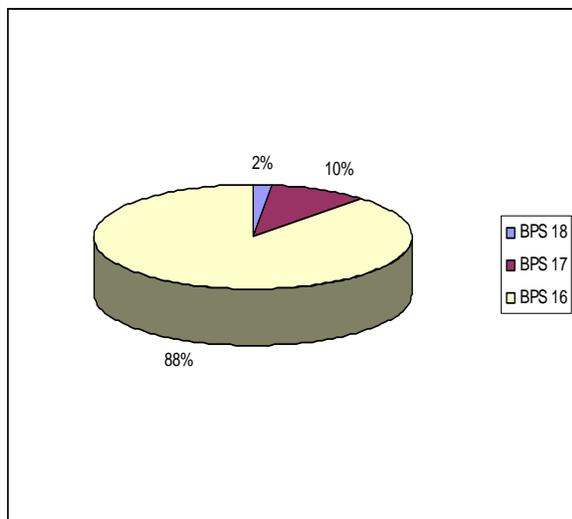


Figure 1. NCS-proposed position proportions

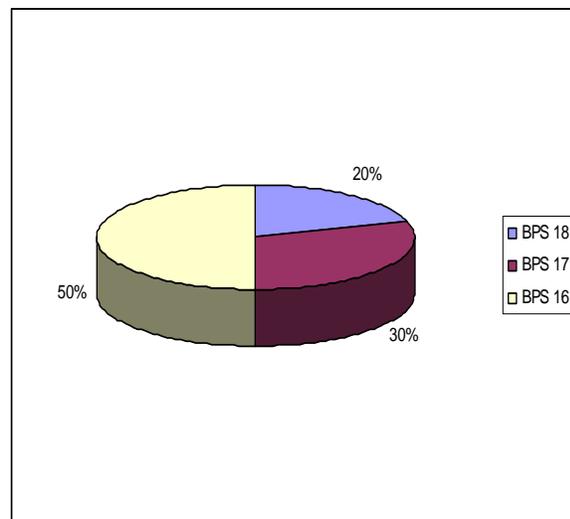


Figure 2. PMRC-proposed position proportions

In practice, only a portion of people ever achieve the top of the ladder. All organizations need to identify individuals with the highest potential and ensure they are developed with the appropriate skills to operate at senior management levels. There is also a need to develop others who will not reach the highest levels but would contribute very effectively in a supervisory capacity. Finally, skill development and improvement should be available to even those who are never promoted but who continue to provide health care services at the basic levels.

A possible career ladder for nurses, which is useful as an example framework to consider for midwives, would be as follows:

- Fifteen percent of nurses who are destined for the most senior positions would spend about half of their career as staff/charge nurses; another third of their career as supervisors/instructors and their remaining years at BPS 18 and above.

- Thirty-five percent of nurses would progress as far as the nurse supervision family of jobs *and no further*, and that progression would be after approximately three-quarters of their career as a charge nurse. Consequently they would spend about one-quarter of their career as a supervisor.
- Fifty percent the nurses will not progress beyond of charge nurse.

These variable career progressions are illustrated in the figure below.

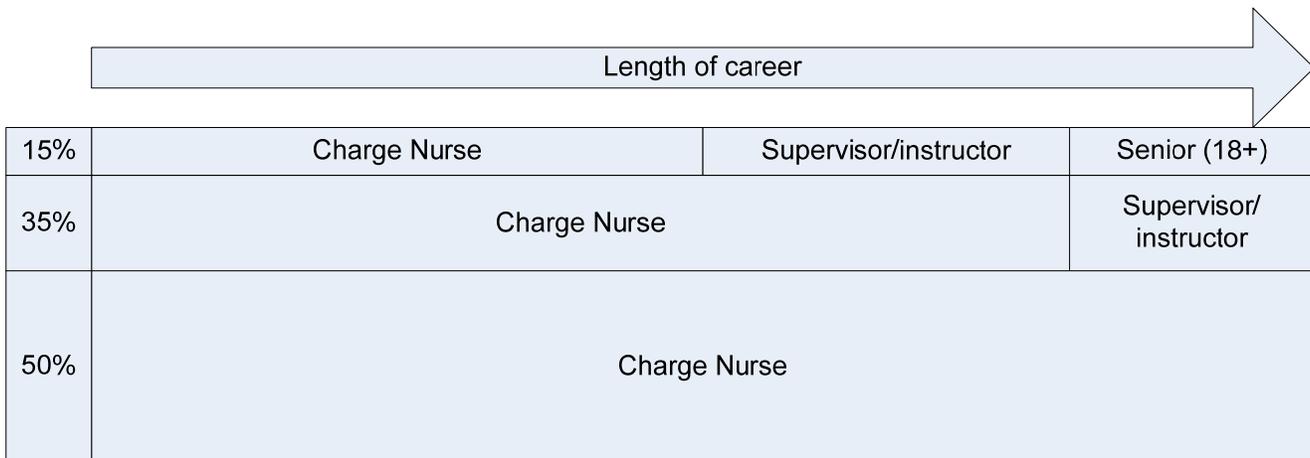


Figure 3. Possible nurse career progressions, as portion of the nurse workforce

These calculations assume that the length of service distribution is relatively flat. If a high proportion of nurses are recent recruits, or alternatively if many are near retirement, then the proportions in the different “level of potential” streams, or the times after which promotions take place, would need to change.

