



NATIONAL REPRODUCTIVE HEALTH STRATEGY

2006 – 2009

**Reproductive Health Task Force
Ministry of Public Health
Islamic Republic of Afghanistan**

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**NATIONAL REPRODUCTIVE HEALTH STRATEGY
FOR AFGHANISTAN
(2006-2009)**

FORWARD

[TO BE WRITTEN FOR DR. FATIMI'S SIGNATURE]

PREFACE

[TO BE WRITTEN FOR DR. NADERA'S SIGNATURE]

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Following individuals have participated in the process of developing and revising of the National Reproductive Health Strategy:

Ministry Of Public Health (MOPH):	Dr. Nadera Buyrani, Deputy Minister
Reproductive Health Directorate:	Dr. Rahela Kaveer Dr. Fakria Husseim Dr. Karima Mayer Dr. