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Factors influencing the retention of midwives in the public sector in Afghanistan: A qualitative assessment of midwives in eight provinces

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ABSTRACT

Objective: to examine factors that affect retention of public sector midwives throughout their career in Afghanistan.
Design: qualitative assessment using semi-structured in-depth interviews (IDIs) and focus group discussions (FGDs).
Setting: health clinics in eight provinces in Afghanistan, midwifery education schools in three provinces, and stakeholder organisations in Kabul.
Participants: purposively sampled midwifery profession stakeholders in Kabul ($n=14$ IDIs); purposively selected community midwifery students in Kabul ($n=3$ FGDs), Parwan ($n=1$ FGD) and Wardak ($n=1$ FGD) provinces (six participants per FGD); public sector midwives, health facility managers, and community health workers from randomly selected clinics in eight provinces ($n=48$ IDIs); midwives who had left the public sector midwifery service ($n=5$ IDIs).
Measurements and findings: several factors affect a midwife throughout her career in the public sector, including her selection as a trainee, the training itself, deployment to her pre-assigned post, and working in clinics. Overall, appropriate selection is the key to ensuring deployment and retention later on in a midwife's career. Other factors that affect retention of midwives include civil security concerns in rural areas, support of family and community, salary levels, professional development opportunities and workplace support, and inefficient human resources planning in the public sector.
Key conclusions: Factors affecting midwife retention are linked to problems within the community midwifery education (CME) programme and those reflecting the wider Afghan context. Civil insecurity and traditional attitudes towards women were major factors identified that negatively affect midwifery retention.
Implications for practice: Factors such as civil insecurity and traditional attitudes towards women require a multisectoral response and innovative strategies to reduce their impact. However, factors inherent to midwife career development also impact retention and may be more readily modified.

Introduction

Maternal and child mortality reduction and reproductive health care improvement globally have received more attention in the last 25 years, with increasing funding and effort surrounding health improvements outlined in the fourth and fifth Millennium Development Goals. Though annual maternal deaths have decreased from 526,300 in 1980 to 342,900 in 2008, six countries contribute more than 50% of maternal deaths (Hogan et al., 2010). Within the safe motherhood movement, an effective midwifery profession is one key approach to improving maternal and child health indicators (Bullough et al., 2005; Currie et al., 2007; Freedman et al., 2007). Several countries have invested heavily in developing or improving the midwifery workforce, with positive results reported for skilled birth attendance and caesarean section rate in Indonesia and reduction in maternal and child

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mortality in Thailand, Malaysia, and Sri Lanka (ten Hoope-Bender et al., 2006; Achadi et al., 2007).

Afghanistan ranks among the six countries disproportionately contributing to global maternal mortality cases (Hogan et al., 2010). Improvements in health care have been complicated by the low socio-economic and educational status of much of the population, with women disproportionately affected. Afghanistan is a low-income country with a gross domestic product/purchasing power parity of US$1100 per capita, ranking 216th of 229 countries, and an estimated unemployment rate of 35% (Central Intelligence Agency (CIA), 2013). On the basis of the 2011 estimates, the national adult literacy rate is 39% overall but only 15% for women (UNICEF, 2011). As a reflection of women's status in Afghan society, girls attend school for an average of seven years compared to 11 years for boys (CIA, 2013). Health care is available through both public and private sector providers, with a higher concentration of services for both sectors in urban areas.

There has been substantial improvement in many health indicators in the last decade in Afghanistan, attributed to improved coverage and quality of care by the public sector (APHI/MoPH/CSO/ICF-Macro/IIHMR/WHO-EMRO, 2011; Edward et al., 2011). Public sector services are provided through the Basic Package of Health Services (BPHS), which comprise sub-centres through community health centres and district hospitals for preventive and primary care, and the Essential Package of Hospital Services (EPHS), which provide provincial and regional referral and specialist services (MoPH, 2010). In 2008, the public sector health service population coverage rate was estimated to be 85% (MoPH, 2010). However, in 2011, 84% of family health expenditures were estimated to go to private sector providers (World Bank, 2013). Regarding maternity services, a 2010 national survey estimated that skilled providers attended 34% of all births, of which midwives provided 20% of the care (APHI/MoPH/CSO/ICF-Macro/IIHMR/WHO-EMRO, 2011). The same survey estimated that 27% of all deliveries were facility-based, of which 5% occurred in private facilities.

