Learning Paper: Improving areas of support to AMWs for effective delivery of MNCH services in the community

Introduction

The Government of the Union of the Republic of Myanmar’s Health Vision 2030 aspires to move towards Universal Health Coverage (UHC) and has set targets for increasing public expenditures on health. Based on a priority to ensure universal coverage of maternal, neonatal and child health (MNCH) interventions and national targets to deploy more trained health providers, significant investments have been directed towards training and deploying new Auxiliary Midwives (AMWs) across the country. It is essential that necessary areas of support are provided to all functional AMWs, in order for this investment to result in an effective scale-up of interventions. This paper summarises learning from stakeholders across 10 townships, including AMWs themselves, on how key areas of support to AMWs could be improved to effectively deliver MNCH services in the community.

Background

Urgent action is required to reduce high maternal and neonatal mortality and morbidity rates in Myanmar. There is an estimated MMR
of 240 per 100,000 live births (compared to the South East Asia average of 140)\(^1\) and under five mortality rate of 72 deaths per 1000 live births and 62 infant deaths per live births.\(^2\) Forty eight per cent of these deaths were during neonatal period. Neonatal deaths as a share of under 5 mortality has increased between 2003 and 2013 (from 24% to 48%) and statistics show differences in geographical distribution of mortality.\(^3\)

The Ministry has stressed the need to focus on scaling up interventions that reduce neonatal mortality and has committed to improving the quality of care for newborns and under-five children by expanding skill-based training, managing supplies, motivating and deploying staff, and enforcing supervision and monitoring.\(^4\)

There is a current human resource shortage, with an estimated coverage of 1.49 doctors, nurses, midwives per 1000 population (falling well behind the global standard of 2.8). The 2014 Myanmar Health System Review also recognises the need to train more locals in hard to reach areas, equipped with basic medicine.\(^5\)

Deploying skilled clinical staff is a long term investment. Many of the top causes of death are preventable, and under nutrition is a strong underlying contribution. A number of these causes can be addressed through public health promotion and prevention and do not require high level clinical skills. Evidence-based interventions undertaken by trained, supported community health workers have been effective in extending services and preventing neonatal and maternal deaths.\(^6\) “A combination of … outreach and family-community care at 90% coverage averts 18–37% of neonatal deaths. Most of this benefit is derived from family-community care, and greater effect is seen in settings with very high neonatal mortality”.\(^7\)

Task sharing is a widely recognised measure for addressing human resource shortages, using community health workers to help extend services to ‘hard to reach’ groups and areas, and in substituting for health professionals for a range of tasks.\(^8\) The 2006 Lancet maternal series argues for community based strategies in addition to intra-partum facility care and the role of community health cadres in providing newborn care as an effective complementary strategy.\(^9\) The Ministry also recommends task shifting to Community Health Workers (CHWs) and AMWs for essential interventions (e.g. Community Based Newborn Care, Community Case Management), based on evidence.\(^10\) Government recognised community health volunteer cadres, AMWs and CHWs, feature in national health plans as a part of the health system and provide a key opportunity to scale up these interventions to reduce preventable deaths and morbidities.\(^11\)

The Ministry of Health has started implementing these plans with a national target to deploy at least one trained health care provider per village. Investments have been made for the scale up of AMWs, with 9,660 AMWs to be trained in the 2014-15

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\(^11\) Ibid
Objective

The purpose of this learning exercise was to identify from key stakeholders, including AMWs themselves, how to improve areas of support needed for AMWs to effectively deliver MNCH services in the community.

