



THE STATE OF AFGHANISTAN'S MIDWIFERY 2021



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Acronyms

ACNM	American College of Nurse-Midwives
AfDHS	Afghanistan Demographic and Health Survey
AKHS	Aga Khan Health Services
AMA	Afghan Midwives Association
ANMC	Afghan Nurses and Midwives Council
AMNEAB	Afghan Midwifery and Nursing Education Accreditation Board
ANC	Antenatal Care
ANMs	Auxiliary Nurse Midwives
BEmONC	Basic Emergency Obstetric and Newborn Care
BPHS	Basic Package of Health Services
CME	Community Midwifery Education
COVID-19	Coronavirus Disease 2019
CYP	Couple Years of Protection
DHIS-2	District Health Information System 2
DRE	Dedicated RMNCAH Equivalent
EPHS	Essential Package of Hospital Services
FIGO	International Federation of Gynecology and Obstetrics
FMIC	French Medical Institute for Mothers and Children
GIHS	Ghazanfar Institute for Health Sciences
IHS	Institute of Health Science
ICM	International Confederation of Midwives
ICN	International Council of Nurses
IMC	International Medical Corps
IMEIs	Intermediate Medical Education Institutes
IMR	Infant Mortality Rate
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KMU	Kabul Medical University
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health

MSF	Midwifery Services Framework
MSH	Management Science for Health
NHWA	National Health Workforce Accounts
NMR	Neonatal Mortality Rate
PNC	Postnatal Care
PPE	Personal Protective Equipment
SBA	Skilled Birth Attendance
SCA	Swedish Committee for Afghanistan
SDGs	Sustainable Development Goals
SoWMy 2021	State of World's Midwifery 2021
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YML	Young Midwife Leaders



Acknowledgment

Under the overall strategic leadership of AMA, the State of Afghanistan's Midwifery 2021 was developed through a participatory and collaborative process that involved the Ministry of Public Health, and national and international stakeholders.

This report will serve as a reliable reference for AMA, the MoPH, ANMC, partners, donors, and policy makers in planning to address challenges in the midwifery profession in Afghanistan and to improve midwifery and maternal health issues in the country.

To all midwives providing services to the people in need across the country, my sincere gratitude and appreciation to you.

My vote of thanks goes to those who contributed to this report, as mentioned below:

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Chapter 1: Executive Summary

Aligning with the global movement and recognizing the potential for a country-specific report, the Afghan Midwives Association (AMA), with the technical and financial support of the Afghanistan Nurses and Midwives Council (ANMC) and the United Nations Population Fund (UNFPA), took the lead in gathering data for the global report and subsequently for Afghanistan's State of Midwifery (SoWMy) 2021. The country report will serve as a reliable evidence-based source for the donor community, partners, and policymakers to further improve the midwifery program from different perspectives.

Midwives provide many essential clinical Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) interventions and can play a broader role in activities such as advancing primary health care and universal health coverage (UHC), responding to violence against women, and addressing sexual and reproductive rights.

Studies show that a substantial increase in coverage of midwife-delivered interventions (i.e., 25 per cent increase every five years up to 2035) could avert 40 per cent of maternal and newborn deaths and 26 per cent of stillbirths. Universal coverage of midwife-delivered interventions would avert 65 per cent of maternal and neonatal deaths and stillbirths. Midwife-led care that includes continuity of care produces additional benefits.

Based on the Afghanistan's country profile reflected in SoWMy 2021, currently, there are 5,098 Dedicated RMNCAH Equivalent (DRE) midwives, who allocate 100 per cent of their time to RMNCAH. Based on projections, the need for midwifery professionals and midwifery associate professionals would be around 24,000 by 2030. At the time of reporting, there are 34,825 graduated midwives consisting of: 8,078 from Community Midwifery Education (4,359 or 49 per cent) and IHS (3,719 or 46 per cent) who are assumed to be competent midwives based on midwifery accreditation criteria. The remaining 26,747 (77 per cent) graduated from the private sector. Given these numbers, Afghanistan has already met its threshold for 2030. However, the competency and quality of skills of those who graduated from the private sector has yet to be determined. Job opportunities should be created for the around 18,000 midwives from both the public and private sectors once their competency and safety has been assured by ANMC.

Currently, there are 173 midwifery education institutions across the country, with private institutions dramatically increasing during the last 10 years. The aforementioned institutes were not included in the accreditation process of the Afghan Midwifery and Nursing Education Accreditation Board (AMNEAB). Based on the midwifery pre-service education rapid assessment conducted by JHPIEGO in 2018, only 31 per cent of private midwifery education institutes met the criteria for clinical sites requiring students to perform minimum 40 births assisted before graduation, while it was 100 per cent and 67 per cent for CME and IHS, respectively.

COVID-19 has impacted the midwifery service, primarily reducing the workforce availability. Access to RMNCAH services had to be prioritized and provided in a safe environment in the midst of the pandemic. RMNCAH workers need to be protected from infection; supported to cope with stress and trauma; and to have creative and innovative solutions to the challenges of providing high-quality services. The COVID-19 pandemic affected service delivery in Afghanistan. According to Afghanistan DHIS-2, there was a decrease in the main maternity services provided by midwives during the pandemic.

Period	1 st ANC coverage	% of SBA deliveries	1 st PNC coverage	% CYP provided by HFs
2019	131%	74%	93%	13%
2020	123%	72%	89%	11%

The ANMC is an autonomous regulatory body established in December 2020 to ensure standards of the highest quality for midwifery and nursing care in Afghanistan.

In terms of professional development, midwifery in Afghanistan has progressed along a route similar to many other countries. Today, AMA is known as a civil society organization, which advocates for women's health and rights, not only in Afghanistan but regionally and internationally. AMA is collaborating with the Afghanistan government and other partners to contribute towards the improvement of maternal, newborn and child health (MNCH). The AMA has expanded to over 3,500 members across the country, and one of its unique features is its presence across Afghanistan through its 34 provincial branches.

In summary, midwifery in Afghanistan needs to improve in four areas:

1. Health workforce planning, management, and regulation

- Compile health workforce data set disaggregated by occupation and location.
- MoPH to advise AMA to develop midwife deployment plan that leverages the wide scope of RMNCAH services midwives can provide.
- Ensure collaboration between education providers and health workforce planners at the relevant levels of the health systems to secure alignment between the number and capacity of midwifery graduates for employment with due consideration for the actual needs with more focus on rural areas.
- Develop and implement strategies to recruit and retain midwives in locations where they are most needed. Focus on family health houses and midwife-led centers.
- Train 18,000 new midwives before 2030 to meet the demand for skilled service providers. Job opportunities in both public and private sectors should be created to absorb these.
- Re-evaluate the certificate exam. The licensing exam should be institutionalized by ANMC.
- Expand mentorship program and develop a strategy for the recruitment of backup midwives.
- Regulate midwifery faculty development program to ensure qualified pool of trainers and preceptors.

2. Quality education and training of midwives

- ANMC and Ministry of Higher Education (MoHE) to monitor and assess the implementation of the midwifery curriculum in all midwifery programs.
- Create career paths that encourage and facilitate midwives to become educators and trainers of the next generation of midwives, especially in the private midwifery education institutes.
- Strengthen accreditation mechanisms for both public and private sector education and training providers.
- All midwives should pass the competency-based licensing exam to graduate
- Continuous professional development should be provided for maintaining midwifery competency.

3. Midwife-led improvements to RMNCAH service delivery

- Communicate evidence about the benefits of midwives as key RMNCAH service providers.
- Promote continuous relationship between midwives and service users to build trust, confidence, and mutual respect.
- Treat midwives as equal and respected partners at all levels, including service delivery, management, and leadership of health, particularly in the involvement in policy development.
- Prepare and enable midwives to participate in audit and data collection processes, including Maternal and Neonatal Death Surveillance and Response.
- Apply the lessons learned from CCOVID-19 to build resilience to better mitigate future health vulnerabilities, so they do not negatively impact RMNCAH worker education, service delivery, and the work environment.
- Midwifery-led centre model of care should be integrated into the health system.

4. Midwives association, leadership, and governance

- Raise midwives awareness on the benefits of AMA membership including development of an online registration system.
- Strengthen the provincial branches of AMA for provincial ownership and decentralization concerning management of midwifery issues.
- Create positions at national and subnational levels, including senior midwives within the Ministry of Public Health, so that midwives are represented in all places where RMNCAH decisions are made.
- Engage midwives in relevant policy decisions, programme planning, implementation, monitoring and evaluation at subnational and national levels.

Chapter 2: Introduction

The State of the World's Midwifery 2021 (SoWMy 2021)¹ provides an updated, evidence-based and detailed analysis of the present progress and challenges to deliver adequate coverage and quality of midwives and midwifery services. The report was launched virtually on 5 May 2021, the International Day of the Midwife. It has been disseminated to the Ministry of Public Health (MoPH) officials and invited guests as part of the World Health Assembly 2021 activities that included the conclusion of the International Year of the Nurse, the Year of the Midwife and the 10th anniversary of the first SoWMy report. The country profiles of the report are available separately,² as well as various supplementary materials. One describes health workforce challenges and provides examples of initiatives to improve access for women, newborns and adolescents in humanitarian and fragile settings applicable in Afghanistan.

The development of the SoWMy series led by UNFPA has involved collaboration with more than 30 international agencies and organizations, including the United Nations Children's Fund (UNICEF), World Health Organization (WHO), International Confederation of Midwives (ICM) and International Federation of Gynecology and Obstetrics (FIGO). Two previous global SoWMy reports were published in 2011 and 2014. Additionally, there have been three regional SoWMy reports and two individual country reports. Dissemination and advocacy workshops for global and regional reports have taken place in the Asia Pacific, Arab States, and East and Southern Africa regions.

Aligning with the global movement and recognizing the protentional for a country-specific report, the Afghan Midwives Association, with technical and financial support of UNFPA and the Afghanistan Nurses, Midwives Council, took the lead in gathering data for the global report and, subsequently, for the Afghanistan SoWMy 2021. Data for the Afghanistan report were collected from different sources such as the MoPH, Ministry of Higher Education and midwifery education institutes and schools, both public and private. In December 2020, in partnership with the RMNCAH Directorate of the MoPH, a one day data visualization workshop was conducted in order to clarify and finalize the data for the Afghanistan SoWMy 2021. The Afghanistan report will serve as a reliable evidence-based source for the donor community, partners and policy makers to further improve the midwifery program from different perspectives.

Objectives:

- To show progress made since the Afghanistan SoWMy 2011 and SoWMy 2014 within the midwifery workforce, midwifery services coverage; and quality, education, regulation and status of midwives;
- To further improve measurability of success through data collection, enabling stronger policy dialogue within countries to strengthen RMNCAH services; and
- To provide recommendations and plan for the next steps.

¹ <https://www.unfpa.org/sowmy>
² [sowmy-2021-profile-af.pdf \(unfpa.org\)](#)

Chapter 3: Midwives: A vital investment

Midwives provide a wide range of essential clinical RMNCAH interventions and play a broader role in service delivery such as advancing primary health care and universal health coverage (UHC), responding to violence against women, and addressing sexual and reproductive health and rights.³ They can be a point-of-contact in the community for sexual and reproductive health services, including contraception, comprehensive post-abortion care, and screening for and treatment of sexually transmitted infections. Midwives play a vital role in preventing and managing pregnancy-related complications such as resuscitating newborns, promoting breastfeeding, and supporting the mother and the family in infant care.

In addition to their clinical roles, midwives also work in education institutions, management, policy, research, regulation, midwives' associations and government. It is important to support and value midwives working in these areas, which are fundamentally important for the development of the profession. Strengthening midwifery at a country level requires multilevel investments, including in those who educate and support midwives in clinical practice and ensure the delivery of high-quality care.

