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FINANCIAL AND NON-FINANCIAL INCENTIVES TO IMPROVE MIDWIFE RETENTION IN PAKISTAN

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DISCLAIMER

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Executive Summary

Background

The current system of education for professional midwifery in Pakistan includes four cadres of midwives: RN/RM (Nurse Midwife) who receive three years of nurse training and one year of midwifery training, Registered Midwives (RMs or *Pupil Midwives*) who complete a 15-month program in midwifery, Lady Health Visitors (LHVs) who complete one year of midwifery training and one year of public health/tropical medicine training, and Community Midwives (CMW), private practitioners who complete an 18-month midwifery training program.

Pakistan is experiencing a generalized Human Resources for Health (HRH) shortage, which includes midwives. In addition, maldistribution of HRH shows in higher vacancy rates in rural and remote areas. Midwives, as with all cadres of HRH, are reticent to accept and continue in rural and remote postings.

Methodology

In order to recommend interventions to countermeasure the midwife retention problem, the TACMIL project undertook the following activities: an international and regional literature review of what works to improve retention, especially in rural and remote areas; focus group discussions (FGDs) with midwives; and key informant interviews with officials who have influence over midwife hiring, posting, and compensation, in four provinces and the federal level. FGDs were conducted in four kinds of areas: remote, rural, peri-urban, and urban. We conducted key informant interviews (KIIs) with government officials in Islamabad, Punjab, Sindh, NWFP, and Baluchistan.

Findings

The most important factors inhibiting midwife retention included not being posted in the same area as their husbands, poor condition of equipment in rural areas, lack of opportunity for clinical in-service training, lack of opportunity for career growth (promotion), substandard or too-expensive housing, and lack of recognition for hard work or good performance. The most salient findings from KIIs included the fact that length of posting rules are not applied, rules about private practice are vague and not applied consistently, and that there is no system in place to plan, measure, or reward performance.

Recommendations

The most important, impactful, and lowest cost interventions to improve retention are:

1. Assure that midwives are posted near their husbands.
2. Require mandatory and fixed-length (two years) remote posting for young midwives, shortly after graduation.
3. Formalize and support midwife private practice in off hours, to mitigate low-pay issues that are driving midwives into the private sector.

Additional interventions include supportive supervision training, recognition for hard work and good performance, assessment and improvement of accommodations, and adherence to a career ladder.

Background

Midwives in Pakistan

The current system of education for professional midwifery in Pakistan includes four cadres of midwives.

- **RN/RM (Nurse Midwife):** This cadre undertakes a 1-year midwifery program after completion of a 3-year diploma in nursing. RN/RMs are facility-based.
- **Direct entry midwives (RMs or Pupil Midwives):** Have completed a 15-month program in midwifery. This program of education is expected to be phased out over the next three years, but RMs will remain in the system until the last of them retires, which could be as late as 2037. RMs are facility based.
- **Lady Health Visitor (LHV):** LHVs complete a 2-year post-secondary school program consisting of one year of midwifery training and one year of public health/tropical medicine training. This program represents a non-nursing, direct-entry midwifery education, developed with the goal of providing skilled professionals in rural areas. LHVs are facility based.
- **Community Midwife (CMW)** is a new cadre created to increase the availability of professional midwives in rural areas. CMWs complete an 18-month midwifery program post secondary school. As with LHVs, this educational program represents a non-nursing direct entry program. CMWs are private practitioners (not government employees) who receive training, mentoring, supervision, and material support (e.g., delivery kits) from the government.

Each midwifery cadre meets the ICM International Definition of the Midwife.

Human Resources for Health Issues in Pakistan

While there are few quantitative statistics concerning midwife numbers and distribution, Pakistan is experiencing a generalized Human Resources for Health (HRH) gap concerning overall numbers of healthcare workers, distribution of the current stock, and inappropriate skill mix compared to needs. Based on service delivery goals, especially of the EHSP, and WHO-accepted ratios of healthcare worker to population, there is an absolute shortage of healthcare workers. Further, there is a maldistribution of the providers there are: the rural parts of the country are experiencing the greatest burden of disease due to proportion of population living in rural areas and other high risk factors, yet have the lowest numbers of health care providers. The skill mix of the current stock of providers does not match the needs of the health team concept in order to provide the EHSP. Inadequacy of current planning, production, and management practices all contribute to these challenges.¹

