

Knowledge Brief

Health, Nutrition and Population Global Practice

COMMUNITY MIDWIFERY EDUCATION PROGRAM IN AFGHANISTAN

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KEY MESSAGES:

- In 2002, maternal mortality ratio was the second highest in the world.
- In 2003, most Afghan women delivered at home, and fewer than 10 percent of births were attended by a skilled provider.
- One barrier to expansion of services was the lack of qualified female health workers, which is critical in a society where women seek care only from female providers.
- In 2003, the Community Midwifery Education Program was created.
- The program's success is attributed to strong engagement of different stakeholders; equity; and strengthened human resources for health.
- Between 2003 and 2013, the number of midwives increased from 467 to 2,245 midwives.
- Stakeholders believe that midwives have greatly helped to reduce maternal mortality, which fell from 1,600 in 2002 to 327 in 2010.

Introduction

Afghanistan's health services in the immediate post conflict period were in a deplorable and chaotic state. In 2002, its maternal mortality ratio was the second highest in the world, reflecting a lack of access and utilization of reproductive health services and skilled care during pregnancy, childbirth, and the first month after delivery. These services are key to saving women at risk of dying due to pregnancy and childbirth complications.

In a society where women seek care only from female providers, one barrier to expansion of services was the lack of qualified female health workers to deploy to remote health facilities to make up for the shortfall of female staff. Some 77 percent of the population was living in rural areas, where women are usually excluded from access to skilled and emergency health care. In 2003 for example, most Afghan women delivered at home, and fewer than 10 percent of births were attended by a skilled provider.

Very few midwives trained in Kabul or other big cities were willing to work in rural areas where the needs were much higher. Moreover, there were no education facilities and too few female school graduates who could be trained in the provinces. Given the dire situation, the shortage of midwives had to be remedied urgently. The Community Midwifery Education (CME) Program was created.

The CME Program

The program aimed not only to train more midwives, but also to ensure both their initial deployment in remote health facilities as well as good retention rates. These aims were realized through the creation of a new health cadre known as “community midwives.” The program itself consists of closely interlinked stages (Box 1).

Three Marks of Success

The program’s success is attributed to strong engagement of different stakeholders, equity, and strengthened human resources for health.

First, the need for this program was communicated across a wide spectrum of stakeholders — from those engaged in policy to those involved in implementation, from donors to communities.

Second, for equity, it encouraged community involvement in all stages. It emphasized equality by providing resources to remote rural communities and respecting

people’s rights to use resources equally in rural and remote areas. It also focused on women by providing opportunities for women in rural areas to receive an education and earn a living, and by offering basic health services to women who had no access.

Third, human resources increased rapidly. In 2003 there were only 467 midwives in the country (Bartlett et al. 2011); by April 2013 (according to the NMEAB), 2,245 students had graduated as community midwives.

Their training and deployment helped improve access to and use of reproductive health services. For instance, in provinces with midwifery schools that had graduated students by June 2006, ANC rates increased faster than in provinces without midwifery schools or which had not graduated students by June 2006. Similarly, provinces that graduated midwives before June 2006 reported a larger increase in the use of skilled birth attendants (SBAs) than in provinces without midwives (Figure 1).

BOX 1: FIVES STAGES OF THE CME PROGRAM

Recruitment: Candidates for the program are recruited from provinces and rural areas, according to the country’s human resources workforce planning needs. Ideally they should have a “commitment letter” from their family and community indicating that they are going to work in an identified health facility with a midwife shortage. Students are selected jointly by the local Ministry of Public Health (MoPH) authority, the implementing agency, and the community.

Admission: This is based on national admission policy and criteria. All candidates should meet the admissions criteria, including age and years of schooling and they must pass the entrance exam.

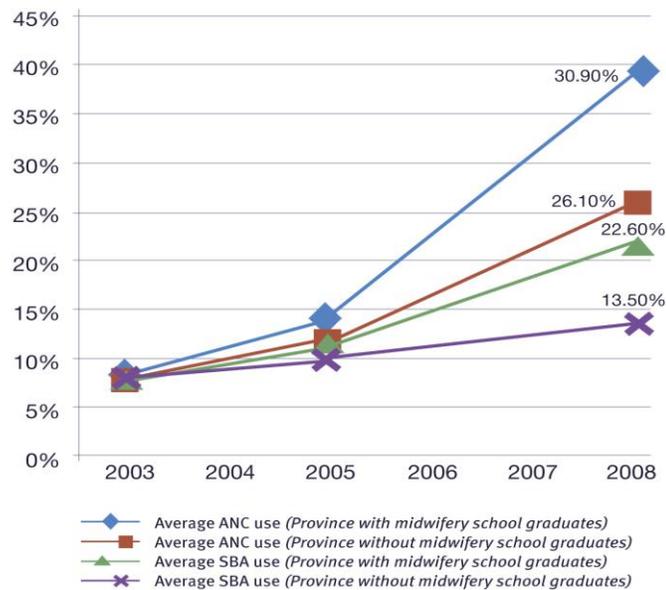
Training and Curriculum: Originally, the program standardized curriculum of 2003 required 18 months’ training, but with the experience of running the program for a few years, the stakeholders lengthened the training to two years. Training is divided into three phases. A series of learning modules in phases 1 through 3 contain theoretical content and clinical skills considered necessary to prepare midwives to provide comprehensive maternal, newborn, and infant care.

