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'Midwives are the backbone of our health system': Lessons from Afghanistan to guide expansion of midwifery in challenging settings ☆

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ABSTRACT

Background: over the last decade Afghanistan has made large investments in scaling up the number of midwives to address access to skilled care and the high burden of maternal and newborn mortality.
Objective: at the request of the Ministry of Public Health (MOPH) an evaluation was undertaken to improve the pre-service midwifery education programme through identification of its strengths and weaknesses. The qualitative component of the evaluation specifically examined: (1) programme strengths; (2) programme weaknesses; (3) perceptions of the programme's community impact; (4) barriers to provision of care and challenges to impact; (5) perceptions of the recently graduated midwife's field experience, and (6) recommendations for programme improvement.
Design: the evaluation used a mixed methods approach that included qualitative and quantitative components. This paper focuses on the qualitative components which included in-depth interviews with 138 graduated midwives and 20 key informants as well as 24 focus group discussions with women.
Setting: eight provinces in Afghanistan with functioning and accredited midwifery schools between June 2008 and November 2010.
Participants: midwives graduated from one of the two national midwifery programmes: Institute of Health Sciences and Community Midwifery Education. Key informants comprised of stakeholders and female residents of the midwives catchment areas.
Findings: midwives described overall satisfaction with the quality of their education. Midwives and stakeholders perceived that women were more likely to use maternal and child health services in communities where midwives had been deployed. Strengths included evidence-based content, standardised materials, clinical training, and supportive learning environment. Self-reported aspects of the quality education in respect to midwives empowerment included feeling competent and confident as demonstrated by respect shown by co-workers. Weaknesses of the programme included perceived low educational requirement to enter the programme and readiness of programmes to commence education. Insecurity and geographical remoteness are perceived as challenges with clients' access to care and the ability of midwives to make home visits.
Key conclusions: the depth of midwives' contribution in Afghanistan – from increased maternal health care service utilisation to changing community's perceptions of women's education and professional independence – is overwhelmingly positive. Lessons learned can serve as a model to other low resource, post-conflict settings that are striving to increase the workforce of skilled providers.

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Introduction

Afghanistan, one of the poorest countries in the world, has some of the most alarming health indicators, particularly for women and children. When Afghanistan emerged from Taliban rule at the end of 2001, the health system was essentially destroyed. In 2002, Afghanistan's national maternal mortality ratio was estimated between 1600 and 2200 maternal deaths per 100,000 live births (Bartlett et al., 2005). Other reproductive health indicators were also concerning; only 4.6% of Afghan women received antenatal care and 6% delivered with a skilled provider. The contraceptive prevalence rate was 2% and the total fertility rate was 6.3 (CSO, 2003).

The education of girls was forbidden during the Taliban regime, resulting in the deterioration of the female skilled health care workforce. In a country where sociocultural practices restrict women from receiving health services from male providers, these circumstances severely hampered women's access to health services. The Human Resources Department reported in 2003 that there was a severe shortage of female skilled birth attendants (SBA) in general and only 467 midwives in the country (MOPH, 2003a).

International aid agencies responded to the health crises, and in partnership with the Government of the Islamic Republic of Afghanistan, significant efforts have been made throughout the last decade to improve maternal and child health. In 2003, the Ministry of Public Health (MOPH) contracted with non-governmental organisations (NGOs) to implement its Basic Package of Health Services (BPHS), which provides community health-oriented primary care. The BPHS, in conjunction with the Essential Package of Hospital Services, remains the cornerstone of health service delivery in Afghanistan.

In response to the appalling health indicators for women and children and to ensure women's access to timely skilled care, particularly in rural/remote areas, the MOPH (2003b) with support from major donors (USAID, World Bank and European Commission) supported two pre-service education programmes to train and graduate midwives: (1) strengthening the existing Institutes of Health Sciences (IHS), a two year programme to provide midwives for provincial, regional, and national/specialty hospitals; and (2) establishing Community Midwifery Education (CME), an 18 month programme for community-based facilities. Both the IHS midwifery programme and the CME programme have the same content and the graduates of each programme have an identical set of essential competencies for midwifery services; the major difference is the planned deployment to the health facility of employment. Both are recognised by the MOPH.