(As of this writing (December, 2009) an exhaustive HRH assessment is currently underway in Pakistan. The assessment is being undertaken by the MOH with support from WHO/Pakistan, the WHO Global Health Workforce Alliance, and the USAID TACMIL project. The results of this assessment will provide substantive quantitative information about the numbers and

¹ *Human Resources for Health Strengthening in Pakistan*, WHO and TACMIL project (USAID), 2009.

distribution of the various healthcare worker cadres in Pakistan. Results are expected to be published by the MOH and WHO/Pakistan in early 2010.)

Methodology

Interventions for retention are generally specific to a population of employees. There are, however, some global similarities in needs of employees related to job satisfaction and retention. To meet the need for information about what works globally, along with specific information about the work lives of Midwives in Pakistan, the Project took the following information-gathering steps:

- International and regional literature review
- Focus group discussions with midwives
- Key informant interviews with Government officials who help set and apply employment policy for midwives in Pakistan

International and regional literature review

Little research is available about job satisfaction and retention of healthcare providers in Pakistan. For this reason, the Project sought additional information in order to base the retention intervention recommendations on known best practices. To this end, the Project Human Resources for Health (HRH) experts conducted a thorough search of the literature on causes of healthcare worker turnover, and best practices for improving worker satisfaction and retention. Where available, special emphasis was given to studies in the Asian region.

Focus group discussions with midwives

The project conducted focus group discussions with midwives in order to learn about their perceptions and experiences about working and living conditions as a midwife working at a government facility. Because working and living conditions are typically different in more rural vs. more urban areas, the Project conducted FGDs in the following four types of geographic areas: urban, peri-urban, rural, and hard to reach. Specifically, the areas for FGDs were:

- Remote: Kalat District, Baluchistan
- Rural: areas outside Mardan, NWFP
- Peri-Urban: Larkana, Sindh
- Urban: Rawalpindi, Punjab

The FGDs included questions on working conditions, living conditions, and support for good performance. (The FGD guide, with all questions, is attached in the appendix.)

Key informant interviews

Because healthcare is owned by the provinces, key informant interviews were done in four provinces: Punjab, Sindh, NWFP, and Baluchistan, as well as in Islamabad for information about Federal facilities. Key informant interviews sought information about current employment practices, as well as the feasibility of implementing additional incentives or policy changes to boost midwife productivity. (The Key Informant Interview guide is attached in the appendices.) Interviewees included officials from

- Ministries of Finance
- Ministries of Health
 - Directors General
 - Accounts Officer

- Nursing Directors
- Controller of Nursing Exams
- Director of Health Services
- MNCH Program Director
- Additional Secretary of Health (Planning)
- Planning department Officials

Findings

Based on our investigations, midwives in Pakistan have a mixed level of satisfaction with their working and living conditions. Midwives in all areas share several views (e.g., burdensome workload). There are, however, some important differences in perceptions between midwives in more urban areas, and midwives in more rural areas.

Focus Group Discussion Findings

The findings of the focus groups in the four areas are summarized in the table on the next page.

Working Conditions

All midwives felt that they had little or no say in the place they were posted. Surprisingly, midwives also indicated that the posting location of their husbands was not taken into consideration when posting them. This practice is a departure from policies in most other countries we have studied, in Sub-Saharan Africa as well as Bangladesh and India (Nepal being a notable exception). All midwives indicated that the workload was too high for the number of staff at their facilities. Medicines of various kinds were usually available in the urban area but frequently in short supply in the other areas. Likewise, equipment was usually available in urban areas but either absent or in disrepair in other areas. Basic utilities were usually missing in the remote area we visited but available in the other three. While team spirit and relations were generally good, some midwives said that doctors were rude or “snubbed”² them.

Salary and compensation

All midwives indicated that their salaries were too low considering their workload. This response is consistent with virtually all employee-satisfaction studies. Medical benefits availability was spotty: midwives in remote and peri-urban areas indicated they received no medical benefits at all, while those in rural and urban areas said they received medical benefits. While all midwives reported taking part in private practice, those in remote areas said the practice was not a practical way to boost their income, because their patients were too poor to pay very much. While all midwives receive 25 days of leave per year, many were not allowed to take it all. Supervision is regular, and generally supportive, but again midwives reported some disrespectful “snubbing” from doctors. No midwives reported the chance to attend higher learning courses; midwives in urban areas did get a chance for some infrequent clinical updates or in-service training.

