SUSTAINING THE MIDWIFERY RECRUITMENT AND RETENTION SCHEME THROUGH ADVOCACY

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Retaining all the graduates from the Health Training Institutions, particularly in the rural and remote areas, is critical in achieving reduced maternal, neo-natal and child mortality. All stakeholders have a role to play to achieve sustainable results.

Background

Northern Nigeria has fewer nurses and midwives per capita than the rest of Nigeria. In fact, the health worker ratios are well below neighbouring countries, even those with lower per capita incomes than Nigeria. The root cause of the shortfall in healthcare workers is severe underinvestment in pre-service training of health workers. Other factors, including graduation rates, recruitment into the workforce, and workforce retention, have room for improvement, but fixing all of these issues is a daunting task. With the population growing at a faster rate than the health workforce, the gap between available health staff and demand for their services will widen over time [i].

The Midwifery Service Scheme (MSS)[ii] was mooted by the Federal Government to mitigate this crisis in 2009. Following initial gains from the scheme, there have been quite a number of challenges in the past few years making the scheme a less sustainable solution to the issue of recruitment and retention of Midwives in rural communities particularly. Major challenges[iii] to the scheme include difficulty in achieving retention, non-availability of eligible candidates to be posted to the far North, insecurity and inability to secure training opportunities for the posted midwives as well as non-uniform levels of commitment from state and local governments across the country. And despite the availability of skilled birth attendants at MSS facilities, cultural attitudes and behaviours mean that women continue deliver at home in some parts of the country.

This brief is a record of the ongoing efforts of Women for Health (W4H) to catalyze the process of sustainably recruiting and retaining midwives in rural communities of five Northern states (Jigawa, Kano, Katsina, Yobe and Zamfara). The goal of W4H advocacy is to reduce maternal and neonatal deaths through increased health service uptake, increased ante-natal care attendance and increased access to skilled birth attendants (SBAs). W4H built on the existing MRRS developed during the PRRINN-MNCH programme and took over support to it in 2013. The W4H State teams have been

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advocating to the state governments, local governments and the communities on recruitment and posting of midwives to rural areas, good and comfortable accommodation for midwives posted; regular payment of salaries and allowances as well as supportive supervision. The last of the 'asks' from the above targets is in-service training for the posted midwives. This has been a major challenge as will be explained.

The Response

MRRS was an important output of W4H at inception. However, this is no longer the case. However, MRRS remains an important advocacy issue. W4H has two main approaches to the issue of recruitment namely: Direct recruitment by W4H and advocacy to government to recruit more nurses and midwives.

a. Advocacy for recruitment and in-service training

Advocacy to state governments to include in-service training for the recruited midwives has been a major challenge. In Yobe state, there have been no professional in-service trainings for the MRRS midwives yet and the state has no formal system for rewarding rural midwives. In Katsina state, trainings have been arranged for the recruited midwives by including them in trainings organised by partners such as UNICEF, WHO, Save the Children, MNCH2 and others.

W4H has encountered varying degrees of challenges in getting the state governments to recruit midwives. In Zamfara, a major breakthrough was achieved as a result of a large number of health workers recruited in 2014 leaving the state service. The Health Service Management Board (HSMB) slotted the W4H midwives into the vacancies. The agreement reached was for the state to gradually take over the incentive package which consists of allowances, training, supervision and accommodation.

In Zamfara State, high level advocacy was conducted to Local Government Area (LGA) chairmen and legislators on recruitment of new graduate midwives. The Health Training Institutions (HTIs) were engaged to forward the names of new graduate nurses and midwives to government. W4H collaborated with State Ministry of Health and Health Service Management Board (HSMB) to prepare a memo on MRRS which was presented to the Governor for his consideration.

In Yobe State, the local governments were made aware of MRRS by W4H, and the LGAs have started to put pressure on the State Primary Health Care Development Board (SPHCDB) to post midwives to the LGAs. W4H has been collaborating with the HTI management and the state advocacy teams and involving them in the advocacy to the state to recruit more health workers, particularly midwives. W4H has also advocated alongside DFID and met with the Governor on MRRS. While in Jigawa State, MRRS was initiated with an advocacy visit to the Governor to secure his understanding and buy-in, to improve supply and retention of midwives in Jigawa.

b. Retention of health workers

While getting government to recruit more health workers remains a very difficult proposition largely because MRRS may not be a priority of government, retaining the few ones recruited is even more difficult. W4H has been demonstrating best practice on recruitment and retention. Decent accommodation for recruited staff in the rural areas has remained one of the most difficult issues.

