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Midwifery retention and coverage and impact on service utilisation in Afghanistan

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ABSTRACT

Objective: to measure the rate of and determine factors associated with community midwifery education (CME) graduate retention in public sector health care in Afghanistan.
Design: cross-sectional.
Setting: performed in public health facilities of 11 Afghan provinces purposively selected by geographic location and security conditions, between October 2011 and April 2012. Facilities were selected by one of two criteria: either a registered deployment site for a CME graduate or randomly selected through population-proportionate sampling.
Participants: facility managers and midwives employed in public facilities at the time of data collection.
Measurements: three quantitative instruments were used: a facility checklist assessed staffing and service volume, and two separate questionnaires for midwives and facility managers, which measured employment duration and perceived barriers to midwife retention.
Findings: at 456 surveyed facilities, 570 midwives were interviewed. Overall, 61.3% (n=209/341) of CME graduates deployed in surveyed provinces were working in public sector facilities, whereas 36.8% were working at their assigned site. Facilities without midwife staff had lower average monthly volumes of antenatal care visits (14.6 (SD ± 22.7) versus 71.5 (SD ± 72.5)), family planning visits (10.4 (SD± 13.9) versus 56.8 (SD± 85.0)), or facility-based deliveries (0.55 (SD ± 2.2) versus 15.7 (SD ± 18.7)). Perceived reasons for leaving employment were insecurity (civil unrest/armed conflict) (46.4%), family disagreement (28.1%), increased workload without compensation (9.9%), and lack of appropriate housing (7.8%).
Key conclusions: CME graduate retention in public sector positions was relatively low and significantly impacted by insecurity and cultural issues related to women working outside the home.
Implications for practice: culturally appropriate measures are needed to attract and retain skilled female health care providers for rural public facilities in Afghanistan and similar settings. Advocacy to encourage family and community support for midwives working in rural facilities and providing amenities such as housing, education for children, and employment for the accompanying male family member are measures most likely to improve midwife retention.

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Introduction

Staffing health facilities with sufficient skilled healthcare providers has been a challenge globally, particularly in insecure (conflict-affected) settings (Simetka et al., 2002; Betsi et al., 2006). Retaining skilled staff in rural facilities poses another challenge for sustainable access to quality health care services (WHO, 2006; Buykx et al., 2010; Sullivan et al., 2011). These challenges apply to midwives and likely contribute to limited access to quality maternal health services, with resultant high levels of maternal and neonatal mortality in settings impacted by these conditions. Armed conflict is not necessarily a barrier to improving health outcomes, evinced by movement toward the Millennium Development Goals (MDGs) in Nepal and Colombia (Nieto et al., 2009; Devkota and van Teijlingen, 2010).

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These issues are writ large in Afghanistan, one of six countries contributing more than half of global maternal mortality cases in 2008 and where continued insecurity requires innovative efforts to work towards MDGs 4 and 5 (Hill et al., 2010; Hogan et al., 2010). One reason for these high rates is the extreme shortage of skilled female health care providers, the only providers culturally permitted to provide reproductive care to women, particularly at delivery (Bartlett et al., 2005; Mayhew et al., 2008). In 2003, only 467 midwives were working in the public sector nationally (TIGA/MSH, 2002). These statistics were the impetus for a government and multidonor collaborative effort to establish, support, and technically strengthen two midwifery educational programmes to rapidly train and deploy competent midwives (Currie et al., 2007; Smith et al., 2008). In response, the Community Midwifery Education (CME) programme was developed in 2003 and currently operates to select students from rural communities, where 75% of the Afghan population resides (Central Statistics Office (CSO), 1978). This programme utilises elements of the workforce planning approach, specifically community mobilisation and pre-planned deployment (Smith et al., 2008). Following training, graduates are employed in lower-level public sector facilities (e.g. sub-centres, basic health centres), which are primary care settings, in underserved rural areas for a five-year commitment. A second midwifery programme at the Institutes of Health Sciences (IHS) focuses on training midwives for district and provincial-level hospital facilities predominantly located in urban areas; IHS enrolment is based on national examination scores and a lottery system and does not have a formal deployment system for graduates. Both programmes are 24 months duration, use the same curriculum, and graduates are expected to achieve the same competencies. In Afghanistan, graduates from both programmes are expected to have achieved competency in manual vacuum aspiration (MVA), manual placental removal, and vacuum-assisted delivery. From 2002 to November 2011, 3269 midwives graduated from schools within both programme tracks.