Living conditions

While all midwives were generally unhappy with the housing available to them, they were displeased for different reasons. Those in urban areas felt that housing was prohibitively expensive, while all other groups reported that adequate housing was simply unavailable. In a departure from what is found in other countries, even midwives in remote and rural areas

² Said derogatory things about them in front of others including patients.

reported the availability of generally good-quality schools for their children. (These comments about schooling run so contrary to the experience of most of the other key informants we spoke with that it bears further investigation before basing the incentives on this one finding.) Communication technology is universally available, but social opportunities and reliable transportation is only available in urban areas. Midwives in remote, rural, and peri-urban areas complained of having to travel with “animals and men.”

Performance support factors

Some midwives receive job descriptions with their appointment letters or thought that their appointment letters served as adequate job descriptions. Others said they had “heard of” job descriptions but had never seen one. All midwives received some verbal recognition for hard work or good performance, but all wanted to receive written recognition, perhaps in the form of a certificate that would be considered when applying for promotion. Because the existing confidential review is confidential *from the midwives themselves* it cannot serve as performance feedback to the midwives. They all expressed a desire for written performance appraisals.

Suggestions for remote-posting incentives

When asked about what incentives to give to induce midwives to serve in rural or hard-to-reach areas, suggestions were similar across the four groups:

- Mandatory posting limited to one or two years
- Salary or allowance increases to the amount of double current salary
- Focus on safety of accommodations
- Provide transport or a higher transportation allowance
- Give preferences in promotion and transfer to those who have served in these areas

Item	Remote (Quetta)	Rural (Mardan)	Peri-urban (Larkana)	Urban (Rawalpindi)
Working conditions				
Posting Choice	<ul style="list-style-type: none"> • None. • Some posted in their own area. • Husband's posting not taken into consideration. 	<ul style="list-style-type: none"> • None • Husband's posting not taken into consideration • Some use influence for posting location 	<ul style="list-style-type: none"> • Mostly no choice. • Some can have choice, others, no. • Transfer/ posting by choice is difficult. • Husbands posting no longer taken into consideration. 	<ul style="list-style-type: none"> • Ultimately up to government where they get posted. • Required long and complicated process. • Husband's posting mostly not taken into consideration.
Patient Load	Too high	Too much, crowded	Not too much because of bad condition of the facility and shortage of medicines. Only big hospitals has client load.	Too high
Enough Staff?	Insufficient (see above)	No experienced staff	Shortage of staff even on big hospitals.	Big shortage, a real problem.
Supply of meds	Not enough	Shortages`	Medicines are often short	Available generally but some shortages of delivery kits due to high numbers of deliveries.
Equipment?	None.	Short of equipment. Repair took too much time.	Available for labor room	Available but short according to patient load.
Water supply	Very rarely available	Available	available	Available
Electricity	Only to some facilities	Available	available	Available
Toilet?		Available. But some are not in working condition.	Some facilities don't have in proper condition	Available
Team Support	Good relations	Good working relations	Supportive	Rude/uncooperative attitude of doctors.
Salary/Compensation				