In the last decade, the Afghan midwifery profession has undergone significant restructuring and development following two decades of civil conflict (Smith et al., 2008). From 2002, the Afghan government and international community have focused on several areas for midwife professional development: strengthening pre-service education and implementing a standardised curriculum, developing a professional midwifery association and national accreditation board, and implementing policies giving midwives a central role in maternal and newborn care (Currie et al., 2007; Smith et al., 2008). This effort has had tangible results; the number of midwives has increased from less than 500 in 2002 to 3269 midwife graduates in 2011 through two separate midwifery education tracks (Herberg, 2005; Bartlett et al., 2011). The Institute of Health Sciences (IHS) trains midwives for district and provincial level hospital facilities, whereas the Community Midwifery Education (CME) programme trains locally nominated women to practice in BPHS facilities in rural communities, where need for skilled care is greatest. CME graduates are deployed to work in facilities in their community for five years, providing the same services as IHS-graduate midwives. Both IHS and CME programmes utilise the same curriculum and graduates of both programmes should be competent to perform manual vacuum aspiration (MVA), manual placental removal, and vacuum-assisted delivery. The CME curriculum has recently added facility management and pharmacology coursework in response to task expansion in small clinics where the CME midwife is the most senior or only provider and must function as a de facto clinical manager.

CME programme implementers work to create a culturally appropriate environment for students, often providing childcare or arranging jobs for *mahram* (in many communities, a male relative, *a mahram*, must accompany women outside the home) during pre-service training. This training is resource intensive and low graduate deployment and employment rates have been reported in some situations, potentially due to factors such as civil insecurity resulting from attacks by armed anti-government groups, and better amenities in urban centres (ANSO, 2011; Mansoor et al., 2011). Assessments of midwifery graduate skill and job satisfaction have been performed (Bartlett et al., 2011), but there are few data regarding public sector workforce retention. The purpose of this manuscript is to describe factors influencing whether CME graduates continue employment in pre-assigned public sector health facilities within a larger evaluation of midwifery retention. The findings from this evaluation will be utilised to improve midwifery policy and programming in Afghanistan.

Methods

Setting

The overall evaluation consisted of a quantitative component directly measuring retention rates in 11 of the 34 provinces in Afghanistan, and a qualitative component examining factors associated with continuing or leaving employment in public sector facilities in eight of these provinces (Farah, Faryab, Ghazni, Hirat, Khost, Laghman, Paktia, and Samangan). The qualitative component reported here investigated factors potentially affecting a midwife throughout the career cycle. Prior to initiation of study activities, the institutional review board of the Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan reviewed this protocol and determined it was a public health evaluation exempt from ongoing review.

Methods and participants

Qualitative retention data were obtained in two phases; please see Table 1 for a summary of interview type and participant characteristics and Fig. 1 for a concept map of the study. For all data collection events, a verbal informed consent process was performed in a private room with only the potential participant and trained staff member present, wherein the reason for the evaluation, requirements for participation, and risks and benefits of participating were discussed. Potential participants then were asked if they were willing to participate and those agreeing were interviewed or scheduled for a focus group discussion (FGD). To protect participant confidentiality, no names were recorded in the audio transcripts and IDIs were conducted in a private room with only the participant and a trained staff member. FGDs were also conducted in private rooms with only the session moderator and recorder present in addition to participants. All interviews with facility managers, midwives, midwifery students, and community health workers (CHWs) were performed by staff of the same sex, in keeping with cultural norms. FGD participants were encouraged to select a pseudonym for their session. All interviews and focus groups were digitally recorded, transcribed verbatim, and translated into English with verification in Kabul. All digital recordings were erased after transfer to a password-protected computer and the audio file was erased following completion and verification of the transcript translation. All interviews were conducted in Dari, English, or Pashto, at the interviewee's discretion.

Phase 1

In Phase 1, key informant IDIs were conducted with 14 midwifery stakeholders in Kabul to assess barriers to selection, programme implementation, and deployment (Fig. 1). Interview guides were developed and pre-tested with collaborators for content validity. Participants, identified based on job positions