Recommendations—Career Ladders for Midwives

Registered Midwives (aka Pupil Midwives)

Although these midwives have had the same length of training in midwifery as LHVs and RN/RMs, they are paid at a very low grade, BPS 5, and they have not had opportunities for development. Anecdotal evidence suggests that those with some potential are not being developed.

Some of these Registered Midwives should be capable of filling the new community midwife positions. They should be identified and selected for a program of advancement to the CMW role rather than offering them only the option to start at the beginning of the 18-month course. An examination of the differences in their training program and their experience compared with the new CMW programs should be undertaken to inform the design of any abbreviated program.

The main implication for RMs is that advancement to CMW would take them out of the security of a civil service position, but it could open up substantial improvements in income for them, particularly if the current instructional and material support remains in place for them as they set up in their own private practices.

Registered Midwives—Recommended Career Ladder

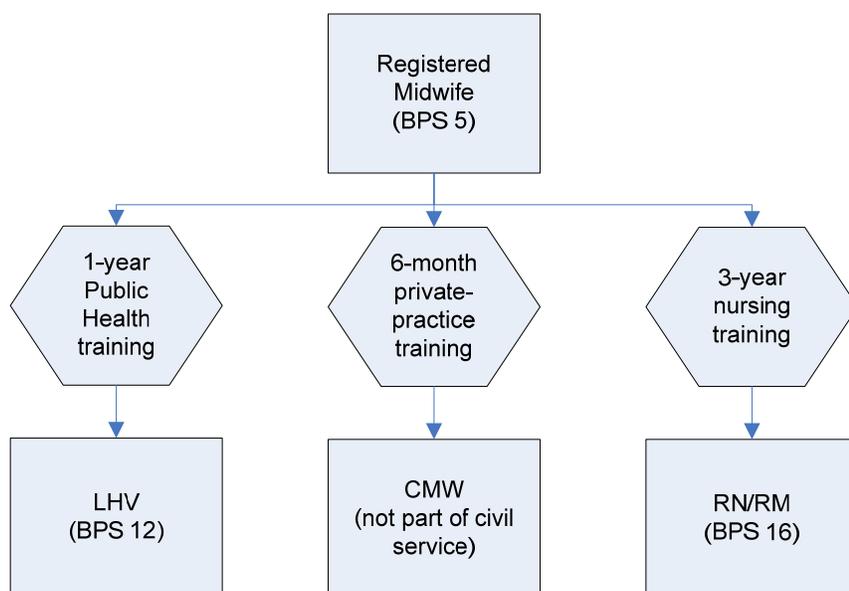


Figure 4. Career ladder options for Registered Midwives

Lady Health Visitors

The 2007 *National Consultation* states Lady Health Visitors are “the most important midwifery group in the public sector... functional in rural areas.” LHV’s operate within small health facilities such as district headquarter hospitals, rural health centers, and basic health units in the rural areas of the country.

After two years of training (including one year of public health), LHV’s are able to provide midwifery services, but their public health training means they enter public service much higher in the pay scale than RMs, at BPS 9. It is believed that very few of these women are receiving any promotions, but one of the 16 senior nurses whose careers we examined came from these ranks after additional training to RN/RM level. Once promoted, she subsequently performed no deliveries.

As with nurses, the Pakistan Medical Research Council has drawn up a proposed career ladder for LHV’s. The features of this proposal are that, like the nurses were before them, they are all upgraded, presumably with no change in responsibilities, to BPS 12. Then half of them would work as LHV’s (BPS 12) or senior LHV’s (BPS 14). The other half is developed into positions from supervisor to principal (BPS 16 plus). Again this plan focuses on trying to satisfy individuals’ expectations for promotion, rather than service delivery requirements. In the plan there would be as many supervisors and tutors as midwives working in rural facilities.

In order to satisfy service delivery requirements, movements into supervisory and instruction roles should be developed, but only for approximately one LHV in five, and advancement should not happen until mid career.

The possibility of developing lady health workers (LHW) into lady health visitors or community midwives should also be considered. A few of these already perform deliveries, even if they have not been trained as midwives or meet any definition of midwife or skilled birth attendant.