Methodology

In the 10 townships where SC provides support through grants from the 3MDG Fund, structured questionnaires were administered to THD, BHS, AMW and SCI field program staff focusing on four key areas of support to AMWs (i.e. training, supervision, supplies and information systems). Responses were obtained from at least one representative (i.e. Township Medical Officer, Township Health Nurse or Health Assistant) of the THD in each Township. To include perspectives from those working in both hard to reach and non-hard to reach areas (as defined by the respective THDs) and those with a range of years work experience, respondents were purposefully selected as follows: Health Assistants, Lady Health Visitors or Midwives from Rural Health Centres (RHCs) with few or no hard to reach villages in their catchment areas and Health Assistants, Lady Health Volunteers or Midwives from RHCs with hard to reach villages in their catchment areas;

12 5922,000 financing agreement with the Ministry of Health to train 4,000 extra auxiliary midwives in 176 townships, 10 November 2014. See: http://3mdg.org/newsroom/maternal-newborn-and-child-health/item/525-922-000-financing-agreement-with-the-ministry-of-health-to-train-4-000-extra-auxiliary-midwives-in-176-townships#VmaXLbWlL_g
AMWs who have more than three years experiences and AMWs with one to three years. Total respondents were 11 from THD, 33 BHS, 55 AMWs and 23 SCI staff. Information was collected from October to November 2015 and data entry and analysis was undertaken in December 2015. Data were analysed using a grounded theory approach of identifying themes from the responses, then coding the responses according to those themes.

Findings

The AMW respondents commonly described the services they provide in communities as ANC, assisted delivery, PNC, health education and assistance to MW or other BHS. Growth monitoring, MUAC screening or treatment of children under five years were also mentioned, but not across a majority of AMW respondents. Observing improved health of mothers and children as well as perceiving family encouragement, social recognition, knowledge acquisition and career development were all described as motivations for being an AMW. Interestingly, most AMWs referred to their role as an enjoyable hobby.

Analysis from all types of respondents indicated that the areas of support perceived as most essential for AMWs to effectively deliver MNCH services in the community included the following: provision of supplies, regular refresher training, close relationships with BHS, regular supervision and incentives (e.g. cash compensation or performance based prizes). An understanding of the current status of key support areas explored (i.e. training, supervision, supplies and information systems) and options to improve these areas were identified through the thematic analysis of data. Detailed findings are presented below:

AMW Training
The availability of funding has allowed for basic and refresher training to be conducted regularly for AMWs, but training methods could be made more context appropriate and skill based.

**Current Experience**

- The standardised AMW manual published by the central MOH is used for training, but content and methodology of training varies at Township and RHC levels; practical sessions with patients are seen as highly valuable for learning.
- Traditional didactic methods of instruction are still primarily used, but the use of simulation models, case scenarios and practice with medical equipment has been introduced in some cases; insufficient numbers of training materials and equipment were noted at RHC level.
- Language barriers were noted as one challenge that THDs face in providing training in Chin and Kutkai.
- Full training at RHC level was noted as a challenge due to BHS routine service delivery workload.
- Post training follow-up does not happen routinely, but in a minority of cases informal follow-up is done by BHS (e.g. asking AMWs about any confusion, experiences, and difficulties or checking ability to take temperature/blood pressure).
- AMWs expressed knowledge and confidence in most areas of their training, but weaknesses were noted around newborn issues, particularly classifying low birth weight and danger signs for referral.

**Options for Improvement**

- Develop detailed training plans in advance of conducting AMW trainings to ensure training sessions go smoothly.
- Provide more opportunities for practice during basic and refresher training by selecting RHCs with sufficient patient case load and skilled health staff.
- Increase the availability of teaching aids, including simulation models and materials in appropriate languages for the local context.
- Integrate more training on community based newborn care, nutrition and drug/supplies management in basic training and refresher training.
- Conduct follow-up training evaluations of AMWs within their first year of service.

**Supervision for AMW**

Supervision from BHS and THD has been perceived to improve motivation and work performance of AMWs, but increasing systematic methods for monitoring performance and skills are desired.

**Current Experience**

- Majority of BHS and THD respondents have conducted AMW supervision, but do not have a specific supervision schedule and frequency varies from monthly to biannually.
- Supervision is described as being dependent on BHS availability and taking place during outreach visits or regular S/RHC meetings.
- Supervision includes discussion of the AMW’s work, provision of supplies, review of data collected and occasionally joint home visits.
- Methods of monitoring AMW performance include checking on AN examination and body weight measurement for mothers, feedback conversations with mothers and review of reports.
Options for improvement

- Use regular RHC meetings as an opportunity to build relationships between BHS and AMW, share updated health information and practice skills.
- Provide on the job training during supervision visits, especially for newly trained AMWs to be confident in their work.
- Provide more supportive supervision to AMWs working in hard to reach areas to ensure continuation of service delivery in these areas of high need.