Item	Remote (Quetta)	Rural (Mardan)	Peri-urban (Larkana)	Urban (Rawalpindi)
Salary	Too Low	Too low as compare to work and cost of living. Three of them didn't receive pay for 8 months (working with some project).	<ul style="list-style-type: none"> • Too low compared to work load and also from other provinces. • Some new midwives didn't get salary for three months. 	<ul style="list-style-type: none"> • Too low compared to workload. • Raises don't keep pace with inflation. • Experience does not count.
Med. Benefits	None	Yes, and they use it freely	None	Yes, but sometimes have to work hard to receive them.
You do private practice?	Some, but most patients too poor to pay for it.	Have to work privately because of low salary.	Yes, "to make ends meet."	Unaware of this practice. When try to do it are highly discouraged.
Leave	25 days, but sometimes not allowed to take it	Get 25 days, but not always allowed to take it.	Get 25 days, some can use it, some can't.	Get leave, but can't use it because of the shortage of staff.
Supervision	Not supportive. Deduct pay on very little issues.	<ul style="list-style-type: none"> • Daily by facility in-charge. • Generally supportive 	Supervisor visits 1 or 2 times a month. Generally supportive, but sometimes "snub" in front of everyone.	Regular, but "snubbing is very common."
Higher learning	No opportunity	No opportunity	No opportunity	
In-service training	Only for some refresher training, but "no clinical training opportunity." Some only for those "close with government officials")	Some have trainings.	We do have training but only for those who have good relations with authorities. Only in Sindh.	Now allowed to attend. (Change from the past.)
Promotion or transfer?	Not available	Transfer very difficult	Promotions not available. Transfers very difficult.	Very hard
Job Satisfaction				
Overall job satisfaction		Mostly not satisfied. Due to low salary and work load.		Not fully satisfied. If got any better opportunity, we'll surely move.
Plan to transfer	Yes, to our own residential locality	Yes, to some higher facilities	No.	No.
Performance Support				

Item	Remote (Quetta)	Rural (Mardan)	Peri-urban (Larkana)	Urban (Rawalpindi)
Job description?	Heard of them, not seen	We have it but don't read it.	Yes, in appointment letters we have job description. Last seen within a month.	We received when we got the appointment letter.
Recognition for good performance?	Some verbal, but want written.	No recognition. Want public notice of good work. Want to be praised in front of other staff.	Some verbal, but want written. Mostly don't appreciate but reprimand often.	No appreciation. Want to be praised with an annual certificate. Very rare, mostly don't appreciate
Performance appraisal system	None		Only verbal. Should be some gifts/ written and in public	Only verbally. It should be written and in some official function.
Living Conditions				
Accommodation	Below living standards	"not good"	Below standard	Very expensive in urban areas.
Utilities (water/electricity)	Very rarely available		Mostly available	Available
Schools for children	Available	Available	Available	Available
Accessibility/Transport	Bad, have to travel with animals and men.	Difficult for females.	Travel is available but conditions are not good. We cannot travel in evening and night.	Available but hard to get because of load.
Communication	Available	Available	Available	Available
Social Opportunities	Nil	Nil	Very rare	Available
Recommendations for posting in Hard area				
Mandatory posting/time period?	No more than 2 years	At least for 1 year	No more than 2 years	Should be mandatory for one year.
Salary differential?	Double plus benefits	Double than normal	Double	50% additional salary
Housing?	Accommodation should be provided with safety	Accommodation with safety	Improved and safe accommodation should be provided.	Should be provided
Schools for children?	(No discussion)	(No discussion)	Some	Must
Transportation allowance?	Transport or transportation allowance should be given	Should be given	Should be given	Should be given

Item	Remote (Quetta)	Rural (Mardan)	Peri-urban (Larkana)	Urban (Rawalpindi)
Preferential access to higher study	Yes, we will go for higher studies. Waiting for a chance.	Preference should be given to those who work in hard area	Should be preferably promoted	Preference should be given to those who work in hard area.

Key informant interviews

The purpose of the key informant interviews was to understand current employment practices, as well as the feasibility of implementing incentives such as increased allowances or mandatory postings. Completed key informant interview guides appear in the appendices. The results are summarized below.

Creating new posts

Baluchistan: Site identifies need, elevates to EDO, MOF signs off on money available.

NWFP: Site, EDO/DGHS, then MOF

Punjab: In-charge of facility, EDO, DG Health, MOF

Sindh: The EDO/DDO identifies the need and sends to the Provincial Health Department

Filling vacant posts

Baluchistan: Grade 15 and below: DGHS and EDO conduct normal advertising and interviewing process. For grades 16+, PSC does it.

NWFP: EDO for posts 1-10, DCO for posts 11-15, PSC for posts 16+, normal advertising and interviewing process.

Punjab: Grades 1-15, EDO does all. Grades 16+, EDO proposes, Finance Department approves, PSC does application process.

Sindh: EDO sends a request to the Secretary of Health. Then follows the standard process of advertisement, short-listing, interview, selection, and approval by the secretary of Health.

Decisions about posting location and duration

Baluchistan: No special rules. DGHS posts midwives where needed. Midwives may apply for specific post, then they go there. The policy is three years in most areas, one year in HTR areas, but these rules are never really applied.