Registered Lady Health Visitors – Recommended Career Ladder

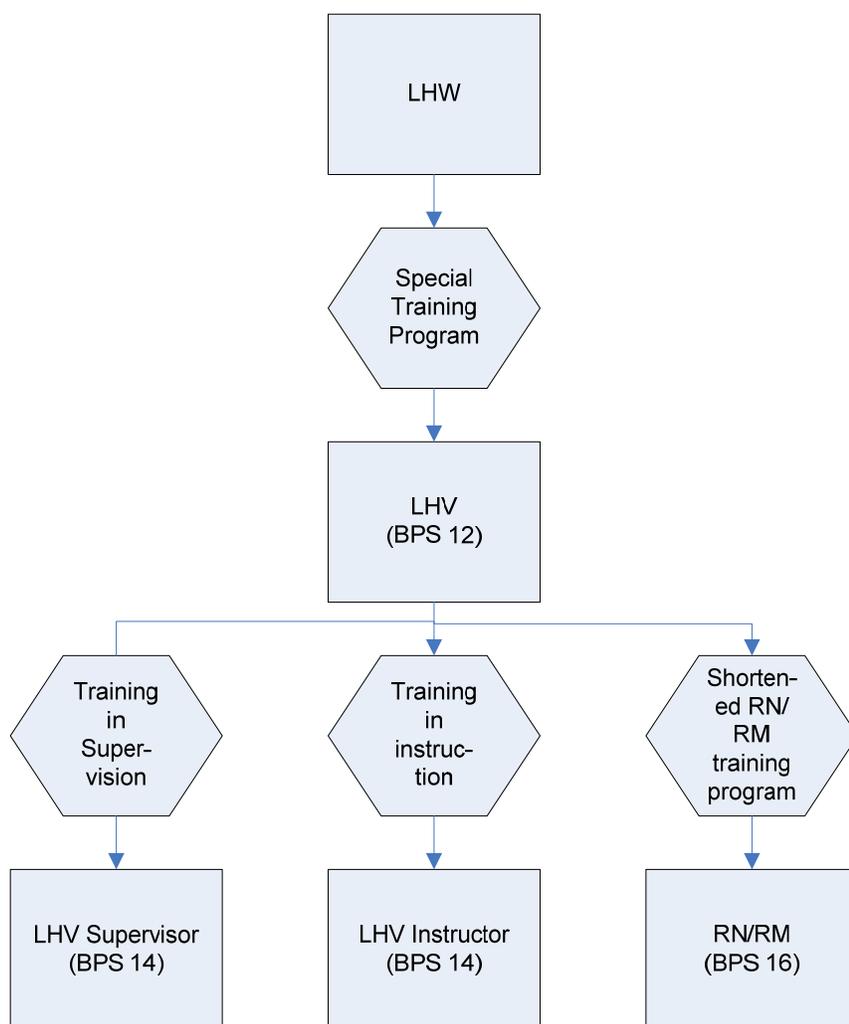


Figure 5. Career ladder options for LHVs

About 15% of the total LHVs would be expected to advance to be supervisors, instructors, or RN/RMs. The remainder would serve out their careers as LHVs.

Community Midwives

The Community Midwife program was initiated by the MNCH project in 2005 and involves a training program of 18 months. CMWs are intended to replace TBAs (*dais*) in communities where household deliveries continue to be common.

The first output of trained CMWs has been 1400–1500, and there are currently between 3000 and 3,500 additional CMW candidates in training. The current target is to train 12,000 CMWs, but the MNHC project team believes the total basic requirement is for some 50,000 CMWs. CMWs will be licensed by Pakistan Nursing Council (PNC) and are planned to be non civil service private providers working in remote and rural areas. It is intended that CMWs will be supervised

monthly by their tutors, receive material assistance (e.g., birthing kits) to set up their practice and will sign a bonding agreement to agree to maintain their practices for a given period of time.⁶

The MNCH project team also indicated that a substantial proportion of the qualifying CMWs they had interviewed are interested in becoming RN/RMs. While this advancement may be feasible for some, it should be discouraged since the objective of the CMW program is for CMWs to operate in underserved communities as private providers, not be part of the civil service.

Conclusion

The career ladders proposed here are indicative and may need to be refined once the results of the upcoming HRH assessment are available. Nonetheless these career ladders do propose options for improved planning and flow of various cadres of midwife. Instituting the abbreviated, cross-over training programs mentioned in these ladders, and offering these options to midwives has the potential not only to improve these health workers' satisfaction with their careers, but also to improve the quality of maternity services offered to Pakistani women.

⁶ Interview with Dr. Farooq Akhtar, MNCH National Program Manager, December 4, 2009.