Supplies for AMW

Regular provision of essential drugs and supplies to AMWs has been widely recognised as fundamental to continuous service delivery at the community level. Integration with the government supply chain system and increased guidance on drug usage would further improve this support in the long run.

Current Experience

- Supplies for AMWs are currently estimated based on vital health information (e.g. number of pregnant women and children under five years of age) and provided based on stock balance from AMW reports.
- Township Health Departments need resources and support to manage the supply chain (i.e. drug storage, transport and distribution) to AMWs at community level.
- Most BHS have limited experience on supporting AMWs to use drugs correctly; few review AMWs reports and stock balance as a part of supervision.

Options for Improvement

- Integrate supplies for community level services into the government supply chain system.
- Coordinate with Midwives to supply drugs and consumables to AMWs based on stock usage on a quarterly basis.
- Allocate resources for THDs to manage the supply chain, including storage, transportation, distribution and oversight of drug usage.
- Support repackaging of drugs according to treatment dosages and provide instruction leaflet on appropriate drug usage to AMWs; make drug information leaflets available in local languages.

Community Health information

Township Health Departments and BHS staff have found community health information collected by AMWs to be useful for planning and management. It would be beneficial to integrate this systematic collection of data from the community and AMW service provision into the government Health Management Information System (HMIS).

Current Experience

- Auxiliary Midwives collect lists of pregnant mothers, children under five years, births and deaths as well as numbers of ANC, deliveries, PNC and some morbidity data which they share with Midwives.
- Community health information is used in township planning and annual reviews conducted by THDs.
Support is provided to the THD and BHS in data collection, review and management of community health information by Save the Children staff.

**Options for Improvement**
- Develop official AMW data collection and reporting tools in line with the AMW service package.
- Integrate community health information and service provision data from AMWs into the government HMIS.
- Allocate focal point staff at the THD level to manage data entry and analysis for improved data usage.
- Provide resources to support THDs in data collection and management through development of computer skills as well as provision of necessary stationary and equipment (e.g. computer).

**Recommendations**

The following recommendations are offered to the Ministry of Health and key stakeholders engaged in supporting AMWs, based on feedback gathered from townships and Save the Children’s experience in providing support:

- AMW training could be further enhanced by updating and aligning it with a defined package of services delivered by AMWs. Facilitator’s guide, training aids, training plan templates and post training evaluation forms for both basic and refresher training would be helpful to complement the existing participant’s manual.
- Emphasis on participatory facilitation and skill-based training methodologies in Training of Trainer (TOT) sessions and other training support from national and state/regional training teams would be particularly beneficial to township level BHS.
- Regular supervision schedules, integrated into BHS micro-plans, would help BHS plan for and allow sufficient time to undertake supervision and support to AMWs.
- Standardised MOH supervision tools, such as checklists focused on essential skills, would facilitate BHS monitoring of AMW performance and help provide tailored support.
- Extend access of MOH supplies to AMWs to ensure they are equipped to deliver the package of services in which they are trained. This effort could be advanced by defining an essential drug and commodity list for AMWs, including AMW supplies in township drug orders, extending data collection on drug use to AMWs and defining mechanisms for distribution of items to volunteers.
- Standardised volunteer data collection tools in line with the AMW service package would facilitate monitoring the quality of their work and its impact at community level. These tools would have the potential to align with and contribute to HMIS.
- Routine management, review and analysis at THD level of data collected from volunteers would contribute to improved health planning and management.
Save the Children would like to thank all township stakeholders for sharing their views with us and the 3MDG Fund for the financial support that made this work possible. Save the Children is solely responsible for the analysis of findings and recommendations presented in this paper.