3.1 Impact of midwives

Analysis conducted as part of SoWMy 2021 showed that midwives substantially contributed in reducing maternal, neonatal mortality and stillbirths in low- and middle-income countries. Eighty-eight countries that account for the vast majority of the world's maternal and neonatal deaths and stillbirths, have shown that a substantial increase in coverage of midwife-delivered interventions (25 per cent increase every five years to 2035) could avert 40 per cent of maternal and newborn deaths and 26 per cent of stillbirths.⁴ Even a modest increase (10 per cent every five years) in coverage of midwife-delivered interventions could avert 23 per cent of maternal and neonatal deaths and 14 per cent of stillbirths. Universal coverage of midwife-delivered interventions would avert 65 per cent of maternal and neonatal deaths and stillbirths. Midwife-led care that includes continuity of care produces additional benefits.

Key messages

Midwives, when educated, licensed, and fully integrated in and supported by interdisciplinary teams, and in an enabling environment, can provide a wide range of clinical interventions and contribute to broader health goals, such as advancing primary health care, addressing sexual and reproductive rights, promoting self-care interventions and empowering women.

Midwives play a vital role in preventing maternal and newborn deaths and stillbirths: increasing access to competent and regulated midwives could save millions of lives each year.

The wide range of contributions that midwives can make to RMNCAH and broader health goals make them an obvious focus for investment.

Evidence indicates that investing in midwives facilitates positive birth experiences, improves health outcomes, augments workforce supply, favors inclusive and equitable growth, facilitates economic stabilization, and can have a positive macroeconomic impact.

3 Kanem N. Midwives – defenders of women's rights. Bangkok: United Nations Population Fund; 2019 (<https://asiapacific.unfpa.org/en/news/midwives%E2%80%94defenderswomens-rights#:~:text=Midwives%20are%20public%20health%20heroes,the%20most%20basic%20human%20rights>, accessed 6 February 2021).

4 Nove A, Friberg IK, de Bernis L, McConville F, Moran AC, Najjemba M, et al. Potential impact of midwives in preventing and reducing maternal and neonatal mortality and stillbirths: a Lives Saved Tool modelling study. *Lancet Glob Health*. 2021;9(1):e24–e32. doi: 10.1016/S2214-109X(20)30397-1.

A systematic review showed that organizational reforms in maternity services that promote midwife-led continuity of care reduce Caesarean-section rates.⁵ Previous research through The Lancet Series on Midwifery showed more than 50 short-, medium- and long-term outcomes that could be improved by care within a midwife's scope of practice. These include: reduced maternal and neonatal mortality and morbidity, fewer stillbirths and preterm births, fewer unnecessary interventions, and improved psychosocial and public health outcomes such as reduced anxiety and increased uptake of contraception and immunization.⁶

Midwives substantially reduce maternal and neonatal mortality and stillbirths in low-to-middle-income countries (LMICs). However, to fulfill this potential, midwives need to have skills and competencies in line with recommendations from the International Confederation of Midwives (ICM). This includes being part of a team with sufficient size and skill, and to work in an enabling environment. If increased coverage of midwife-delivered interventions can be achieved, health systems will be better equipped to provide effective coverage of essential sexual, reproductive, maternal, newborn, and adolescent health interventions.⁷

Some low- and middle-income countries already on the path to achieving targeted reductions in their maternal mortality ratio (MMR) have significantly increased midwives' role as key attendants for normal births over the last two decades.⁸ Despite resource constraints, 28 low- and lower-middle-income countries reduced their MMR by more than 50 per cent between 2000 and 2017.⁹

In 2002, Afghanistan's maternal mortality ratio (the proportion of women who die of causes related to pregnancy or childbirth) stood at 1,600 per 100,000 live births, the second-highest in the world at the time.¹⁰ Based on estimation by UNFPA, WHO, UNICEF, World Bank Group, and UN Population Division in 2019, the maternal mortality ratio is 638 per 100,000 live births, which shows a 60 per cent decline from the level of 2002. The neonatal mortality rate (NMR) decreased from 80 in 2002 to 23 per 1,000 live birth in 2018.¹¹ The Ministry of Public Health of Afghanistan set targets for Sustainable Development Goals (SDGs) to reduce the MMR to 140 per 100,000 live births and NMR to 15/1,000 by 2030.

3.2 Multiple returns from investing in midwives

A strong health system is essential for achieving UHC and ensuring progress towards the SDGs. While the health workforce is a core element of the health system, it often turns out to be its weakest link as it is usually perceived as driving costs rather than producing positive health and social outcomes. However, there is growing recognition that creating jobs for health workers not only bolsters population health but also supports sustainable economic growth and progress towards other SDGs. Discussion of the economic and broader social benefits of investments in health has, in recent years, focused on the concept of "the investment case," arguing in favor of investment. The key term "investment" reflects the fact that the benefits of an adequate health workforce outweigh the costs of their education, training, and employment.¹²

5 Chapman A, Nagle C, Bick D, Lindberg R, Kent B, Calache J, et al. Maternity service organisational interventions that aim to reduce caesarean section: a systematic review and meta-analysis. *BMC Pregnancy Childbirth*. 2019;19(1):206. doi: 10.1186/s12884-019-2351-2

6 Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet*. 2014;384(9948):1129–45. doi: 10.1016/S0140-6736(14)60789-3.

7 Nove A et al 2020 Potential impact MW preventing reducing maternal and newborn mortality

8 Van Lerberghe W, Matthews Z, Achadi E, Ancona C, Campbell J, Channon A, et al. Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality. *Lancet*. 2014;384(9949):1215–25. doi: 10.1016/S0140-6736(14)60919-3.

9 The State of World Midwifery 2021

10 Linda A Bartlett, Shairose Mawji, Sara Whitehead, Chadd Crouse, Suraya Dalil, Denisa Ionete, Peter Salama, 'Where Giving Birth is a Forecast of Death: Maternal Mortality in Four Districts of Afghanistan, 1999–2002', *The Lancet* 365 (2005), doi: 10.1016/S0140-6736(05)71044-8.

11 Afghanistan Health Survey 2018

12 The State of World Midwifery 2021

3.3 Investment in Midwives in Afghanistan

3.3.1 Expand Access

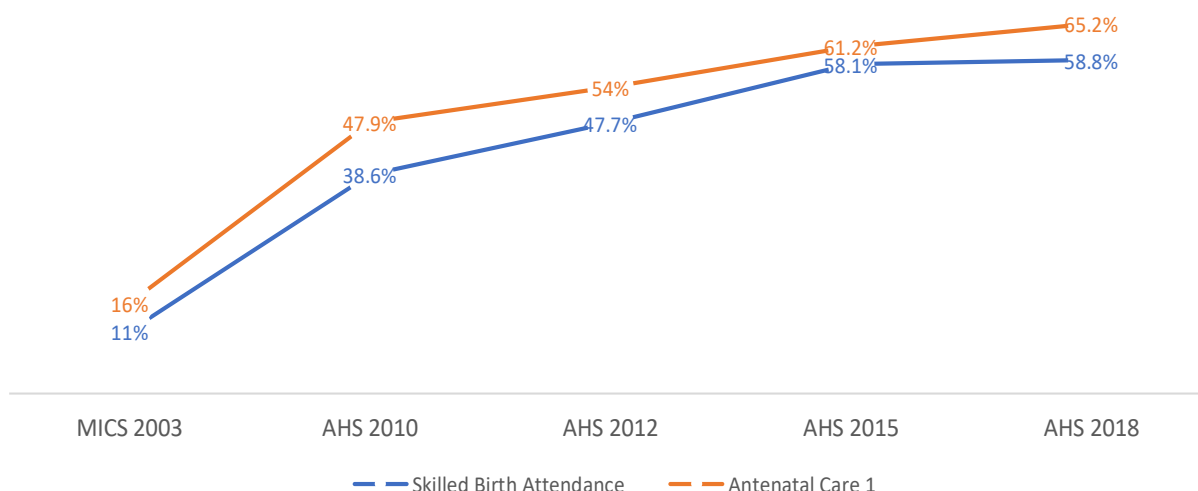
Afghanistan has been internationally recognized for the significant health gains made over the past 15 years. The rebuilding of the health system has significantly improved maternal, newborn, and child health outcomes, with the rebuilding of the health system. Many of these gains have been the result of the focus on primary care as manifested in the Basic Package of Health Services (BPHS), composed of evidence-based essential maternal and child health interventions. This has been supported by the Essential Package of Hospital Services (EPHS). Gains in RMNCAH have included:¹³

- Increased access to health services,¹⁴ including maternal and child health services:
 - 60 per cent of the population live within one hour's travelling time to a health facility, and 88 per cent are within two hours' travelling time.
 - All secondary and tertiary health facilities have midwives, and 90 per cent of primary care facilities have midwives.
 - Health posts with a male and a female community health worker (CHW) have been established in more than 15,000 communities of 1,000–1,500 people. They provide family planning services community case management of childhood illnesses, and selected MNH activities. In 6,500 of these communities, the health promotion activities of the community health workers are supported by an FHAG.
 - There are Family Health Houses run by a community midwife in 246 remote communities in 14 provinces.
- Increased use of key health care services:
 - Antenatal care
 - Births attended by a skilled healthcare provider, mostly in health facilities
 - Use of modern birth spacing/family planning methods
- Declines in maternal, neonatal, post-natal, and child mortality.

Nearly 3,000 public health facilities offer RMNCAH services, with at least one midwife at each facility. According to the Afghanistan Health Survey 2018, there is a remarkable improvement in maternal health indicators from 2003. As shown in Figure 1, skilled birth attendance (SBA), and antenatal care coverage (ANC1) have both increased markedly over the past 15 years. Nationally, SBA rose from 11 per cent in 2003 to 58.8 per cent in 2018; ANC rose from 16 per cent to 65.2 per cent.¹⁵

13 National Reproductive, Maternal, Newborn, Child and Adolescent Strategy 2017-2021
 14 Ministry of Public Health. Afghanistan, National Health Strategy 2016-2020
 15 Afghanistan Health Survey 2018

Figure 1 Trend of Maternal Health Indicators 2003-2018



In 2003, the MoPH contracted non-governmental organizations to implement BPHS which provides facility and community-based primary health care. This remains the primary channel of public sector health services provision in Afghanistan, alongside the EPHS, which provides provincial and regional referrals.

Recognizing the challenges posed by Afghanistan's alarming maternal and neonatal mortality, the MoPH and its national and international partners decided to focus on strengthening midwives as a cadre of female health providers who were distinct from nurses and dealt exclusively with maternal and neonatal health. In 2003, the MoPH identified the need for both conventional midwives based in hospitals and community midwives deployed to basic health facilities offering the BPHS with a strong emphasis on outreach. Supported by USAID, the World Bank and the European Commission, the Ministry established two pre-service education programmes to accommodate two sets of needs, for hospital and community-based midwives. Both were required to meet the ICM essential competencies of a midwife.

Since 2002, the health sector has made significant progress in improving the health status of the population, particularly in access, coverage, and quality of health services. From 9 per cent in 2002, by 2014, nearly 87 per cent of the population have access to health services within a two-hour distance. The downward trends in infant, under-five, and maternal mortality demonstrate favourable improvement in health outcomes. Trends are also upward in antenatal coverage and institutional deliveries.¹⁶

More than 40 years of conflict affected the health sector as well. In 2019, Afghanistan ranked 9th in the Fragile States Index. Health workers, especially female health workers, are at risk. The World Health Organization (WHO) reported 119 attacks on health care workers in Afghanistan in 2019,¹⁷ wherein 25 of 151 health workers were killed. Nurses and midwives have been on the frontlines, such as Maryam, a midwife who was killed in the attack on 12 May 2020 in the MSF-supported maternity hospital in Kabul.

¹⁶ Ministry of Public Health. Afghanistan, National Health Strategy 2016-2020
¹⁷ <https://reliefweb.int/report/afghanistan/attacks-health-care-afghanistan>



3.3.2 Education

In 2002, there were only 467 midwives serving the entire country, with substantial variation in their capacity.¹⁸ With increased international aid into Afghanistan, the opportunity to rebuild the health care system became possible. This set the stage for the two great achievements of the MoPH and the international community, the revitalization of midwifery education as per the standards of the ICM and the establishment of the AMA. To date, 34,825 midwives have been educated. Of those, 6,376 are in practice.