Evaluations have been conducted to assess pre-service midwifery education quality through measuring competence and stating the deployment rate of graduates reported by both programmes (Bartlett et al., 2011; Mansoor et al., 2011). Generally, evaluations were positive; a 2009 pre-service education quality assessment among midwives in eight provinces reported deployment rates of 82% for IHS and 89% for CME graduates (Bartlett et al., 2011). In Hirat province, among 170 women selected for midwifery school by community-led nomination, by the National University Entrance Examination, or by the IHS process, post-graduate employment rates were higher among community recruited midwives (96%, $n=48$) than among those selected by the National University Entrance Examination (82%) or by regional Institute of Health Sciences examination (74%), respectively (Mansoor et al., 2011). However, there are less current data concerning the retention of graduates following deployment specifically for public sector facilities or by third-party evaluation for the CME graduates and the level of midwife staffing present within public sector facilities. The purpose of this evaluation is to measure the retention rates of CME graduates specifically and the presence of midwives in public sector facilities generally and determine factors associated with leaving or continuing employment by midwives in the Afghan public sector. The results of this assessment are intended to guide CME and IHS programmes during a period of critical re-structuring as the Ministries of Higher Education and of Public Health assume greater oversight of programme implementation.

Methods

Setting and participants

This cross-sectional assessment was performed between October 2011 and April 2012 utilising qualitative and quantitative methods. Eleven provinces (Farah, Faryab, Ghazni, Hirat, Jawzjan, Khost, Laghman, Paktia, Samangan, Saripul, and Takhar) were purposively selected to effect geographic, security status, and donor diversity (Fig. 1). With regard to security status, civil insecurity was determined through levels of attacks by anti-government forces and other armed conflict or known anti-government group activity impeding regular service delivery. Provinces deemed insecure were in agreement with designations made in September 2011 by the Afghan Non-government Organisation Safety Office (www.afgnso.org).

Only public sector facilities were included in this evaluation. The public health sector in Afghanistan is divided into two sections: the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). BPHS facilities provide primary care and preventive services and serve smaller catchment areas; facilities in this group include health posts, sub-centres, mobile health teams, basic health centres, community health centres (CHCs), and district hospitals (Ministry of Public Health (MoPH), Islamic Republic of Afghanistan, 2010). The EPHS system includes provincial hospitals, serving large catchment populations. Labour and delivery services for uncomplicated cases are provided at all facility levels except health posts and mobile teams; only select CHCs, district hospitals, and EPHS facilities have operative capacity (MoPH, 2010). Each level of public sector facility is intended to have capacity to provide ante/postnatal care services, well-child care, and family planning (MoPH, 2010). The public health sector is funded through the Ministry of Public Health (MoPH), with a substantial proportion coming from directed donations by international partners. Most public sector facility-based deliveries occurred in hospitals or CHCs. However, a separate 2010 survey noted that 54% of rural households rely upon the private sector for obstetric care, largely from physicians (Belay et al., 2010). This figure may underestimate services provided by midwives in the private sector as many practice from their homes rather than through facilities. Midwives in this sector largely provide uncomplicated obstetric care and some combine these duties with public or private sector facility employment to have a facility for referral of new-onset complications.

Participants were facility managers and midwives currently working in public sector facilities in the directly evaluated provinces. Facility managers were interviewed regarding perspectives on current staffing levels, the need for midwife providers, and current service volumes. All providers in midwife positions as designated by the Human Resources Department (HRD) of the MoPH, including CME and IHS graduates, midwives educated outside Afghanistan, and community health workers (CHWs) who received additional training, were interviewed. All providers working as midwives were included for two reasons: first, to provide a detailed perspective on current availability of reproductive health care in the public sector and, second, to provide a comparator group for the CME graduates with regard to longevity of employment, job satisfaction, and service type and volume provided.

Prior to study activity initiation, review and determination that this activity constituted a public health evaluation other than research was obtained from the institutional review board of the MoPH of the Islamic Republic of Afghanistan.

Sampling and data collection

In selected provinces, all facilities listed as original deployment or most recent employment sites for CME graduates per CME implementer report were included in the sample. Of remaining public sector facilities in that province, 50% were randomly selected using population-proportional sampling based on facility delivery volume from September 2010 to 2011. National and provincial-level official approvals were obtained prior to visiting the

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