Following a successful pilot (2002–2004), the CME programme was endorsed by the MOPH in 2003 and consequently, the number of programmes proliferated at a rapid pace. A national standardised curriculum binds the programmes, and the quality of education is regulated by a National Midwifery and Nursing Education Accreditation Board (NMNEAB).

Methods and approaches

The evaluation of the pre-service midwifery education programme in Afghanistan, the first of its kind in the country, was conducted with midwifery schools in eight provinces from 2008 to 2010. Qualitative findings were drawn from in-depth interviews with 138 graduated midwives and 20 key informants, as well as 24 focus group discussions with women.[1]

For the first stage of the sampling plan, eight accredited schools were purposively selected from the 24 schools that were operating in the country within the evaluation period. Geographical location (included areas in north, south east and west), school type, donor support and security were considered; the sampled schools were deemed to be broadly representative of midwifery schools in Afghanistan in regards to ethnicity, language and culture.

Interview guides consisted of 28 questions exploring how to improve both the midwifery education programme and the deployment experience of recently graduated midwives. The tools were piloted in a simulated environment. Inter-assessor and intra-assessor reliability checks were performed (83% and 98% respectively) to ensure homogeneity of the assessors' cohort. The interviews were recorded and transcribed verbatim in Dari[2] and translated into English. Their accuracy was checked by researchers fluent in both languages. The 26 interviewers were selected from the Afghan Midwifery Association (AMA) and midwifery faculty from schools which were not part of this assessment. Interviewers were trained in qualitative interviewing techniques, the interview tool, and research ethics including confidentiality. Given the AMA membership is over 2000, many midwives are members and it would not have been feasible to engage midwives who were qualified as interviewers/assessors who were not part of the AMA, particularly in regards to criteria such as ability to travel. The study team did not perceive involvement of the AMA as assessors to be a conflict of interest, as the AMA has no financial involvement in CME programmes.

The second stage of the sampling plan identified all (~1800) working (trained) midwives and selected a random sample of 20 midwives from each school (in schools with fewer than 20 midwives, all were interviewed). Individual interviews were carried out with a total of 138 midwives to capture their perceptions on the quality of their training, the impact of their deployment in the community, barriers to providing optimal reproductive health care, and their recommendations to improve the pre-service education programmes and deployment experience.

Key informants (KI) were interviewed to obtain their perspectives on the strengths and weaknesses of the programme and their recommendations for improvement. In total we planned to interview 28 individuals, representing different institutions from the eight target provinces. 19 individuals willingly participated and included: directors of midwifery schools, health service managers, provincial and national health directors and representatives from the AMA and NMNEAB. There were nine non-respondents.

Focus Group Discussions (FGDs) were held with women in the catchment areas of 14 health facilities (a subset of the original 138 midwives studied). Two focus groups were conducted: one with 'the midwives patients' and the other with women who were not her patients. In insecure provinces it was not possible to conduct FGDs as planned and a total of 24 FGDs in seven provinces occurred.

An inductive qualitative approach was used to analyse the transcripts and produce a conceptual framework of categories and themes, 'close to the data, words and events' (Sandelowski, 2000). Following the identification of main and subthemes, we provided interpretation of the themes by including information from field notes to elaborate each theme. We intended to present descriptions of views expressed by study participants and direct quotes from midwifery graduates, key informants and the women are shared.

Ethical approval for human subjects' research was obtained from Johns Hopkins University and MOPH ethical review committees. Written or verbal consent was obtained from study respondents based on their education/literacy level.

Findings

All midwives were female per cultural preference. Of the midwives identified, 92% worked in service provision (for varying

[1] The quantitative results have been submitted separately for publication.

[2] Dari is one of three official languages in Afghanistan.