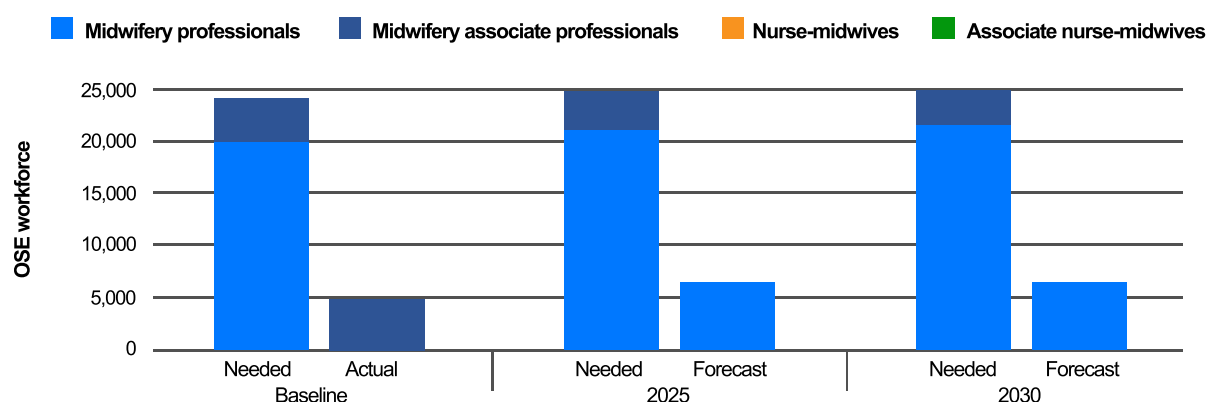
A crucial factor in this success was the system-wide approach taken by the MoPH and its international partners. Demand for midwives was generated in communities, and recruitment occurred on the basis of deployment plans. The Afghanistan Midwifery Education Accreditation Board (AMNEAB) helped maintain the quality of education and, in 2005, the AMA was established to support the professionalization of midwives, advocacy, and in-service education.

Chapter 4: Need for and availability of midwives and other RMNCAH workers

The composition of the RMNCAH workforce varies: different countries use different job titles to describe occupations, and the roles and responsibilities of occupation may differ between countries using the same job title.¹⁹

In the National Health Workforce Accounts (NHWA)²⁰ there was a good availability of headcounts for midwives, nurses, and doctors, and reasonably good availability of graduate numbers for midwives and nurses. SoWMy 2021 used data collection methods different from those used in previous SoWMy reports and defines occupation groups differently. For example, some countries that previously reported having professional midwives now report that their midwives are associate professionals.

Figure 2 Midwives and nurse-midwives

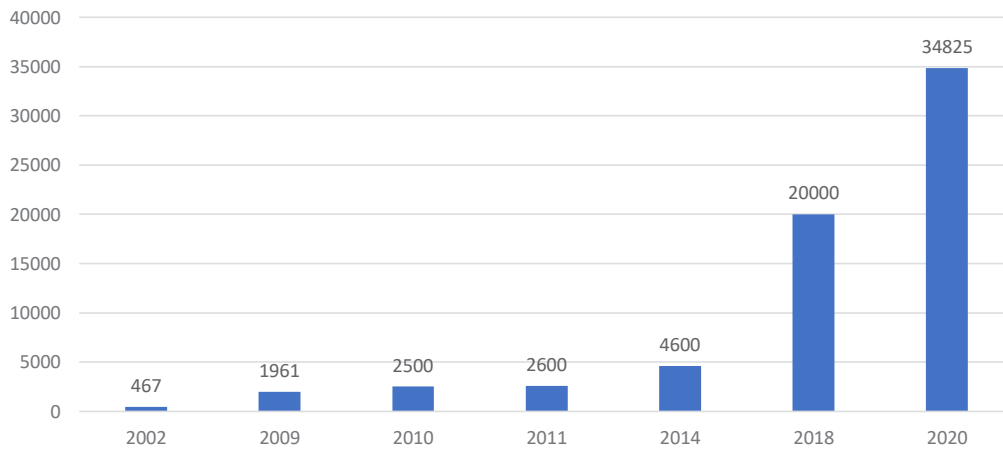


Based on Afghanistan country profile reflected in SoWMy 2021, currently, there are 5,098 midwives Dedicated RMNCAH Equivalent (DRE), which means 100 per cent of their time is allocated to RMNCAH. Based on projections, the need for midwifery professionals and midwifery associate professionals would be around 24,000 by 2030. At the time of reporting, there are 34,825 graduated midwives: 8,078 of them from CME (4,359; 49 per cent) and IHS (3,719; 46 per cent) which are assumed to be competent midwives based on midwifery accreditation criteria; the remainder 26,747 graduated from the private sector (77 per cent). However, with due consideration of the total number of graduated midwives, Afghanistan has already met the threshold for 2030, but the competency of graduated midwives from the private sector is unknown and a concern.

¹⁹ The State of World's Midwifery 2021

²⁰ National health workforce accounts: a handbook. Geneva: World Health Organization; 2017 (https://www.who.int/hrh/documents/brief_nhwa_handbook/en/, accessed 17 March 2021)

Figure 3 Total graduated midwives 2002-2020

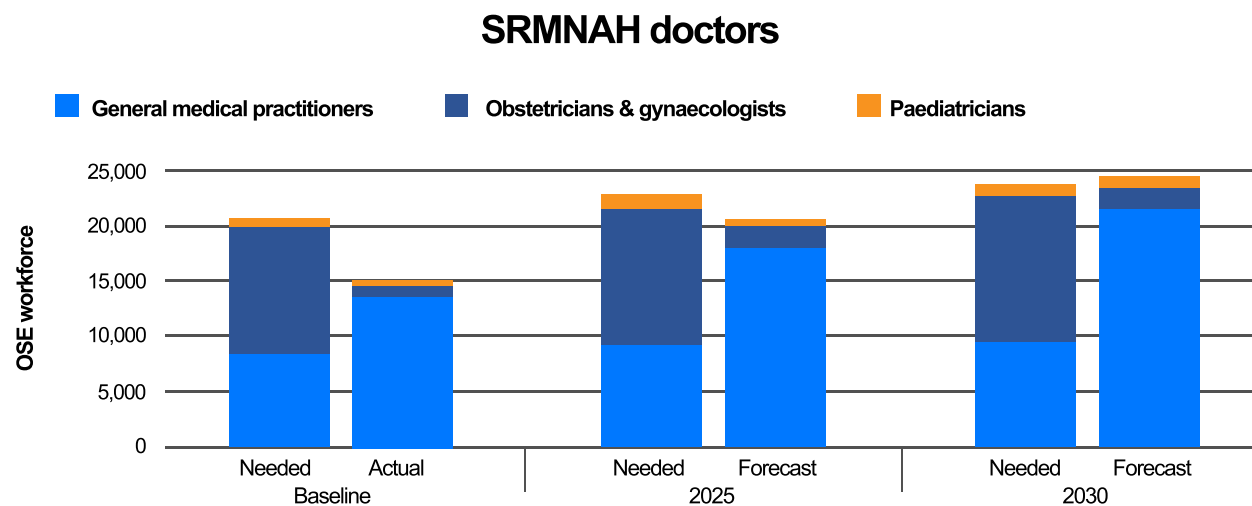


As indicated in Figure 3, after 2014, there was a dramatic increase in the number of graduated midwives, with 43 per cent of midwives graduated during last two years (2018-2020). It seems the education of midwives was not based on the absorption capacity by the job market, and only resulted into more unemployed midwives (82 per cent) in the country.

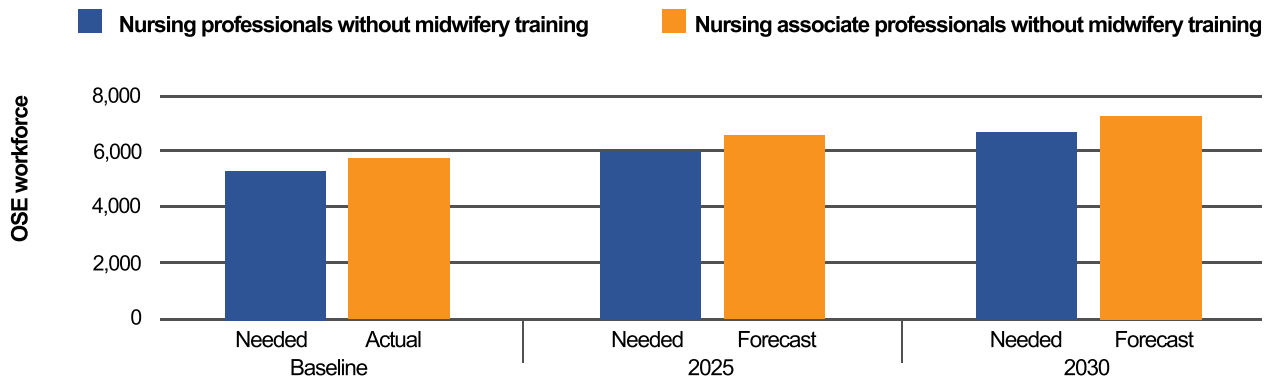
Considering the required number of midwives until 2030, job opportunity needs to be provided for around 18,000 midwives in both public and private sector once their competency and safety has been assured. The private sector adopts a business model which is not sustainable for the work force planning of skilled midwives. In order to balance demand and supply in the production of midwives in the private sector there is a need to:

- reduce the number in education programs
- reduce the number of schools
- increase the number of employed midwives while addressing the current imbalance between rural and urban positions, increasing midwives specifically in rural and hard-to-reach areas.

Figure 4 RMNCAH doctors and nurses



Nurses

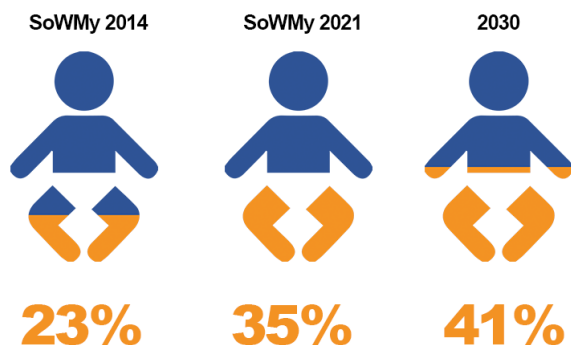


The actual number of obstetricians and gynecologists is more than needed, either as the baseline and as the target for 2025 and 2030, but similar to midwives, there is maldistribution (with urban bias) and shortages of this cadre in remote and under-served areas.

Figure 5 Potential to meet need and demand 2019 and 2030

POTENTIAL TO MEET NEED AND DEMAND, 2019 AND 2030

$$\text{Potential to meet NEED} = \frac{\text{Workforce time available}}{\text{Workforce time needed for universal coverage of essential SRMNAH interventions}}$$



Since 2014 there is a 12 per cent increase in met need for RMNCAH services. With the current composition and distribution, Afghanistan's RMNCAH workforce could meet 41 per cent of the need for essential RMNCAH care.

Globally, 6.5 billion RMNCAH worker hours would have been required to meet all the needs in 2019. This is projected to increase to 6.8 billion hours by 2030. About 55 per cent of the global need for health worker time for essential RMNCAH care is for maternal and newborn health interventions (antenatal, childbirth and postnatal care), 37 per cent is for other sexual and reproductive health interventions such as counseling, contraceptive services, and detection and management of sexually transmitted infections, and 8 per cent is for adolescent sexual and reproductive health interventions. The amount of time needed for postnatal care is more than double the time

needed for antenatal care. This is mainly because postnatal care is needed for two people: in the first 24-48 hours postpartum, new mothers and newborns should both receive interventions, which are more time-consuming than antenatal care visits. Also, some essential postnatal care interventions, although less common, are very time-consuming, e.g., caring for small and sick newborns and women with severe morbidities.²¹ Evidence-based recommendations on the ratio of skilled health personnel such as midwives are needed aligned with increasing care expectations, e.g., one-to-one continuous intrapartum care. Further, by harnessing the demographic dividend through the strategic use of preventive care the efficiency of RMNCAH work hours could be even greater.