In Yobe state, the LGAs and communities have become very active in the process of retaining the recruited staff. Part of the 'asks' from the states, LGAs and communities include payment of monetary midwife specific rural allowance, women-friendly, comfortable rural accommodation, in-service training and placement of midwives in functional rural health facilities. W4H has advocated to the LGAs and communities to give the recruited staff appropriate and befitting accommodation and allowances.

At the beginning of MRRS in Katsina State, there were no formal in-service training arrangements for MRRS midwives. W4H support existing initiatives by sending MRRS midwives to state or NGOs organized trainings, such as Lifesaving Skills training workshops. There is no specific award or recognition for midwives in the state. However, some communities (e.g. Tandama) give awards to midwives to honour their achievements.

In Jigawa state, W4H also advocated to meet with the stakeholders and agreed to build 7-unit midwives accommodation that can accommodate 28 midwives. The Government as a result of W4H and stakeholders' advocacy, reciprocated and built and furnished 26 rural midwives accommodation for 52 midwives. In 2016, the Government plans to build 26 rural midwives accommodation.

The Result

The annual MRRS evaluation has revealed that the scheme is progressing well in all the 5 of the W4H supported states, although they are all at different stages of implementation and maturation because of the complex interplay of social, political and security related factors that are unique to each of the states.

The initial challenge of recruitment of midwives for service in rural areas is, steadily albeit slowly, being overcome through the engagement of midwives from the Midwives Service Scheme (MSS) and other Government sponsored initiatives as well as the acceptance by the state governments in all the W4H states to absorb these midwives after serving in rural areas. After mandatory service, the midwives are encouraged to apply for a permanent and pensionable appointment with the state during the last recruitment exercise. No recruitment has been initiated in the very challenging 2015 election year.

Retention of midwives in rural areas has been relatively successful as evidenced by relatively low attrition rates in all the states. However this can potentially get worse in future because most of the MRRS midwives in the scheme now are young and unmarried, do not get paid their full allowances regularly, have some problems with their accommodation, are eager to further their studies, and are from cultural backgrounds that are different from that of the host communities.

In Zamfara, the state has promised to take on the incentive package, but apart from provision of rural accommodation and supervision, professional trainings are not done except the ones that are partner-supported and allowances are only paid by few LGAs.

In Yobe State, as a result of W4H advocacy, the state government in 2015 recruited 92 nurses and midwives, and there is room to employ more midwives[v]. Furthermore, the team has been able to push for the inclusion of renovation of midwives' accommodation across the state in the 2015 annual health budget. Monthly integrated supportive supervision and mentoring have been going on, and the outcome of the exercise is shared with the SPHCMB for further action. Similarly, the LGAs have taken over the payment of the rural accommodation allowance to the midwives working in the rural areas. To fulfil its pledge, the Yobe State government in 2015 has re-absorbed all the midwives under the pay roll of W4H. The state government approved the state Human Resources for Health (HRH) policy in 2015. Chapter 4 of the document specifically addresses gender and health equity in human resources development and management.

W4H Community Engagement initiatives have been yielding strong results too as more citizens are now positively engaged. Some of the communities in Yobe State (e.g. Murfa Kalam community) have shown a high level of ownership and commitment by providing security for the midwives working in their health facilities. Junbam Community has provided an electricity generating set and stipend for fuelling the generator on a monthly basis, while some other communities provide accommodation for the midwives posted to their areas. The MRRS midwives receive a rural allowance of N20, 000, and W4H pays the salary of W4H supported midwives.

In Katsina State, a high level of political commitment and ownership for MRRS is evidenced by the fact that the State has agreed to adopt a harmonised bundle consisting of rural allowance for midwives, in-service training, mandatory transfer for rural midwives after two years of service in a rural area and award (at state level) as well as reward (at all levels) for high performing rural midwives.

Katsina state has adopted a gender mainstreamed HRH policy signed by the State Governor. Danmusa LGA in the state shows a good level of political commitment and ownership towards the MRRS by recruiting and paying for two midwives to work in rural health facilities in the LGA. Yantumaki community provides free accommodation, security, spiritual and psychological support to the midwives in their community to encourage them to stay in the area. The state has a functional SPHCMB that is collaborating with W4H on the MRRS program.

Table 1. Number of rural midwives funded by organization/ scheme in Jigawa by April 2015

Name of organization/ Scheme	Number of rural midwives
MSS	76
SURE- P[iv]	90
W4H	16
SMoH	90
TOTAL	**272**

In Jigawa state, the sum of N30, 000 is paid to all midwives serving in rural facilities. Table 1 refers to the number of rural midwives funded by various organisations and schemes as of April 2015.

Jigawa rewards hard working staff including midwives through recognition, award of gifts, promotion, and scholarship for training and employment of midwives after their mandatory service. Training in Jigawa is continuous. The state has provision for continuing education training for all staff in their HRH policy. Retention rate for midwives was 69% in 2013 improving to 77% in 2014[vi].

Lessons learnt and recommendations

W4H is a programme that spans 5 states in Northern Nigeria. The contexts differ from state to state. The political actors are also different from state to state. Even though the advocacy issues are similar, the challenges are not exactly the same. So W4H has had to apply approaches that differ from state to state in its approach to advocating on MRRS.

Collaborating with various partners working on MRRS is quite important. It is critical that all partners harmonise their position on this important issue so that they can always speak with one voice to government.

The legislature has very important roles in MRRS that is not yet being fully pursued. It is important that this important arm of government is engaged fully on this through advocacy going forward.

The community has a great role to play in MRRS. Experience shows that engaging the community can lead to ownership of the process by the community, as evidenced in Yobe. Decent accommodation can be made available by the community and they can provide the needed security to enable recruited midwives to feel at home and wanted.

Success with MRRS has been shown to be directly proportional to the level of political will by state government and level of community support for the initiative. Presence of a powerful and functional HRH forum that understands the need for MRRS is also critical.

Presence of a strong Primary Health Care Agency in a state has been found to be important for a sustainable MRRS. It is important to include advocacy for a functional Primary Health Care Agency in all efforts to get MRRS going in each state.

Challenges to W4H advocacy

Bureaucracy has been a major problem in getting the state government to understand the issue and take action. This has tended to delay advocacy action to a very large extent. Getting government commitment especially in getting the needed funds to recruit and retain midwives in rural communities remains a major challenge.

Lack of Local Government autonomy makes the LGAs unable to carry out a number of responsibilities required of them.

The year 2015 has been challenging. It is an election year when no recruitment of midwives has been done by any of the states and there has been long and painful transition in three of the states due to change of government. This has made advocacy on MRRS very difficult because the target influencers for the advocacy teams were not available for much of the time.

It is difficult to find indigenous and self-sustaining civil society organization (CSO) to sustain the gains of W4H on MRRS Advocacy. W4H will have to find at least one CSO to sustain the advocacy particularly getting communities to continue to play their key roles.

Getting midwives to take up employment even if government decides to recruit is difficult in some of the states where insecurity is an issue, particularly in Yobe state.

Efforts of Government should go beyond strengthening HTIs and the subsequent increase in the number of recruited health workers. Absorbing all the graduates from the HTIs and retaining them, particularly in the rural and remote areas, is absolutely necessary if the desired impact of significantly reducing mortality among mothers, new-borns and children will be achieved.

While the state governments are expected to lead the process of recruiting and retaining health workers, all stakeholders have important roles to play to achieve sustainable results. The local governments and the communities need to take ownership of making the health workers comfortable at their posts.

Efforts of key development partners, such as the one demonstrated in the W4H intervention, can only catalyse the process at best. Government and the community should aim to adopt this best practice and scale it up if we ever aim to achieve the impact of significantly reducing mortality among mothers and children.

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[i] Root Cause Analysis of Northern Nigeria's Health Worker Crisis; PRRINN-MNCH; Oct 2013
[ii] http://www.rand.org/health/projects/born/mss.html
[iii] http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001211
[iv] Subsidy Reinvestment Programme
[v] http://www.nursingworldnigeria.com/2015/06/yobe-government-recruits-92-graduate-nurses-from-sonm-damaturu
[vi] MRRS evaluation report 2014

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