

Good on paper: the gap between program theory and real-world context in Pakistan's Community Midwife program

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INITIATIVE:
More skilled birth attendance =
Fewer maternal deaths



Sri Lanka:
SUCCESSFUL REDUCTION IN MMR



Indonesia:
MMR REDUCTION TARGETS NOT MET



Pakistan:
SUB-OPTIMAL PERFORMANCE



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Program Theory

Is the construction of a plausible and sensible model of how a program is supposed to work

(Rossi,
2007)


Pakistan's CMW Program

- Village women
- 18-months training
- Home clinics in private sector
- Domiciliary care
-10,000



A photograph showing two women and a baby in what appears to be a hospital or clinic. One woman, wearing a white headscarf and a red and white checkered shirt, is leaning over and touching the baby. The other woman, wearing a red and yellow patterned headscarf and a black floral patterned shirt, is looking directly at the camera. The baby is lying down, wrapped in a yellow and black patterned blanket. The background shows a simple room with a bed and some medical equipment.

X 8,000



1-3 %

OBJECTIVES

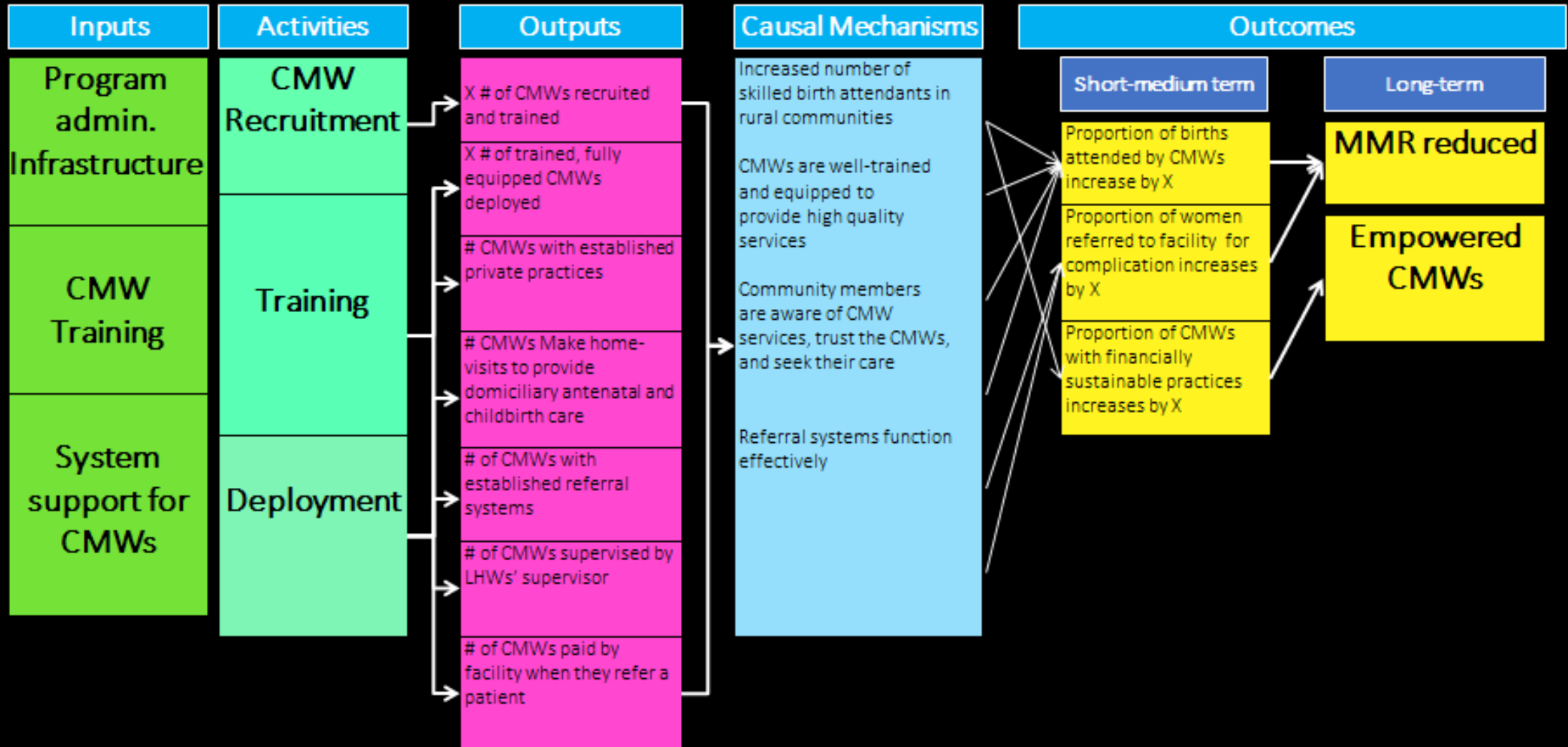
- 1) Demonstrate the need for greater attention to program theory
- 2) Highlight the importance of identifying and incorporating 'real world' contextual factors in development of program theory