Figure 6 RMNCAH worker time needed at each stage of the continuum of care

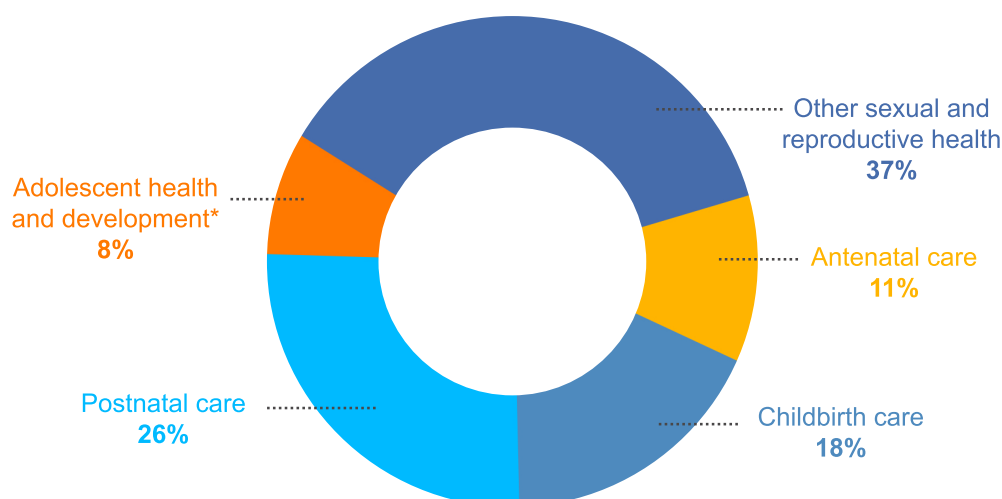


Figure 6 estimates the amount of RMNCAH worker time needed at each stage of the continuum of care to achieve universal coverage: these figures do not represent the amount of time actually devoted to each stage. In many countries, including Afghanistan postnatal care coverage is much lower than ANC coverage. In those countries, the RMNCAH workforce may devote more of its available time to antenatal care than to postnatal care even though the amount of time needed for postnatal care is greater, leading to more unmet need for postnatal care than for antenatal care. If available in sufficient numbers and if fully educated, regulated, and integrated within an interdisciplinary team, midwives could meet about 90 per cent of the global need for essential RMNCAH interventions.²²

To meet universal health coverage and SDG-related targets, WHO identified 4.45 physicians and nurses/midwives per 1,000 population.²³

Comparing the forecasted number of midwives by 2030 in the country profile, even up to the end of 2020 the gap for midwives is now saturated in terms of quantity of professionals. Quality is still unknown, for which the ANMC should strictly work on licensing and accreditation. Without job opportunities for midwives, they will lose interest in the profession.

Data of those in paid work in the private sector is unknown, but still there is a huge gap between graduated and practicing midwives.

²² The State of World Midwifery 2021

²³ Health workforce requirements for universal health coverage and the Sustainable Development Goals, WHO, 2016

Chapter 5: Education and regulation of midwives to ensure high-quality care

5.1 Education

The midwifery profession in Afghanistan started way back in 1911, when King Amanullah sent 12 Afghan females abroad to be trained as nurse-midwives. In 1940 the first nursing and midwifery school was inaugurated in the country. Before the December 1977 invasion of Afghanistan by the Soviet Union, an educational program for Auxiliary Nurse Midwives (ANMs), nurses, and nurse-midwives were established. In 1978 a Post-Basic School of Nursing was opened in Kabul as the “first teacher training institute” for the preparation of nursing teachers in the country. Since then, the Soviet education systems were initiated throughout the country, and the responsibility for basic nursing and midwifery education was transferred to the Intermediate Medical Education Institutes (IMEIs).

To cement Afghanistan’s position as a regional leader in developing the midwifery profession, it is essential to establish educational standards, delineate prerequisites for students and educators, and establish a national curriculum and educational regimen. This is only possible through an education policy which establishes an education framework to prepare competent midwives and trained faculty members. Afghanistan is amongst the first countries in the region to develop a cohort of internationally recognized degree-level midwives. The Nursing and Midwifery Council was established in 2020, which will act as a regulatory body in the area of nursing and midwifery.

Until 2011, midwives were educated through two routes: a two-year direct entry programme through the Institute of Health Sciences (IHS) and a direct entry community midwifery programme (a two-year course since 2011). The two programmes have identical competencies and teach a standardized curriculum with quality regulated by the National Midwifery and Nursing Education Accreditation Board. The IHS entry route is intended to educate midwives at secondary and tertiary health facilities, often in urban areas, while the community midwife route is for women practicing in rural areas.

When the Community Midwifery Education (CME) programme was extended to two years in 2011, seven new modules were added to develop additional competencies as per ICM standards, including content that provides the skills needed in small clinics where the midwife may be the only health provider. Entry into this programme is dependent upon nomination by communities to help ensure community-based midwives are supported in their work and reliably return to work in their home communities.

In 2013 the number of schools had dropped to 22 from 32 due to lack of funding.²⁴ However, it was planned that the number of community midwifery schools should have been increased to 31 by 2018, but due to the funding gap for the Sehatmandi Project, currently, there are only 17 schools across the country.

²⁴ Sabera Turkmani, Sheena Currie, Jaime Mungia, Nassim Assefi, Ahmed Javed Rahmanzai, Pashtun Azfar, Linda Bartlett, ‘Midwives are the Backbone of our Health System: Lessons from Afghanistan to Guide Expansion of Midwifery in Challenging Settings,’ Midwifery (2013)

By the end of 2019, IHS and CME have educated 8,078 midwives, who have supported efforts to reduce Afghanistan's maternal mortality ratio. The number shows an increment of 43 per cent compared to the total graduated midwives in 2014.

An evaluation published in 2013 found that satisfaction with the educational programme was high amongst midwives, though many reported that the low threshold for prior education (nine years of schooling) hampered learning. Nine years was instituted to ensure adequate numbers of eligible candidates from rural areas where levels of education are lower. Since Afghanistan started with a severe shortage of midwifery teachers, many fresh graduates were channeled directly into teaching and had insufficient opportunity to practice their skills outside the classroom.²⁵ An assessment of factors affecting retention rates for community midwives in public sector health facilities found that the pre-service education programmes were not of uniform quality, particularly in terms of access to practical work and the quality of instruction—as there is no monitoring and supervision regimen for trainees.²⁶

To address concerns about retention and following advocacy by the AMA, the National Policy and Strategy for Nursing and Midwifery Services (2011–2015) identified a need to strengthen direct-entry midwifery education in alignment with international standards and to develop a bridging programme to build the capacity of existing midwives for entry into a single, professionalized cadre.

With support from the Ministry of Higher Education, this has led to the development of a new four-year direct entry programme intended for students without prior professional credentials and provides a full course of education which produce skilled and competent midwives with bachelor degrees, and is designed according to international standards. It was launched in 2014 and offered by the Faculty of Nursing and Midwifery at Kabul Medical University, which designed it in accordance with the Global Standards for Midwifery Education developed by the ICM. Students are admitted to the midwifery programme on the basis of a complete course of secondary education (12 years of schooling) and a national university entrance examination. By the end of 2017, a total of 73 bachelor of midwifery students have graduated from the Faculty of Nursing and Midwifery of the Kabul Medical University.

To help existing midwives to improve their education at the bachelor level, and thus refresh their skills and gain credibility as professionals in their field, the Ministry of Higher Education has supported a two-year Midwifery Bridging Programme at Zawul Institute of Higher Education, a private institution in Kabul established in 2015. To date, 90 bachelor's degree midwives graduated from the institute.

Part of the direct entry bachelor program of midwifery by the Ministry of Higher Education (MoHE) are eight private institutes. Between 2016 and 2019, total of 1,843 bachelor midwives graduated from these institutes. This brings to 2,006 the total of midwifery bachelor's degree graduates from all public and private institutes, with only 4 per cent educated in the public sector. However, there is no exact data on the deployment status of these midwives. The MoPH and MoHE should coordinate to ensure that they contribute to the system either in terms of providing healthcare services or education, as well as quality assurance such as through accreditation of midwifery and nursing education and teaching hospitals.

²⁵ Ibid.

²⁶ Molly E Wood, G Farooq Mansoor, Pashton Hashemy, Emily Namey, Fatima Gohar, Saadia Faye Ayoubi, Catherine S Todd, 'Factors Influencing the Retention of Midwives in the Public Sector in Afghanistan: A Qualitative Assessment of Midwives in Eight Provinces', *Midwifery* 29 (2013)

Table 1 Midwifery education institutes offering midwifery bachelor programme

No	Educational Institution	Government/Private	Total graduated
1	Kabul-Abo Ali Ibe Sina Medical Science University	Government	73
2	Khatam Alnabeyin University	Private	433
3	Hakim Sanayee University	Private	103
4	Rabia Balkhi University	Private	121
5	Zawol Institute of higher education	Private	90
6	Ahle Bayt Institute of higher education	Private	51
7	Afghan Pamir Institute of higher education	Private	108
8	Payman Institute of higher education	Private	0
9	Kawon Institute of higher education	Private	104
10	Razi Institute of higher education	Private	923
Grand Total			2006

Currently, there are 173 midwifery education institutions across the country. Private institutes significantly increased during the last 10 years but most have not gone through the AMNEAB accreditation process. Based on a midwifery pre-service education rapid assessment conducted in 2018,²⁷ only 31 per cent of private midwifery institutes have met the criteria requiring students to perform a minimum of 40 births assisted to qualify for graduation. Compliance rate for CME and IHS were 100 per cent and 67 per cent, respectively.

Table 2 All midwifery education institutions

Education entity	Number
Bachelor's degree - Public	1
Bachelor's degree - Private	4
Institute of Health Science	9
Community Midwifery Education	17
Private midwifery education institutes	147
Total	178

27 JHPIEGO, Midwifery Pre-Service Education Rapid Assessment in Afghanistan, 2018

The global SOWMy Report 2021 revealed that nearly all (91 per cent) of 74 responding countries offered midwifery qualification of bachelor's degree level or higher. But only 6 per cent of all midwives graduated from the bachelor's degree program, reflecting that the shift to degree-holder midwives is happening at different paces.

In Afghanistan, midwives working in government facilities are required to have at least a bachelor's degree, posing problems for some midwives who finished only Grade 12 or lower. In the long run, it will be a hindrance to work in government facilities because they will not be qualified to obtain the employment form P2.

On average, only two-thirds of midwife educators worldwide are themselves qualified midwives, and this is again a challenge to the provision of high-quality education.²⁸ This finding is the same for Afghanistan, especially for private institutes. A rapid assessment conducted by JHPIEGO in 2018 indicated that non-compliance with some ICM standards (e.g., number of births attended by students) undermined the quality of education.

Parween Gulzara

Faculty, Midwifery Department, Kabul Medical University

I have done my Master's degree in midwifery from Tehran University-Iran. Since 2016, I have been working with Kabul Medical University (KMU) as a trainer in the midwifery department. In the past year, I was promoted as head of the department. I have membership in the research committee of KMU, as well as the promotion commission of Kabul University. I am an active member of AMA and have membership in the executive board and education committee of ANMC.

The KMU four-years direct-entry midwifery programme contributes to the midwifery profession in terms of educating midwives to provide quality healthcare services to mothers and newborns; and reduce maternal and child mortality consequently.

As of now, 73 students graduated from the midwifery department of Kabul Medical University. I have the following recommendations for the improvement of midwifery education at KMU:

Expanding the structure and human resource capacity, including teachers

More focus on capacity building for teaching, administration, and technical areas

Strengthening of collaboration between clinical sites and MoPH teaching hospitals



Mastoora Stanekzai

Midwifery Program Coordinator, Ghazanfar Institute of Health Science

I graduated from the midwifery department of GIHS in 1986. I have worked at Malalai Maternity Hospital for five years. Before that, I also worked in Muqur district of Ghazni province. Since 1993 I have been working with GIHS as a midwifery trainer. During my career, I upgraded my knowledge and studied midwifery licentiate program.