NWFP: Most apply for specific posts. Some midwives are posted near their homes. Grades 16+ are sent where they are needed. Postings *should be* for three years.

Punjab: Usually posted near their homes, or they apply for a specific posting, or the EDO decides.

Sindh: Decided by the Secretary of Health or DG Health in consultation with the EDO. Posting should be for three years, but this policy is never applied. Personal connections help to get a good posting.

Opportunities for promotion or other advancement

Baluchistan: Based solely on seniority and qualifications.

NWFP: Five years in current post, availability of position, ACR record.

Punjab: Currently under review, but by seniority and qualifications.

Sindh: Based on vacancy, seniority, and qualifications.

Regulations concerning private practice by public-service doctors and nurses

Baluchistan: Allowed after normal hours. No non-practice allowance for midwives.

NWFP: Midwives are not allowed to do private practice.

Punjab: No rules, it is allowed. No non-practice allowance for midwives.

Sindh: No rules, but everyone does it.

Performance evaluation, recognition for good performance, sanction for poor performance

Baluchistan: No formal system of performance review or recognition.

NWFP: No formal system of performance evaluation or recognition.

Punjab: No clear system. Some nurses (RN/RMs) do receive commendation letters, but this never happens for midwives (RMs).

Sindh: No performance evaluation and no recognition for good performance.

Process for increasing allowances or preferential treatment for rural and remote postings

Baluchistan: Facility in-charge proposes to EDO/DGHS, then to MOF.

NWFP: Secretary of Health would propose, MOF would approve.

Punjab: In-charge, EDO Health, Health department, Finance Dept, Secretary Health/Chief Secretary/Chief Minister.

Sindh: Proposed by EDO or Secretary of Health. Finance department must approval all budgetary amounts.

Recommendations

Based on the international and regional literature review, our findings from FGDs and KII's, and experience in many other countries, our recommendations for retention interventions appear below. The recommendations are broken into two sections: interventions for improving midwife retention in general, and for reducing post vacancies in rural and remote areas.

Interventions for retention in all locations

Posting at same location as husband.* Perhaps the most important change in order to keep midwives in any post, is to be sure to post them where their husband is posted. As would be expected in any country, being required to live apart from their husbands and/or families would make it difficult for any midwife (who are all female in Pakistan)

to keep her post. The decision for women whether to keep a government job or keep their family in one location will likely be a quick one.

Assessment of accommodation issues. From our FGDs, housing problems appeared most often in complaints about government service as a midwife. The MOH should develop basic minimum standards for government housing. Based on these standards, an assessment of government housing should be commissioned. Where housing does not meet minimum standards, contractors should be employed. In addition, one employee in the District Health Office should be given responsibility for maintaining the quality of government housing for midwives. In urban areas such as Karachi and Islamabad, the MOH should assess the costs of housing compared to the allowances, and make adjustments for cost of living.

Clarification and innovation of private practice policies. * The ability to do some limited private practice is important to allow midwives to augment their salaries, which they feel are below subsistence level. Based on experiences in other countries, Provincial Governments could institute pilot studies on allowing midwives to conduct private practice in their government facilities, after normal work hours. These types of practices offer several advantages, at little or no cost to the Government. These advantages include better income for the midwives, increased traffic in facilities by patients who may utilize other services while there, and less chance of equipment and supplies being borrowed for use in private facilities.

Supportive supervision training. At fairly low cost, Provincial MOHs can adapt and implement an existing supportive supervision curriculum. Through a cascade training method (Federal to Province to District) supportive supervision skills could be upgraded significantly. In most global studies of retention, the relationship with the supervisor is one of the most important factors for retaining employees of all types. Supportive supervisors could also help deliver much-desired recognition for good performance, described in more detail below.

Performance review system. As part of the supportive supervision system described above, midwives should receive formal, annual performance planning and review sessions. Performance planning reinforces job roles and quality standards. Performance review based on good job descriptions helps midwives improve their performance, and builds morale, especially among good performers, whom the government services are most keen to retain.