Methods

Institutional ethnography

- National program level – 20 policymakers & 45 health care providers. Critical policy document review
- Community level – 36 CMW and 136 community members

Logic Model

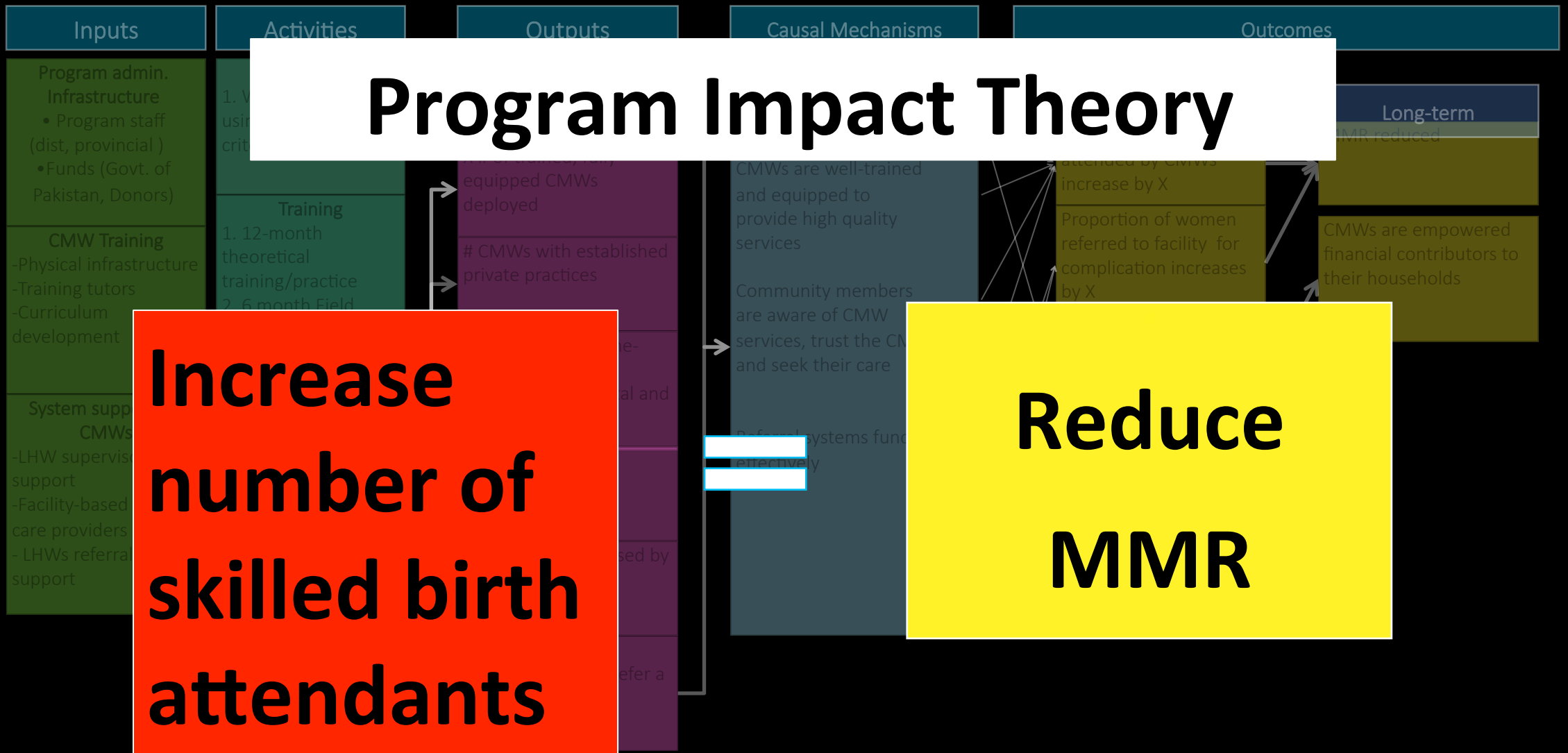


Program Impact Theory

**Increase
number of
skilled birth
attendants**

**Reduce
MMR**

=



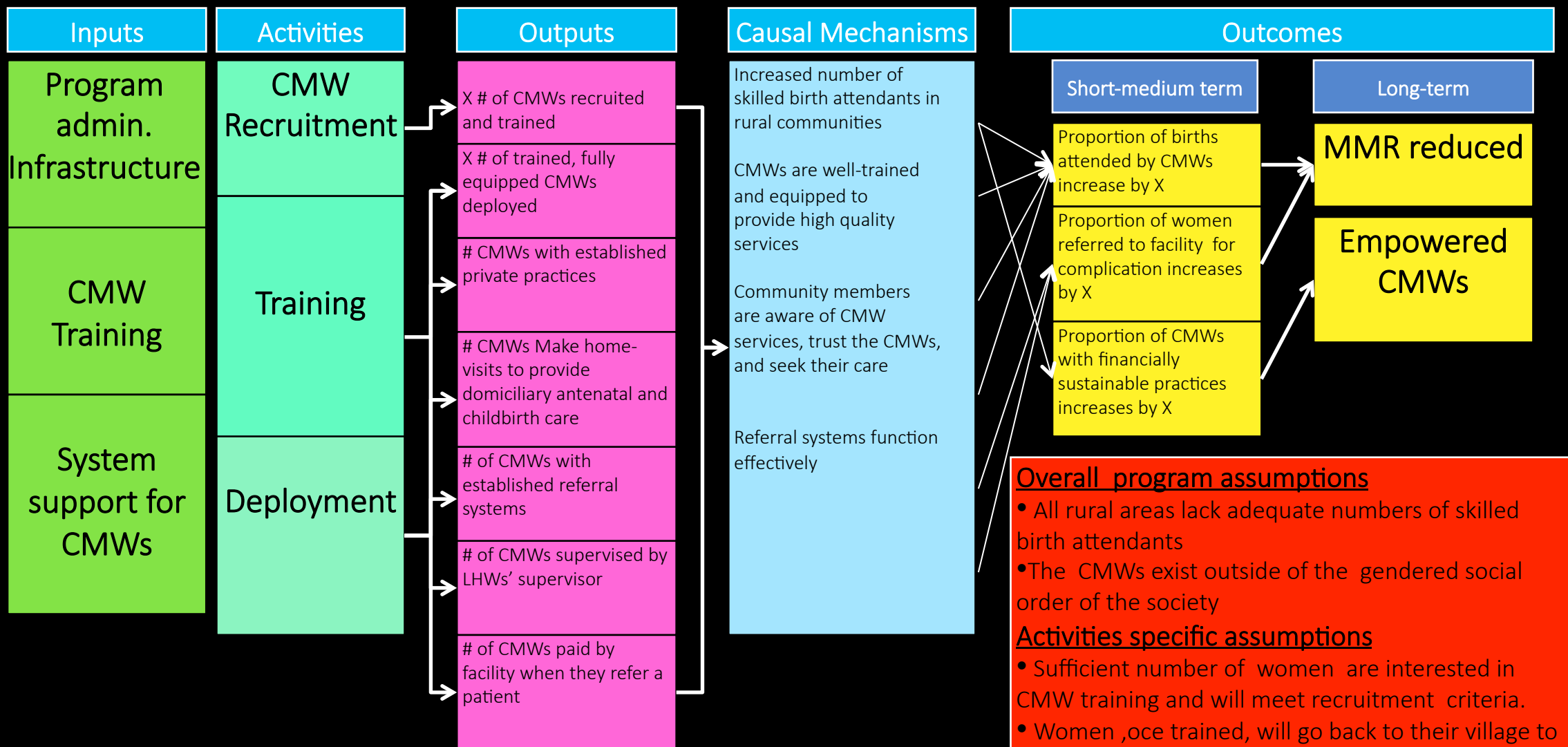
Program Process Theory

Recruited

Trained

Deployed

Private practices
↑
Services

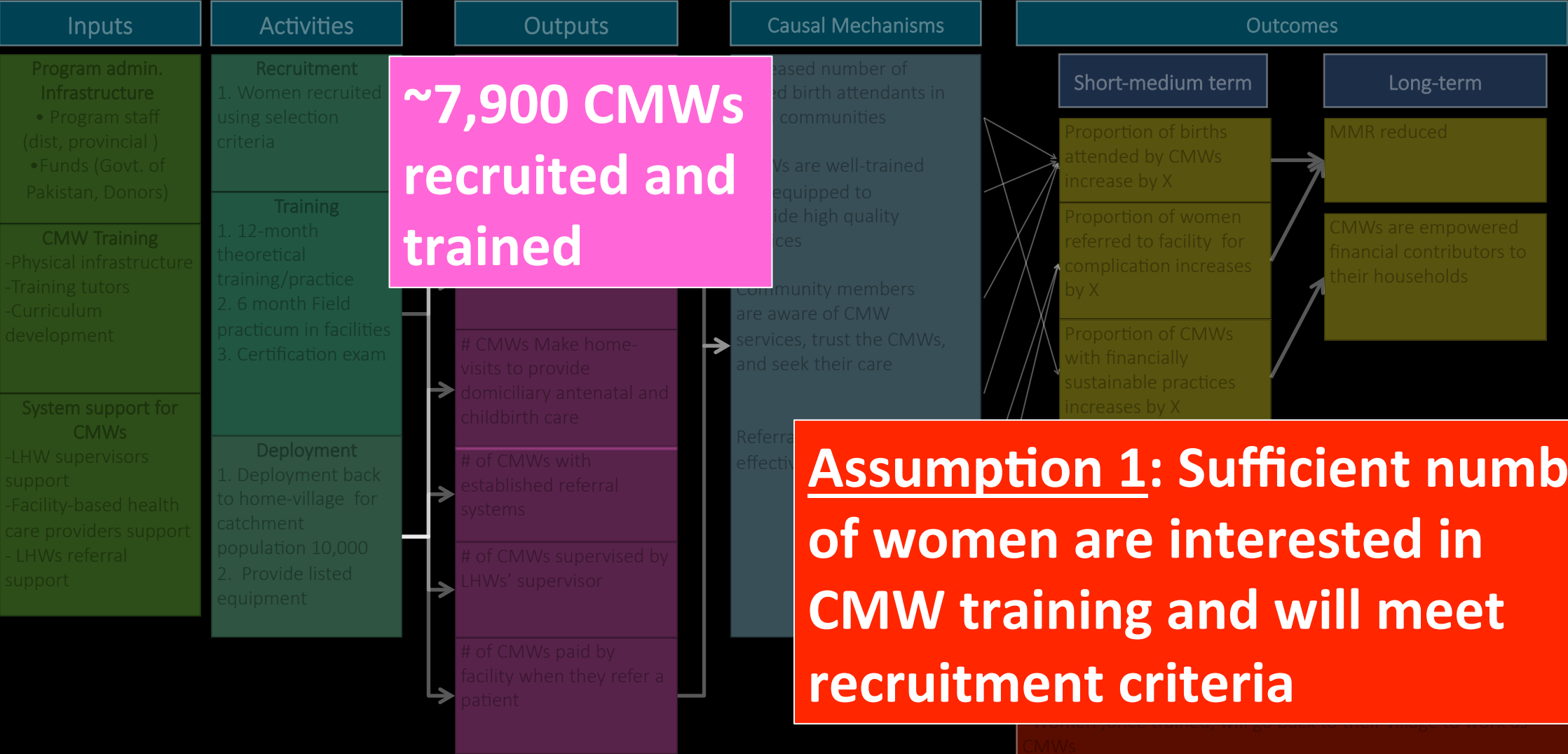


Overall program assumptions

- All rural areas lack adequate numbers of skilled birth attendants
- The CMWs exist outside of the gendered social order of the society

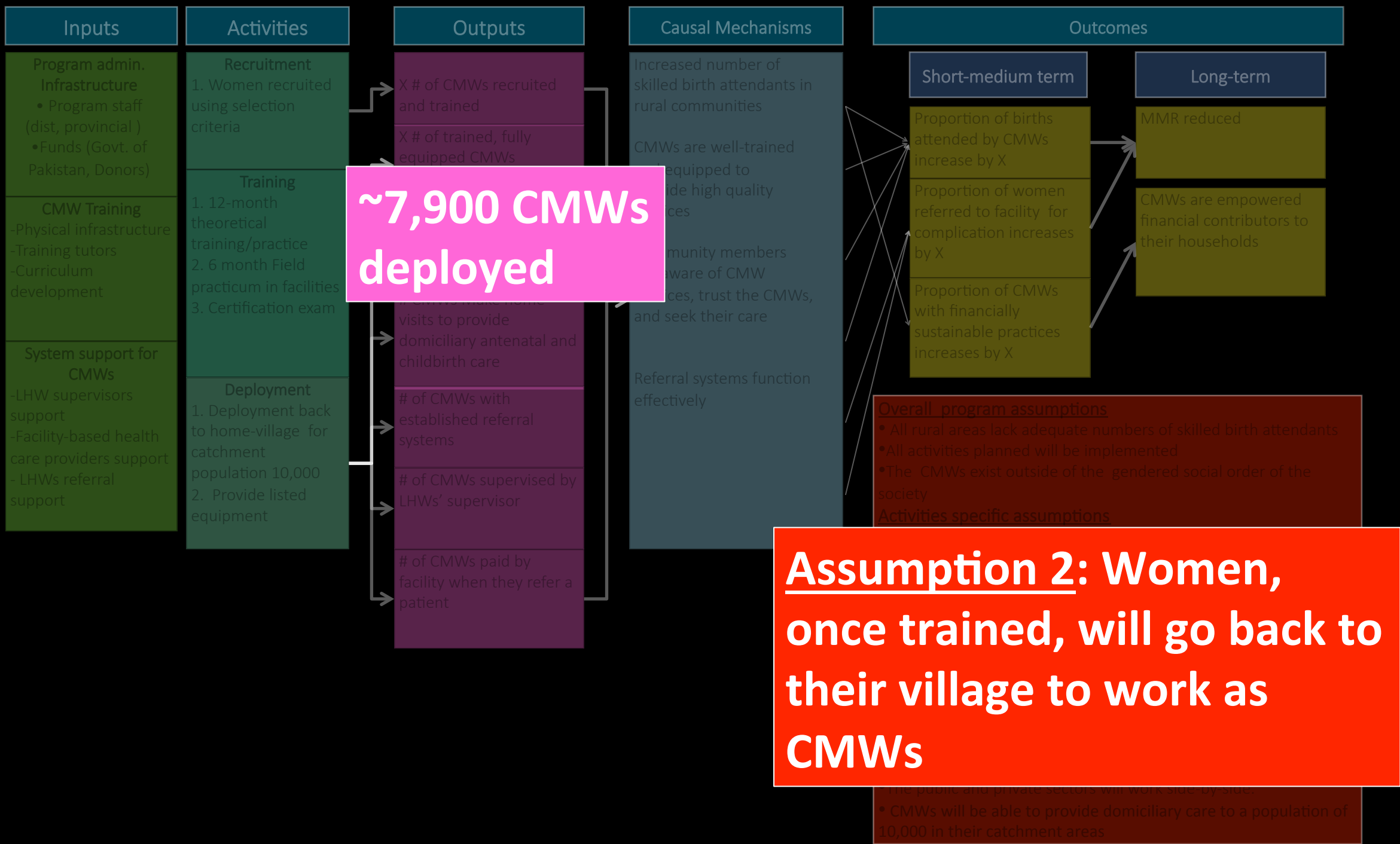
Activities specific assumptions

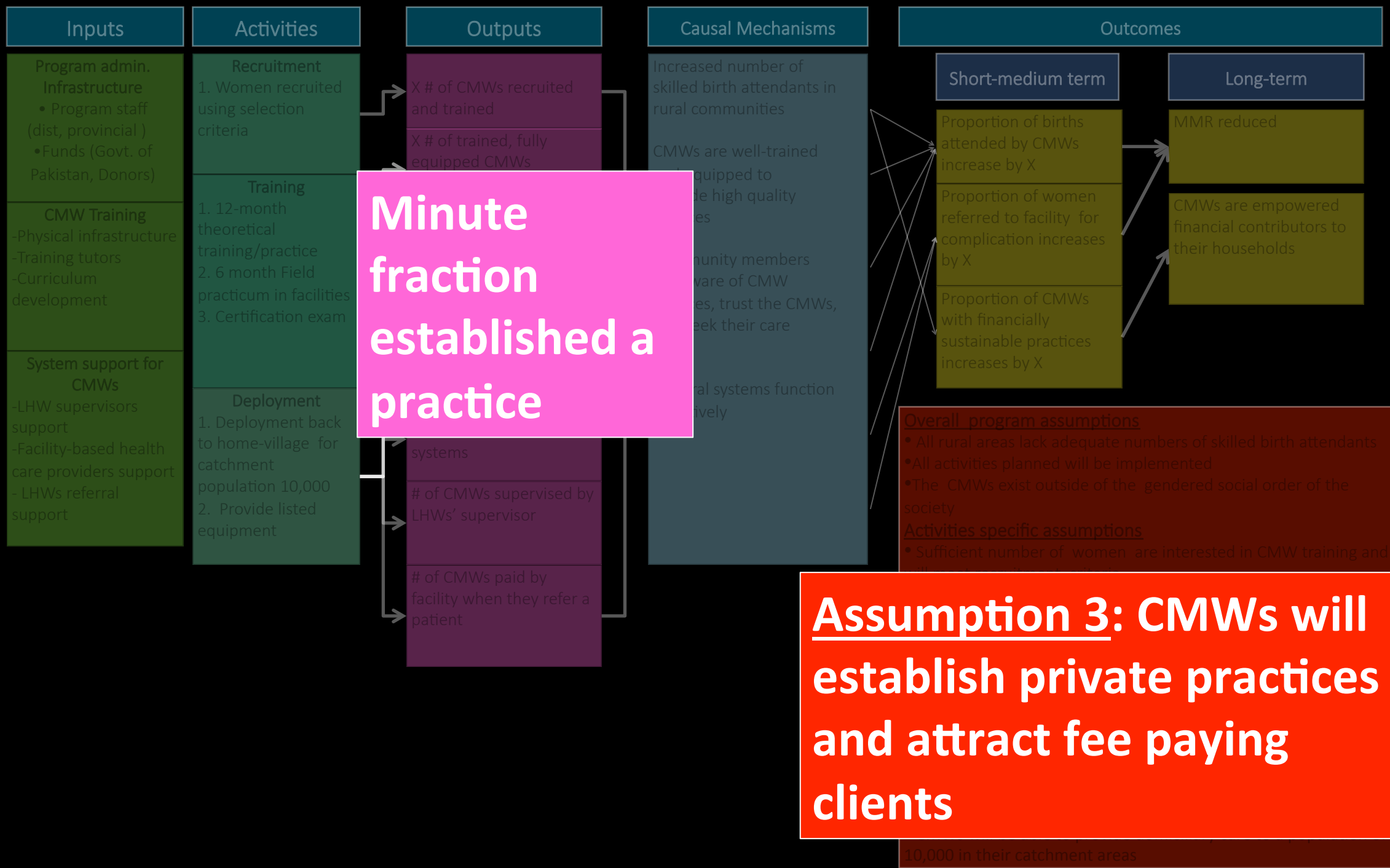
- Sufficient number of women are interested in CMW training and will meet recruitment criteria.
- Women, once trained, will go back to their village to work as CMWs
- CMWs will establish private practices and attract fee paying clients
- The community accepts CMW care and are willing to pay for it
- CMWs will be able to provide domiciliary care to a population of 10,000 in their catchment areas

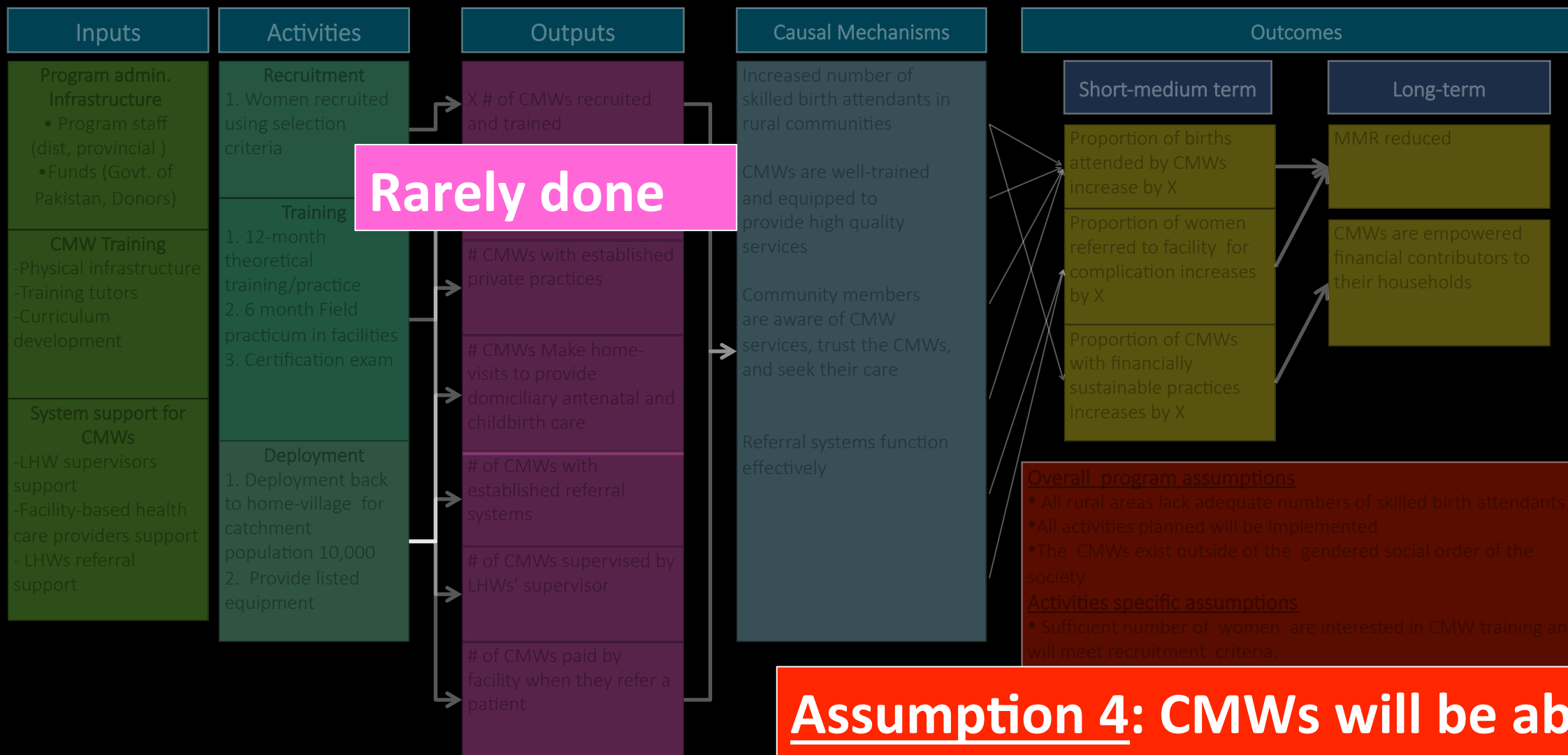


Women, once trained, will go back to their village to work as CMWs

- CMWs will establish private practices and attract fee paying clients
- The community accepts CMW care and are willing to pay for it
- Facilities/physicians are willing to act as referral centre for CMW referred patients.
- LHW supervisors will be willing / are able to supervise CMWs
- The public and private sectors will work side-by-side.
- CMWs will be able to provide domiciliary care to a population of 10,000 in their catchment areas





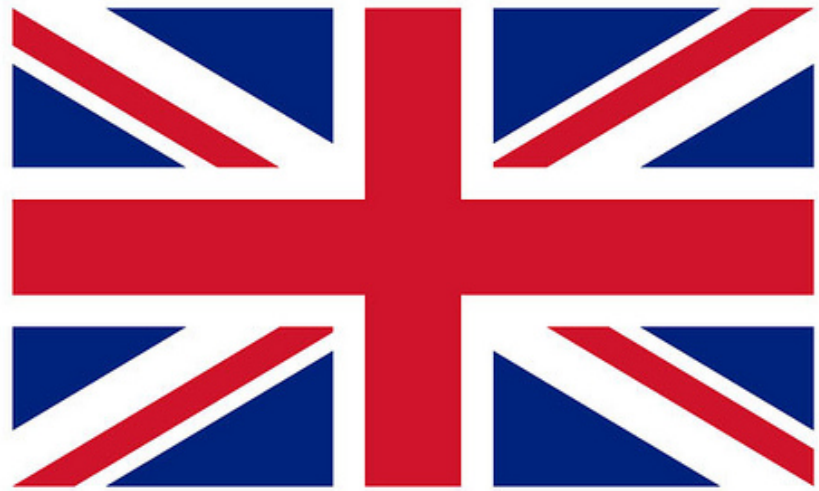


Assumption 4: CMWs will be able to provide domiciliary care to a population of 10,000 in their catchment area



So, what now?

Acknowledgements



UKaid

from the British people



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