When I was working in Ghazni province, I observed that most mothers and newborns die due to obstetric complications and lack of midwifery services. This problem encouraged me to start a private practice in Mugur district and proudly saved many lives.

Before 2002, women were not allowed to work outside their homes, I continued my work at home and helped lots of women to have normal delivery and prevented complications. Back then, there was limited number of midwives in the country, but now with the support of international partners a large number of midwives were educated through the the GIHS and CME program.

Midwifery education comprises three pillars: knowledge, skills, and behavior. Midwifery education should focus on all pillars to graduate competent midwives, and should be regularly assessed based on ICM standards by AMNEAB.

During my professional life as a trainer I faced some challenges, including, but not limited to: outdated training materials; insecurity, which consequently resulted in delay in the completeness of educational calendar; low capacity for accommodating all students admitted through direct entry system; restrictions in clinical sites; and lack of transportation.

During the last decade, the private sector is largely involved in education of midwives and a huge number of midwives graduated from private institutes. Currently, there are around 34,000 graduated midwives mostly from the private sector. To ensure the quality of private midwifery education, all institutions should be accredited by the ANMC.



5.1.1 Deployment

By the end of 2019, a total of 34,825 midwives graduated. Currently, 18 per cent (6,376) are practicing midwifery, while 82 per cent are unemployed. Midwives remain unemployed mainly due to structural issues with BPHS and EPHS scheme, in which implementing NGOs are allowed to recruit certain number of midwives as stipulated in the strategies. There is also a disconnect between demand and supply for midwives.

This issue is a concern for the midwifery profession. In 2019, around 9,500 midwives graduated mainly from the private sector. With the growing number of midwives graduating from the private sector, employment will continue to be a challenge for the Ministry of Public Health.

In the 2018 Midwifery Pre-Service Education Rapid Assessment in Afghanistan, job security emerged as a key issue, especially for IHS and private schools. It is necessary to formally study the successes of CME programs in recruiting, deploying, and retaining midwives to a number of remote facilities and to support other programs to use the health workforce development model in their programs.²⁹

Quality midwifery education is essential to prepare midwives to provide quality RMNCAH care. Despite evidence of the benefits produced by the investment, midwifery education and training remain grossly underfunded in many countries.³⁰ Research across Africa and South Asia has shown that inadequate education and training significantly jeopardize the professional identity, competence and confidence of midwives as primary RMNCAH care providers.³¹

In 2019, UNFPA, UNICEF, WHO, and ICM identified three strategic priorities for midwifery education: (1) every woman and newborn to be cared for by a midwife who is educated and trained to international standards and enabled to legally practice the full scope of midwifery (the title “midwife” to be used only for providers who are educated to international standards); (2) midwifery leadership to be positioned in high-level national policy, planning and budgeting processes to improve decision-making about investments for midwifery education to help achieve UHC; and (3) coordination and alignment between midwifery stakeholders at global, regional and country levels to align education and training processes, knowledge, research, evidence-based materials, indicators, and investment.³²

5.1.2 Impact of Covid-19 on midwives' education and practice

Covid-19 impacted many activities in 2020 and 2021, including midwifery education and practice. Public health policies, including lockdowns, caused significant disruption to essential health services.³³ Midwifery education, like other health occupations, was also disrupted, with limited access to clinical placements and changes in students' direct patient care contact hours.

Key messages

Covid-19 has prompted new ways of providing midwifery education and services. These need to be developed and used effectively, including innovative digital technologies and online learning opportunities. Their effectiveness also needs to be assessed during normal conditions.

Covid-19 has prompted new ways of providing midwifery education and services. These need to be developed and used effectively, including innovative digital technologies and online learning opportunities. Their effectiveness also needs to be assessed during normal conditions.

29 JHPIEGO, Midwifery Pre-Service Education Rapid Assessment in Afghanistan, 2018

30 The state of world's midwifery 2021

31 Filby A, McConville F, Anayda P. What prevents quality midwifery care? A systematic mapping of barriers in low- and middle-income countries from the provider perspective. PLoS ONE. 2016;11(5):e0153391. doi: 10.1371/journal.pone.0153391.

32 World Health Organization, United Nations Population Fund, United Nations Children's Fund, International Confederation of Midwives. Strengthening quality midwifery education for universal health coverage 2030: framework for action. Geneva: World Health Organization; 2019

33 Furuta M. 2020 international year of midwifery – in the midst of a pandemic. Midwifery. 2020;87:102739. doi: 10.1016/j.midw.2020.102739.

Midway through 2020, ICM launched a global Covid-19 survey to determine the role of midwives associations in response to the pandemic's impact on the midwives they represent. The survey revealed high levels of stress and burnout among midwives, and most (70 per cent) reported that midwives had experienced a lack or shortage of personal protective equipment (PPE). Associations reported that midwives had resourcefully addressed this situation by making their own PPE, purchasing their own, or improvising with whatever was available. Some associations reported that midwives had reused single-use PPE (30 per cent), worked without (26 per cent), or just not attended work (7 per cent). This lack of sufficient PPE has put them in substantial health risks of contracting Covid-19 as they continue with life-saving service delivery during the pandemic.

Over half (54 per cent) of responding associations reported that midwifery education courses had been closed in their countries, 90 per cent of courses had changed to online learning, and 25 per cent to small group learning. Only 50 per cent of those associations felt that students had access to practice areas or clinical placements some of the time, while 25 per cent had no access. Almost two-thirds (61 per cent) of responding associations reported delays in midwifery students completing their studies.

Covid-19 has reduced workforce availability. Access to RMNCAH services needs to be prioritized and provided in a safe environment, despite the pandemic. RMNCAH workers need protection from infection, support to cope with stress and trauma, and creative/innovative solutions to the challenges of providing high-quality education and services. The COVID-19 pandemic also affected service delivery in Afghanistan. Based on Afghanistan DHIS-2³⁴, there is a decrease in key maternal services provided by midwives.

Table 3 effect of COVID-19 on maternal health services

Period	1 st ANC coverage	% of SBA deliveries	1 st PNC coverage	% CYP provided by HFs
2019	131%	74%	93%	13%
2020	123%	72%	89%	11%

Table 3 indicates 8 per cent decline in ANC 1, 2 per cent decline in SBA deliveries, 4 per cent decline in PNC1 and 2 per cent decline in CYP in 2020 comparing to 2019.

5.2 Regulation

Midwifery regulation governs the education, practice, and licensure of midwives. Appropriate legislation and regulation are vital to protect both midwives and the public they serve. It protects the public, including the most vulnerable, by ensuring that the high standard of care comes from competent providers who are registered and accountable to a central authority. Critically, legislation and regulation also support midwives by enabling them to work autonomously in a supportive professional environment and be acknowledged as health care professionals. This includes the establishment of a recognized regulatory body that sets standards for practice and ethics, registers midwives, and applies sanctions for misconduct. It also includes accrediting education programmes and ensuring that “midwife” is a protected title with a recognized definition and scope of practice.

In February 2016, the MoPH agreed to implement the ICM Midwifery Services Framework (MSF) tool to identify gaps in maternal health service provision that are leading to the high rates of maternal and child mortality in Afghanistan. During the MSF workshop, priorities and important activities were discussed, considering the contextual implementation of these services and their effective implementations. As a result of the MSF, establishing a regulatory body for the midwives that can independently protect their profession and the safety of the public was confirmed as the priority.

On 13 June 2018, the Government endorsed the establishment of the Afghan Nurses and Midwives Council (ANMC). This milestone was the result of nearly nine years of advocacy and extensive collaboration between many partners working with the Afghan Midwives Association, Afghanistan Nurses Association and MoPH. Having ANMC in place is extremely significant because an effective professional and regulatory organization contributes to public safety and welfare by ensuring the deployment of competent and licensed practitioners within healthcare settings. The ICM considers professional regulation essential to ensure public safety through the provision of a competent and autonomous midwifery workforce. This view is echoed by the International Council of Nurses (ICN), which believes that profession-led nursing regulation contributes to public protection and quality patient outcomes through establishing, promoting, and enforcing standards of practice. Hence, the role of regulation is vital to safeguard the provision of quality services and support professional integrity.³⁵

After various delays, the ANMC was established in December 2020 as an autonomous regulatory body. The Council will ensure standards of the highest quality of midwifery and nursing care in Afghanistan.

The establishment of ANMC is a game-changer for nurses and midwives in Afghanistan in terms of giving both professions more autonomy and governance, addressing persistent challenges in assuring the quality of pre-service education (PSE) and licensing new graduates. However, operationalizing and ensuring that ANMC functions (according to the approved legislation) efficiently and effectively is challenging. The first assembly of the ANMC was inaugurated by the honourable Minister of Health on 1 December 2018, followed by the first board meeting and election of key officers. This exciting step initiates the implementation of ANMC, and focuses on identifying regulatory priorities for the next five years as well as ensuring the related legislation becomes law. These are complex undertakings and require a significant investment of political will and time and financial and human resources through dedicated fund allocation to ANMC by government and major donors until the Council income reaches the sustainability threshold. The midwives and nurses of Afghanistan have demonstrated incredible resilience and commitment in realizing their vision of establishing a Council. They will need the ongoing support of their networks inside and outside the country to maintain and strengthen this resilience within their professions to enable the significant contribution they can make to improving health outcomes in Afghanistan.³⁶

The role of the ANMC is to develop, improve and maintain the quality of midwifery and nursing education and services delivered to individuals and communities in Afghanistan in accordance with Government policies and the guidelines of the ICM and ICN. The ANMC serves as a technical coordinating body to effect policies and maximize the efficiency of resources that enable midwives and nurses to provide the highest quality of care. The ANMC Act outlines the composition and terms for council membership and defines the mandate of ANMC as the regulatory body of the midwifery and nursing professions in Afghanistan responsible for:

- Protecting the public from unsafe practices
- Ensuring the quality of education and service to foster the development of the profession
- Conferring responsibility, accountability, identity, and status of the midwives and nurses

35 M. Jafari, S. Currie and W.M. Qarani et al. / Midwifery 75 (2019) 1–4
36 M. Jafari, S. Currie and W.M. Qarani et al. / Midwifery 75 (2019) 1–4

Licensing and regulatory systems are essential for safe practice, but not sufficient to maximize midwives' contribution to improved health outcomes. The State of World's Midwifery 2021 revealed that, in many countries, midwives do not have the authority to perform tasks typically considered part of the midwife's scope of practice. For example, in most responding countries, midwives are authorized to provide five of the seven basic emergency obstetric and newborn care (BEmONC) signal functions, but in half of the countries they are not authorized to undertake deliveries using vacuum extraction or manual vacuum aspiration for early pregnancy bleeding. Fortunately, in Afghanistan, midwives are authorized to provide each of the BEmONC signal functions and practice at all levels of health facilities. Still, there are many limitations placed on midwifery, especially in those health facilities where midwives are not allowed to provide services autonomously.

Fahima Naziri

ANMC Vice President

I have more than 13 years professional experience in the field of midwifery clinical education and management since 2007 at CURE International Hospital, Afghan Midwives Association, and recently at Afghanistan Nurses and Midwives Council.

I graduated in 2007 from the Midwifery Program of Ghazanfar Institute of Health Science and obtained a bachelor's degree through the Midwifery Bridging Program in 2018. I am BLS Instructor of American Heart Association since 2012.

I have the experience of working with the Afghan Midwives' Association volunteer positions as AMA Provincial Director in Kabul from 2013 to 2016, and as AMA President from 2016 to 2018. I am currently the AMA Vice-President.



Midwives and nurses in Afghanistan did not have a legal regulatory body that could independently protect their profession and the safety of public. Additionally, there is a growing concern among stakeholders regarding the quality of service of midwives and nurses in the country. The quality of pre-service education in private sector is especially a big concern. Afghanistan Nurses and Midwives Council as an autonomous regulatory body established in December 2020.