Recognition for good performance.* As part of a comprehensive supportive supervision and performance evaluation system, providers should receive recognition for extra effort and for good performance. At a minimum, supervisors should verbally praise good performers. Midwives in Pakistan are also interested in receiving written recognition for good performance, perhaps in the form of certificates of achievement. Such written recognition certificates, placed in employee personnel files, could be used when making decisions about promotions. Finally, notices in national or provincial newspapers of the *employee of the month* or similar systems, have improved morale and helped providers strive for high-quality of service.

* Interventions with little or no additional funding necessary.

Interventions for retention in rural and remote postings

Fixed/required length of posting—adherence to policy.* Perhaps the single most important change that can be made to reduce rural/remote vacancies is to 1) require remote posting for young providers, typically immediately following graduation. Young midwives are less likely to have families, and are intrinsically motivated to serve the citizens of Pakistan, thereby paying back for their midwifery education. A fixed length of service (one to three years, determined by in-depth studies of the motivation of midwives in Pakistan) is crucial to allow midwives to keep their postings. Seeing “the light at the end of the tunnel” is a vital psychological factor that has proven successful in many developing countries.

Wherever possible, midwives should be recruited from, and posted to, their home areas. Midwives from more urban areas may be reticent to serve in remote areas for safety reasons. In these cases, the locally-recruited midwives may prefer to stay in remote or rural areas which would be allowed.

Classification of posts A-D. Following a practice that has been successful in a few developing countries and is showing promise in several others, we recommend that provinces categorize health care facilities in A-D categories. Facilities should be rated most- (A) to least-desirable (D) according to criteria set nationally. The criteria should be selected by panels of experts, including midwives themselves, but will include factors such as distance to urban centers, availability of transport and communications (mobile phone and internet), reliability of utilities, and proximity of schools, shopping, and community centers.

Adherence to career ladder (new). In FGDs, midwives in rural and remote areas complained of being sent far away from government institutions and “forgotten.” The clear perception is that once in such a posting, career opportunities and advancement stop completely. We recommend that Ministries of Health act on recent recommendations to establish clear career ladders for midwives. The career ladders will show the advancement opportunities available to midwives, along with the educational and experiential requirements for advancement. While some midwives will prefer to stay in their entry-level positions for their entire careers, others will want a clear path forward. Career ladders empower midwives to take control of their own career progression, and such self determination in and of itself improves morale and retention. Finally, a clear career ladder shows midwives that a move outside of public service is not the only path for advancement, which could improve retention.

Availability of clinical training. Midwives in urban centers have access to clinical in-service training that is unavailable to rural and remote posted midwives. One of the most plentiful interventions typically sponsored by donors is training events. Provincial MOHs should set up a schedule of training for rural and remote midwives so they receive clinical updates at least once per year. Donor-funded training initiatives can be guided away from the usual urban-center delivery sites, and rural/remote midwives can be brought together at central training venues in rural areas.

Improved transportation allowance. Based on the A-D categorization of facilities described above, MOHs should conduct an analysis of actual out-of-pocket expenses

incurred for travel by midwives in remote locations. Allowances should be set to cover the actual costs, reducing the penalty for serving in these locations.

Equipment supply and maintenance. There is a clear differential in availability of equipment, and the level of maintenance and repair of what equipment there is, between urban and rural areas. Provincial MOHs should develop a minimum-equipment list for deliveries for each type of facility. Facility in-charges should be oriented to the lists, and should appoint a staff member responsibility for reporting missing equipment or that in disrepair. EDOs should likewise plan and budget for ongoing equipment purchase and repair, in order to be responsive to requests from the facilities.

* Interventions with little or no additional funding necessary.

Conclusions

Midwives in Pakistan are suffering from low morale, which leads to problems with retention. While improvements are needed in all areas of the country, these issues are even more acute in rural and remote areas, where vacancy rates are even higher. While the list of interventions above may appear daunting, there are a few high-impact and low- or no-cost interventions that can be implemented immediately. Federal and Provincial MOHs, if they have the political will, can make immediate changes that will impact morale and retention significantly, at no impact to their budgets. Therefore, we recommend MOHs take the following actions immediately, while formulating a more comprehensive plan for midwife retention.

1. Assure that midwives are posted near their husbands.
2. Require mandatory and fixed-length (two years) remote posting for young midwives, shortly after graduation.
3. Formalize and support midwife private practice in off hours, to mitigate low-pay issues that are driving midwives into the private sector.