Phase 1 covers management of normal pregnancy, labor, postnatal, and newborn care. Phase 2 builds the student’s skills in management of complications of pregnancy and childbirth. Phase 3 addresses other reproductive health topics, with a focus on family planning as well as the management of service provision and professional issues.

Accreditation: Administered by the National Midwifery Education Accreditation Board (NMEAB), accreditation has played a large role in improving the quality of midwifery graduates and the quality of care provided by midwives in general.

Deployment and Retention: Admission guidelines aim to ensure that students are recruited from areas where they can be deployed, supported, and supervised after completing the program. Although there are no national data on retention of community midwives in the public sector or their deployment, based on an assessment of 11 provinces the overall retention rates of CME-graduate midwives in the public sector is 61.3 percent, with 36.8 percent working at their original deployment sites.

FIGURE 1: AVERAGE ANC AND SKILLED BIRTH ATTENDANCE USE BY TIME AND TREATMENT GROUP, 2003–08



Source: Jhpiego/Health Services Support Project, Kabul.

Community midwives undoubtedly played a key role in expanding and improving access to health services. ANC utilization, for example, appears to have more than tripled during the period 2003 to 2010. The increased access to services was especially marked in rural Afghanistan (Afghanistan, APHI/MoPH 2010).

Challenges

A frequent difficulty has been selecting students for CME, jeopardizing later stages, including training, deployment, and retention. Various problems include influence peddling by local authorities, including by force, as well as the lack of eligible students in some targeted communities. Accreditation of the CME schools is sometimes an issue, especially in provinces where security is a problem, as is the limited number of National Midwifery Education Accreditation Board (NMEAB) assessors. The deployment and retention of midwives working at their original deployment sites is too low at less than two out of five. Finally, the lack of a national tracking system for CME graduated midwives should be rectified.

Stakeholders' Perspectives

Stakeholders consider Afghanistan's progress in access and utilization of health care and reproductive health services as one of the greatest health achievements of the last decade. Notably, midwives have helped to fill the shortage of professional human resources in health, especially for midwives and female health workers in rural and remote areas. Stakeholders also believe that midwives have greatly helped to reduce maternal mortality, which fell from 1,600 in 2002 to 327 in 2010. They also acknowledge that deployed midwives address the communities' needs for health services.

The communities themselves believe that people now have easy access to services, and more women are visiting and using the health facilities. The role of community midwives as change agents is well recognized among health sector stakeholders, including the communities. Midwives facilitate behavior change at the family and community levels. Health-seeking behavior has picked up, and more people (especially women) are visiting health facilities. People's knowledge of health services, particularly reproductive health, has improved, as have their attitudes and practices. Finally, graduated midwives themselves have also seen huge changes in their own personal and social lives, and most are satisfied with their earnings and social status in their communities as health service providers.

Some of these views are given in stakeholders' own words in Box 2.





BOX 2: IN THEIR OWN WORDS ...

“A lot of women come to the health facility because a midwife is hired in our health facility” — **a health worker in a Basic Package of Health Services (BPHS) health facility, December 2012.**

“Now about 80 percent of patients are visiting our midwife, few go to the doctor, because most of the patients are female” — **a health worker, December 2012.**

“After deployment of our midwife, people’s thinking has changed, all mothers are visiting the clinic and the midwife is at their service day and night, during official and unofficial times” — **male representative of a health committee, December 2012.**

“After I started to work in this health facility, the data for antenatal care, deliveries, and postnatal care improved; night duty became regular and registration improved” — **a community midwife in a BPHS facility, December 2012.**



Sustainability and Scaling Up

The CME Program — through selecting women from local communities, providing training, and deploying them back to their communities — sustains impact. Trained midwives are community resources who can have long-lasting and sustainable impact through their services to the community. The MoPH considers the program a successful intervention and believes that there is great potential to replicate this model to train other health professionals and reduce the shortage of other human resources for health. The MoPH has already started the Community Health Nursing Education (CHNE) based on the successful experiences and lessons learned from the CME Program.

References

1. Afghanistan, APHI/MoPH (Afghan Public Health Institute, Ministry of Public Health). 2010. Afghanistan Mortality Survey. Kabul.
2. Bartlett, L., A. LeFevre, H. Gibson, J. Rahmanzai, K. Viswanathan, K. Yari, L. Steinhardt, M. Azimy, N. Ansari, N. Assefi, P. Manalai, P. Azfar, R. Callaghan, and S. Turkmani. 2011. Evaluation of the Pre-Service Midwifery Education Program in Afghanistan. Kabul: Jhpiego/ Health Services Support Project.

This HNP Knowledge Brief highlights the key findings from the HNP Discussion paper “Community Midwifery Education Program in Afghanistan” written by Khalil Ahmad Mohmand, published in August 2013.



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