Vision: The ANMC vision is to be a significant regulatory body and partner in Afghanistan's healthcare system, striving for excellence and innovation in midwifery and nursing practice, research, education, and service provision to protect the public.

Mission: The mission of ANMC is to regulate the midwifery and nursing professions through registration, licensing, and accreditation to produce competent midwives and nurses who will ensure public safety.

Main goal: Establish a mechanism for midwifery and nursing education and practice to ensure people have access to high quality services from community to facility levels.

Since accreditation of pre-service education is the ANMC's Second Strategic Objective, ANMC is committed to ensuring the quality of the pre-service education in both the public and private sectors.

5.3 Professional associations

In terms of professional development, midwifery in Afghanistan has progressed along a route similar to that of many countries. The development of a national professional association was the first step towards becoming a recognized profession in the country; it raised midwifery to its rightful place in society in terms of value and respect. The Afghan Midwives Association (AMA) was established in 2005 to take a unique leadership role in influencing quality service delivery by midwives and advocate for necessary policy and legislative changes. This incredible endeavor was supported by USAID, ICM, JHPIEGO, and the American College of Nurse-Midwives (ACNM).³⁷

The ICM recognizes professional associations as vital partners in developing midwives into a dynamic, collaborative, and effective team of professionals. A strong non-profit professional association is required to protect both the rights of women and the midwifery practitioners and contribute to a better health system through lobbying and increasing awareness.

The process was commenced in May 2005 by a small group of Afghan midwives, around 80 from Kabul and a few other provinces, who endeavored to establish the reason for having a professional group to advocate for the role, status, training, and education of midwives.³⁸ In the first gathering, the midwives set a professional vision to improve the quality of care for all women in Afghanistan and be recognized nationally, regionally, and globally.³⁹ At the same time, a governing body was appointed and the AMA Constitution was developed. To ensure sustainability and accountability, a membership fee system was put in place. AMA was registered with the Ministry of Justice as a civil society organization.

In November 2005, AMA became a full-fledged member of the ICM⁴⁰. It seeks to:

- Advocate for and within the midwifery profession
- Build partnerships to support women's health and empowerment
- Gain national recognition as the technical body for midwifery education, providing support to pre-service programmes, and ensuring that Afghan midwives achieve the highest quality standards
- Work towards the establishment of a Midwives and Nurses Council to better regulate the profession
- Ensure that the AMA and its business affiliate, the Organization for Afghan Midwives, are sustainable

Today, AMA is known as a civil society organization, which advocates for women's health and rights, not only in Afghanistan but regionally and internationally. AMA is working collaboratively with the Government and other partners to contribute towards the improvement of maternal, newborn, and child health (MNCH) in Afghanistan. Gradually, over the first 10 years, AMA improved its capacity and, to date, AMA is known as a credible source of expertise for national policy, as well as other aspects of organizational capacity: strengthening infrastructure, governance, financial management, membership, and communication. Because of its organizational stability, AMA was able to apply for grants and has received funding from different donors.⁴¹

37 Sabera Turkmani, Fatima Gohar, Farida Shah, Saleha Hamnawazada, Pashtoon A. Zyaee, Strengthening Midwifery Education, Regulation and Association; A case study from Afghanistan, *Journal of Asian Midwives (JAM)*, Vol. 2, Iss. 1 [2015]

38 Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. *Midwifery*. 2007;23(3):226-34.

39 AMA. Afghan Midwives Association Constitution In: AMA, editor. Vision and mission Kabul, Afghanistan: AMA; 2006.

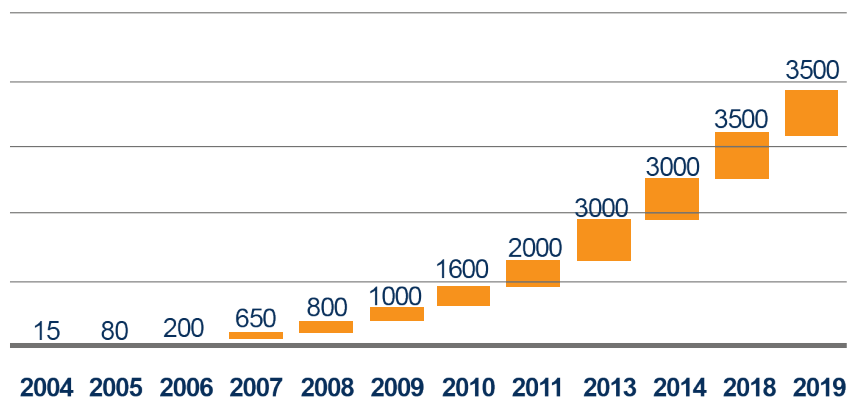
40 State of Afghanistan's Midwifery 2014

41 Sabera Turkmani, Fatima Gohar, Farida Shah, Saleha Hamnawazada, Pashtoon A. Zyaee, Strengthening Midwifery Education, Regulation and Association; A case study from Afghanistan, *Journal of Asian Midwives (JAM)*, Vol. 2, Iss. 1 [2015]

The AMA has engaged in many advocacy activities to claim a fully independent identity for midwifery. In 2002, midwifery was designated as a separate profession from nursing, but confusion persisted among the public and policy makers. For instance, in 2005, most midwives were still appointed to nursing positions, even though the country needed midwives. Most policies did not reflect the rules and regulations or standards specifically for midwifery. It was also frustrating that the public had no clear idea what constituted midwifery practice and who could be identified as a midwife. AMA took several initiatives to influence these policies, and engaged all stakeholders for more effective lobbying and advocacy to get recognition for the profession.

AMA had a critical role in influencing midwifery practice, pre-service and in-service education in Afghanistan through involvement in different task forces and working groups at the national level in the MOPH. This was an opportunity for AMA to create a strong foundation and contribute to a change in policy. Some of these policy areas include: giving independent full identity to midwifery; the development of midwifery competencies and autonomy of practice; improvement of pre-service midwifery education; establishment of midwifery education accreditation system; professional service development; influencing employment; staffing and salary policies; providing mentorship and supervision for rural midwives; advocacy for establishing a regulation system; and career progression opportunities for higher education. These are some ways AMA as a professional association has brought about structural changes in midwifery in Afghanistan. The AMA celebrated significant achievements since its foundation. AMA advocacy was critical in the Ministry of Higher Education's decision to develop Afghanistan's first four-year degree midwifery programme and the two-year bridging degree programme.

Figure 7 AMA membership trend 2004-2019



The AMA experience during the past 15 years shows that the organization has achieved one of its goals of increasing visibility of the profession and in advocating improvement in maternal and child health. Supporting the capacity-building efforts of health professional associations, particularly among countries with poor MNH outcomes, represents an innovative and sustainable approach towards meeting SDG 3. The AMA membership has expanded to over 3,500 across the country, and one of its unique features is its presence across Afghanistan through its 34 provincial branches. The number of AMA members shows a 34 per cent increase from 2011 and 14 per cent from 2014. However, taking into account the number of graduated midwives (34,825), only 10 per cent of them are members of AMA. In December 2020, through the strong advocacy and lobbying by AMA, the Afghan Nurses and Midwives Council was established, a major achievement for the association.

Only 10 per cent of graduated midwives have AMA membership.

Pashtoon Azfar Ziaee

Member, AMA Advisory Board

I am a registered midwife with a bachelor's degree in social science and has worked as a midwife in Afghanistan and abroad. I also worked with the International Medical Corp (IMC) as midwife trainer; with MSH as Midwife Technical Advisor; and with JHPIEGO as Midwifery Advisor, Midwifery Strategic Director, and different positions up to 2010. From 2010-2014 I worked with ICM as Midwifery Regional Advisor for Asia. Then from 2014-2018 as a Technical Midwife Advisor at the ICM headquarter. I was the first elected president for AMA.

As part of efforts to rebuild the health system, we initiated the establishment of Afghan Midwives Association in 2004 with 15 midwives to introduce the midwifery profession at national and international level through a professional body. The first midwifery congress was conducted on 2nd May 2005 and six months later, in November 2005, we were privileged to become a member of ICM. During the first year of AMA, we established 17 provincial branches. AMA was known as a women's organization providing services for well-being of women and families across the country. We advocated for the establishment of accreditation system to ensure the quality of pre-service midwifery education.

As an association is the backbone of each profession, AMA plays a critical role in midwifery in Afghanistan, including:

- Representing the interest of the profession, which is the legal function of AMA
- Advocating for efforts, thoughts, and ideas of all midwives with regards to the profession
- Synchronizing the presence of midwives across the country
- Advocating for leadership and policy change
- Building a sense of belonging and ownership for all midwives
- Mainstreaming and managing changes
- Working on the professional development of midwifery in Afghanistan
- Providing technical support to MoPH and partners
- Advocating for quality of pre-service education

As founder of AMA, I have the following recommendations for further strengthening of AMA at national and sub-national levels:

- Strengthening programs for leadership, including investing in young potential midwives
- Promoting data use and evidence-based decision making
- Scaling up of midwife model of care in the country since midwifery is an autonomous profession to ensure availability, accessibility, acceptability, and quality
- Promoting evidence-based practices, including the use of technology
- Investing in having a pool of leaders, managers, tutors, and faculties
- Translating data into action



Gette Saduzai

Executive Director, AMA

I was born in Kandahar province, I am a registered midwife with a Bachelor of Business Management degree with 7 years experience working in various positions with national and international NGOs in the field of health and nutrition in Afghanistan. I worked as a midwife for two years with BPHS and 5 years with Save the Children International in maternal and newborn care projects, health, and nutrition in humanitarian response in the remote areas of Kandahar.

As the current Executive Director of Afghan Midwives Association in Kabul, I adhere to the ICM criteria for midwifery associations:

A. Governance: The Association should have a Board and/or an Executive Committee governed by a Constitution and by-laws. B. Management practices and leadership: Administrative policies and procedures – the Association should have policies and procedures for electing leaders and office-bearers.

C. Financial Resource Management: The Association should have an accounting system.

D. Functions: Membership services, advancing professional practice, quality control for care:
- The association should have a clearly defined communication strategy for internal and external relationships (e.g., MoPH, members, women, donors).

- The association should have a system in place to facilitate advocacy for women, midwives and newborns.

- The association should have the relevant resources to achieve its mission

-The association should have collaboration, partnerships and networks (e.g., with women, government, other NGOs).

AMA has 34 active branches in 34 provinces of Afghanistan. It started with only 80 members in 2005. Now, it is known as one of the strongest and biggest professional associations in Afghanistan with more than 3,500 members from 34 provinces.

AMA will take the following approaches to increase its membership up to 2025:

- Develop a mechanism to identify the needs of members.
- Organize annual general membership meetings.
- Orient and know all the midwives in a membership structure.
- Develop an online platform to facilitate the membership registration process.
 - Strongly advocate for recommendations on salaries and working conditions of its members.
- Continue and strengthen mechanisms to provide continuing professional education for its members.
- Advocate for preference for AMA members for job requirements.

Chapter 6: Midwife leadership

Healthcare leadership is essential to enable midwives to work to fulfill their potential. While 70 per cent of the health and social care workforce are women, just 25 per cent of senior roles are women.⁴²

Table 4 Midwives in a leadership position in Afghanistan

Does the country's national healthcare system support midwife-led continuity of care?	yes
# of midwives in leadership positions in national MoH	0
# of midwives in leadership positions in sub-national MoH offices	331
# of midwives in leadership positions in regulatory authorities	7
# of midwives in leadership positions in health facilities	259
Please enter a link to the govt website(s) used to collect this data	NA

At the time of data collection for SoWMy 2021, there were 597 midwives in leadership positions at sub-national (55 per cent), regulatory authority (1 per cent), and health facilities (44 per cent), but there was no midwife in a leadership position in the Ministry of Public Health. Lack of midwives in leadership positions at the MoPH is a priority advocacy agenda for AMA and ANMC. Appointing senior midwives as leaders at the national level would provide a significant lever for building capacity. They will play a critical role in advocating maternity care during the development of national policies and strategies, as well as designing service delivery models.

Based on the definition of leadership position from ICM, the position holders should have the authority of budgeting, structure, and development of policy documents. However, there are some positions at the national and sub-national levels but they are not fulfilling the requirement as per ICM standards.

Limited opportunities for leadership and the scarcity of women in leadership positions as role models hinder midwives' ability to climb the leadership ladder. It is also likely that when no midwives hold mid-level leadership positions, such as at the district/provincial level, there is a significant gap in the capacity at these levels to provide supportive supervision and to mentor to midwives, as well as the ability to make sound decisions on issues that affect midwives.⁴³

⁴² Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. Geneva: World Health Organization Global Health Workforce Network's Gender Equity Hub; 2019 (<https://www.who.int/hrh/resources/health-observer24/en/>, accessed 9 March 2021).

⁴³ The State of World Midwifery 2021

Figure 8 Percentage of countries with midwives in leadership positions

WHO REGION	Number of countries reporting/total	% of countries with midwives in leadership in...				
		National MoH	Subnational MoH	Regulatory authority	Health facilities	Any level
Africa	29/47	66%	52%	45%	62%	69%
Americas	12/35	75%	75%	67%	92%	92%
Eastern Mediterranean	8/21	50%	75%	63%	63%	88%
Europe	13/53	15%	23%	54%	46%	54%
South-East Asia	7/11	29%	71%	43%	71%	57%
Western Pacific	11/27	45%	64%	64%	73%	73%
INCOME GROUP						
High	19/61	21%	42%	68%	58%	63%
Upper middle	12/55	75%	75%	67%	75%	83%
Lower middle	29/49	48%	52%	45%	55%	66%
Low	20/29	70%	65%	45%	60%	80%
TOTAL	80/194	51%	56%	54%	60%	71%

MoH = Ministry of Health.

Note: A few countries reported "don't know": they are included in the denominators for the above percentages. They may have midwife leaders, but were unable to specify how many.

Source: ICM survey.

To align with global data, midwives' appointment in leadership positions in regulatory authorities and MoPH leadership should be strongly advocated.

The intersection of gender, ethnicity, age, geographic location, and socioeconomic status contributes to multiple layers of disadvantage, including aspects of occupational segregation. Women are more likely to work part-time: an additional barrier to accessing formal leadership roles.⁴⁴ Lack of investment in women's professional development, especially in developing and utilizing leadership skills, inhibits them from advocating their case and further perpetuates gender segregation.⁴⁵

The ICM Young Midwife Leaders programme is an example of support for midwives in developing their leadership skills.

Building the next generation of midwife leaders

ICM's Young Midwife Leaders (YML) programme enables young midwives (aged under 35) from low and middle-income countries to learn how to develop as leaders of the profession and strengthen their national midwives' associations. The objectives of the ICM programme are to:

- increase leadership-related knowledge, skills, and self-confidence (e.g. for strategic planning, project management, and policy advocacy);
- increase awareness of health systems; and
- increase commitment to the professionalism of midwives, their education, the policies that govern them, national/regional midwives' associations, and the health system in which they operate.

Reference: *The State of World Midwifery 2021*

44 Boniol M, Mclsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender equity in the health workforce: analysis of 104 countries. Health Workforce Working Paper 1. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWFGender-WP1-2019.1-eng.pdf?ua=1>, accessed 17 March 2021).

45 George AS, McConville FE, de Vries S, Nigenda G, Sarfraz S, Mclsaac M. Violence against female health workers is tip of iceberg of gender power imbalances. *BMJ*. 2020;371:m3546. doi: 10.1136/bmj.m3546.

The Afghan Midwives Association implemented the Young Midwifery Leadership (YML) program in October 2020 led by Pashtoon Azfar Zyaee (AMA founder and advisor) with 10 participants from Kabul and the provinces. The program is expected to assist in the development, expansion, and strengthening of midwifery education, regulation, and associations in Afghanistan to address the maternal and newborn health needs through taking the lead in the provision of care, formulation of policies which influence maternal, newborn and child health and convincing other interested parties.



6.1 Global recognition

Four Afghan women (two midwives and two nurses) have been recognized among the nominees for the 100 outstanding women nurses, midwives and leaders by the Women in Global Health in partnership with WHO, UNFPA, ICN and ICM. The nominees were recognized for their pivotal role in providing health services in difficult times from 43 countries and across 6 global regions, to recognize these women and the millions of nurses and midwives around the world.

The four were Zahra Mirzaei, a midwife awarded as a Community Hero; Shukriya Musafirzada, a midwife awarded as Young Nurse and Midwife Leader; Shabana Halyen, a nurse awarded for Human Capital development; and Marufa Muradi, a nurse awarded as Community Hero.⁴⁶



Ms. Zahra Mirzaei is an experienced midwife with over a decade of experience providing technical support and guidance in the development, management, and evaluation of midwifery education programs in Afghanistan. She supports efforts to strengthen midwifery nationally in collaboration with various stakeholders. For the past 14 years, Ms. Mirzaei has also served as the president of the Afghan Midwives Association (AMA), an organization committed to advancing the careers of midwives to improve maternal and newborn health in Afghanistan.

Ms. Mirzaei has worked extensively with various organizations, including the Swedish Committee for Afghanistan (SCA), Ibn Sina International, Afghan Midwives Association, Aga Khan

Health Services (AKHS), and JHPIEGO. Ms. Mirzaei began her career as a hospital midwife in Sar-e-pul Provincial Hospital in 2006 as newly graduated midwife. As she progressed quickly into management, she implemented changes through the creation of committees within the hospital. Through her own experience, she realized that midwives needed additional support, particularly capacity building and continuing education. Her advocacy efforts led her to join the Afghan Midwives Association as a volunteer, helping to boost membership in the country. She became further involved as a teacher at the Community Midwifery Education (CME) school and after five years, was promoted to the CME coordinator position.

In 2012, Ms. Mirzaei became the provincial volunteer director for the AMA, representing the organization by participating in health promotion programs. In 2018, she was elected as an executive board member and later as president of the AMA. This position has allowed her more opportunities to increase advocacy efforts for women's rights within the fields of midwifery and nursing. Technical support has led to the establishment of the Afghan Nurses and Midwives Council (ANMC) and expanded the membership of the AMA.

Throughout her 13 years as a midwife, she has faced many challenges that have made her a more resilient and better educator. Meeting families face-to-face to advocate for more women to join the CME program as a student was among the most difficult. But this challenge has led to great success, and the program has educated far more midwives than she had imagined. Today, Ms. Mirzaei continues to fight for recognition for the CME midwives in hospitals as they are not registered in Afghanistan's health system, despite the critical role they play in maternal health and primary care.

Shukria Musafirzada is a midwife and teacher at the French Medical Institute for Children and Mothers in Kabul, Afghanistan. There she aids in safe birth care of women and newborns, improving the odds of survival for many of her patients.

Shukria was raised during wartime in Kabul, Afghanistan, and fled to Pakistan as a refugee. In 2004, she returned to Afghanistan and started a new life in Kabul. In her early career, Shukria was deeply involved in promoting education among women and girls, even before finishing her own education. Through the support of her family, she began school to earn a bachelor's degree in business administration. However, partway through school, she learned about Afghanistan's shockingly high maternal mortality rates. This knowledge changed her career path towards medicine and, ultimately, midwifery.



Shukria began working as a midwife in 2012 in a private hospital and then moved on to the famous Rabia Balkhi government hospital. As one of the only midwives there, she realized what it means to be a frontline worker. Her work is often under challenging conditions, but she accepts her role gladly because she knows she is improving the health and well-being of so many women. Shukria believes that the safe delivery of a child should be a fundamental right for all.

Her career has taken her to the French Medical Institute for Children and Mothers (FMIC) in Kabul, where she is now the head midwife. In her leadership role, she has had to endure seemingly impossible situations. Her hospital has been attacked by terrorists and has had to deliver newborns under gunfire. Her experiences have made her stronger, she feels and has cemented her belief that midwifery has been the right path. She is now a member of the Afghani Midwives Association and volunteers with the Aga Khan National Council Health Committee. She remains grateful for her chosen path and is thankful to Allah and her family and mentors who have supported her in becoming someone that helps women in children in Afghanistan.

Chapter 7: Progress since 2011

The first SoWMy in 2011 called for investments in midwifery education and regulation and in midwives' associations, especially to improve quality of care. There has been some progress, with greater recognition of the importance of quality in addition to quantity. SoWMy 2011 called for the recognition of midwifery as a distinct profession, with posts at the national policy level. Training and retention of midwives, and applying innovative approaches such as midwife-led maternal delivery centers stipulated in the MoPH national strategic plan 2011-2015 as well as in the Reproductive Health Strategy 2011-2016 and its revision as National Reproductive, Maternal, Newborn, Child and Adolescent Health 2017-2021.

Correspondingly, the 2011 recommendations included: ensuring that midwifery graduates are proficient in all the essential competencies required by their government and regulatory body; using globally recognized standards to improve quality and capacity, with attention to theory– practice balance; recruiting teachers, trainers, and tutors, and maintaining and upgrading their competencies in midwifery and transformative education; promoting research and academic activities; and supporting the development of midwifery leadership.

Strengthening and enabling midwives' associations to provide much-needed leadership, partnership with women, and advocacy has been a strong theme in SoWMy. The 2011 report highlighted that associations could raise midwives' profile and status in the national policy arena and strengthen their input into health plans and policy development. Midwives' associations are essential for effective collaboration with other professional associations, with regional and international federations, and with women and communities. SoWMy 2011 also emphasized the need to establish solid governance of midwives associations, strengthening their administrative capacity and improving financial management.

The State of Afghanistan's Midwifery 2014 reported that the country does not have enough RMNCAH workers to meet the needs of the people. However, as of 2021, the number of midwives trained are even more than what was projected. But taking into consideration the level of proficiency of the graduates, improving their skills remains a priority area until 2030.

Many countries, including Afghanistan show improved workforce availability since 2014. SoWMy 2014 called for comprehensive, disaggregated data to articulate 10 essential data items to be reported by every country.

SoWMy 2014 showed that midwifery was a “best buy” in primary health care and the evidence presented in SoWMy 2021 strengthens this message. It shows that investing in midwives contributes to achieving a “grand convergence” of ending preventable maternal and newborn deaths and improving health and well-being. SoWMy 2014 introduced the Midwifery 2030 pathway (reproduced on the inside back cover of this report), starting from the premise that pregnant women are healthy unless complications arise, and therefore, they require some preventive and supportive care with access to emergency care when needed. Midwives promote woman-centered and midwife-led models of care, which achieve excellent outcomes at a lower cost than medicalized models. The pathway remains valid in 2021. The recommendations in this report all aim to make Midwifery 2030 a reality for Afghanistan.⁴⁷

Gender imbalances in the RMNCAH workforce (as in the wider health workforce) highlighted the need for a gender transformative policy environment, especially for midwives, who are nearly all women. This report also draws attention to the importance of decent work that is free from violence and discrimination and the need to utilize social dialogue to promote consensus building and democratic involvement and empower the workforce.

Chapter 8: Way forward to 2030

SoWMy 2021 calls for a strong focus on universal access to essential RMNCAH services, addressing equity at all levels, and leaving no one behind. To improve accessibility and quality of care, greater investment in midwives is needed in four key areas: (1) education and training; (2) planning, management, and regulation of the health workforce and its work environment; (3) leadership and governance; and (4) service delivery. These investments should be considered by governments, policy-makers, regulatory authorities, education institutions, professional associations, international organizations, global partnerships, donor agencies, civil society organizations, and researchers. Within several of these areas, there are ongoing efforts to build on, including frameworks, mechanisms, and tools for strengthening midwifery and assessing and accreditation of midwifery education, including an action plan to enhance quality midwifery education.

The following four areas need more significant investment:

1. Health workforce planning, management and regulation in the work environment

- Compile a health workforce data set disaggregated by occupation group and location, including the following data items: density; graduation rate from education and training programmes both public and private; the number of certified midwives; the proportion of employed midwives; the proportion of practicing and non-practicing midwives.
- Capture and analyse the various non-clinical roles of midwives, such as in education, management, policy, research, regulation, midwives' associations, and government; all these roles are important for the development of the profession.
- Improve understanding of the amount of time allocated by different occupation groups to RMNCAH.
- MoPH advised to develop midwife deployment plans that leverage the wide scope of RMNCAH services midwives can provide.
- Ensure collaboration between education providers and health workforce planners at the relevant levels of the health systems to secure alignment between graduate numbers and capacity to employ them with due consideration of actual need with more focus on rural areas.
- Develop and implement strategies to recruit and retain midwives in locations where they are most needed. Focus should be on family health houses and midwife-led centers.
- Create career pathways for midwives and link these to educational opportunities and career advancement.
- Use regulatory processes to ensure continuing competence and continuing professional development for midwives.
- 18,000 new midwives need to be trained before 2030 in order to meet the demand in skilled service delivery. Job opportunities in both the public and private sectors should be created to absorb these.
- Consider the CME graduates as diploma midwife (in collaboration with MoE, issue of baccalaureate should be considered).

- Re-considering the situation of certificate exam. The licensing exam should be institutionalized by ANMC.
- Midwives' job discretion should be revised with a focus on ICM competency requirements.
- ANMC should conduct a rapid assessment of midwifery education institutes and advocate to urgently close non-accredited institutes presenting current gaps and underperformances.
- Promote research-based graduation in midwifery pre-service education.
- Mentorship program should be expanded and recruitment of backup midwives should be adopted.
- Regulate midwifery faculty development program to ensure qualified pool of trainers and preceptors.

2. High-quality education and training of midwives

- ANMC and MoHE should monitor and assess the implementation of the midwifery curriculum in all midwifery programs
- Ensure that all midwife educators and trainers are equipped with the skills and knowledge they need for teaching and can maintain their own professional competencies.
- Create career paths that encourage and facilitate midwives to become educators and trainers of the next generation of midwives, especially in the private midwifery education institutes.
- Ensure that there are sufficient experienced and skilled preceptors to provide guidance and supervision during clinical placements.
- Strengthen accreditation mechanisms for both public and private sector education and training providers to ensure that midwives meet established standards for competence and can confidently provide high-quality care to the full extent of their scope of practice.
- Design curricula to include interdisciplinary modules to build collaboration, increase understanding of unique and shared skills, and encourage teamwork; pandemic and emergency preparedness and response (including in fragile and humanitarian settings); and principles of respectful care.
- Assess the need to produce more diploma-level midwives, build their capacity, and focus on bridging system (post-registered midwives' program).
- All graduated midwives should pass a competency-based licensing exam.
- Continuous professional development should be considered for maintaining midwifery services by competent midwives. ANMC, jointly with MoPH, should come up with strategies on the development of a platform for the professional development of midwives.

3. Midwife-led improvements to RMNCAH service delivery

- Communicate evidence about the benefits of midwives as key RMNCAH service providers.
- Promote continuous partnership between midwives and service users to build trust, communication, and mutual respect.
- Treat midwives as equal and respected partners at all levels, including service delivery, management, and leadership of health, particularly involvement in policy development.
- Develop a conducive and enabling environment in which midwife-led continuity of care can flourish, including collaborative partnerships with other healthcare professionals such as nurses, obstetricians, gynecologists, anesthetists, pediatricians and neonatologists.
- Prepare and enable midwives to participate in audit and data collection processes, including Maternal and Neonatal Death Surveillance and Response.
- Apply the lessons learned from Covid-19 to build resilience to future health vulnerabilities, so they do not negatively impact RMNCAH worker education, service delivery, and the enabling work environment.
- There should be a midwifery department at each hospital level with full responsibilities.
- Midwifery-led centre model of care should be integrated into the health system.

4. Midwives association, leadership, and governance

- Raise the awareness of midwives on membership of AMA, including the development of an online registration system.
- Strengthen the provincial branches of AMA for provincial ownership and decentralization concerning management of midwifery issues.
- Create positions at national and subnational levels, including senior midwives within the Ministry of Public Health, so that midwives are represented in all places where RMNCAH decisions are made.
- Engage midwives in relevant policy decisions, programme planning, implementation and monitoring and evaluation at subnational and national levels.
- Build and strengthen institutional capacity for midwives to provide leadership and advocacy to enable high-quality care and increase engagement in health policy decision-making and planning processes.

Annex: Afghanistan profile reflected in SoWMy2021

THE STATE
OF THE
World's
Midwifery
2021

Afghanistan



This country profile should be read in conjunction with the "How to use the country profile" document which can be found at unfpa.org/sowmy

Map is an approximation of actual country borders.

Estimated population	2019	38,041,757
Women of reproductive age (aged 15-49)	2019	8,929,462
Adolescents (aged 10-19)	2019	9,635,671
Total fertility rate (births per woman)	2015-2020	4.56
Live births	2019	1,212,400
Pregnancies	2019	1,782,609
Adolescent birth rate (births per 1,000 women aged 15-19)	2017	62
Maternal mortality ratio (maternal deaths per 100,000 live births)	2017	638
Neonatal mortality rate (deaths within 28 days per 1,000 live births)	2018	37
Stillbirth rate (per 1,000 total births)	2019	28
Births attended by skilled health personnel (%)	2018	59%
Modern contraceptive prevalence rate (% using modern method)	2019	16%
Unmet need for family planning (% of women of reproductive age)	2019	17%
Caesarean section rate (% of live births)	2010-2015	3%
Coverage for 4+ antenatal care visits (% of live births)	2018	21%

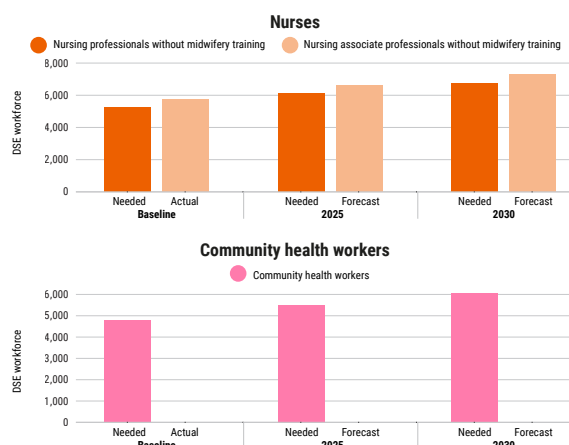
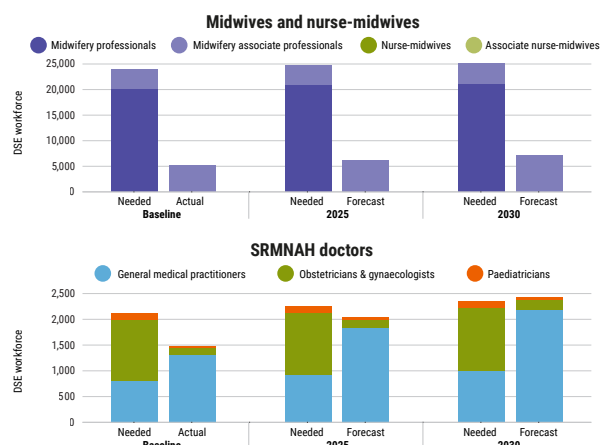
Data sources: see "How to use the country profile" document.

FULL SRMNAH WORKFORCE AVAILABILITY

Occupation group	Year	Headcount (A)	Percentage of time on SRMNAH (B)	Dedicated SRMNAH Equivalent (DSE) (A*B)	Graduates Year	Number	Density per 10,000 population
Midwifery professionals	nr	nr	na	nr	nr	nr	nr
Midwifery associate professionals	nr	nr	na	nr	nr	nr	nr
Midwives not further defined	2018	5,098	100%	5,098	nr	nr	1.3
Nursing professionals	nr	nr		nr	2018	4,507	nr
with midwifery training	nr	nr	na	nr	nr	nr	nr
without midwifery training	nr	nr	na	nr	2018	4,507	nr
Nursing associate professionals	nr	nr		nr	nr	nr	nr
with midwifery training	nr	nr	na	nr	nr	nr	nr
without midwifery training	nr	nr	na	nr	nr	nr	nr
Nurses not further defined	2018	11,483	50%	5,742	nr	nr	3
Community health workers	nr	nr	na	nr	nr	nr	nr
Paramedical practitioners	nr	nr	na	nr	nr	nr	nr
Medical assistants	nr	nr	na	nr	nr	nr	nr
General medical practitioners	nr	nr	na	nr	nr	nr	nr
Obstetricians & gynaecologists	nr	nr	na	nr	nr	nr	nr
Paediatricians	nr	nr	na	nr	nr	nr	nr
Total SRMNAH workforce		16,581		10,840			4.4

Source: National Health Workforce Accounts (NHWA) data platform, accessed Dec-2020, most recent available year.

PROJECTIONS TO 2030, DEDICATED SRMNAH EQUIVALENT (DSE) WORKFORCE

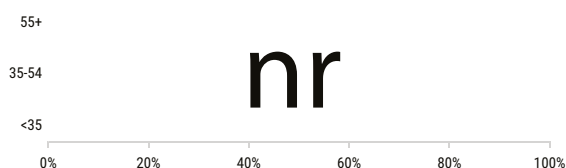


Source: SoWMy analysis, using NHWA data platform, accessed Dec-2020

Afghanistan

WIDER MIDWIFERY WORKFORCE DEMOGRAPHY - Midwives and nurse-midwives (professionals and associates)

Age distribution



Source: National Health Workforce Accounts (NHWA) data platform, accessed Dec-2020, most recent available year.

Gender distribution



ENABLING ENVIRONMENT

Policy environment

National policy guideline that recommends midwife-led care for pregnancy and/or childbirth and/or postnatal period for mother only, or both mother and newborn? *

Pregnancy	Childbirth	Postnatal
no	no	no

Number of midwives in leadership roles in national MoH / sub-national MoH / regulatory authorities

National MoH	Sub-national MoH	Regulatory authorities
0	331	7

Education

National policy / guideline on education of midwifery care providers based on ICM competencies? *

yes

Midwifery education pathway (direct entry / post-nursing / combined)?

Direct entry	Post-nursing	Combined
yes	no	no

Duration of direct entry / post-nursing / combined education programme (months)

Direct entry	Post-nursing	Combined
48	na	na

% of midwifery educators who are midwives

100

Regulation

National policy sets a competency framework for maternal and/or newborn care? *

no

National policy on regulation of midwifery care providers based on ICM competencies? *

yes

Regulatory body for midwifery practice?

yes

Is licensing compulsory prior to practise? / Is there periodic relicensing? / Is continuing professional development a requirement for relicensing?

License compulsory	Periodic relicensing	Continuing development requirement
no	na	na

Association

Is there a professional association specifically for midwives? Is there another professional association open to midwives?

Association specifically for midwives	Other association open to midwives
yes	no

Source: 2020 ICM survey, except those marked * which are from 2018-2019 WHO SRMNAH policy survey

Key:
na = not applicable
nr = not reported

dk = don't know
MoH = Ministry of Health

POTENTIAL TO MEET NEED AND DEMAND, 2019 AND 2030

Potential to meet **NEED** = $\frac{\text{Workforce time available}}{\text{Workforce time needed for universal coverage of essential SRMNAH interventions}}$

SoWMy 2014[§]



23%

SoWMy 2021



35%

2030



41%

Potential to meet **DEMAND** = $\frac{\text{Supply of health workers}}{\text{Health workers system can support}}$



2030 supply is **severely below** capacity to employ

§ or most recent regional SoWMy report: East & Southern Africa 2017 or Pacific States 2019

EXPLANATORY NOTES

There are 2 types of direct-entry midwife education programme: (1) a 48-month Bachelor's programme and (2) a 24-month Diploma programme.

Source: Additional information provided by national stakeholders during data collection and validation.



THE STATE OF AFGHANISTAN'S MIDWIFERY 2021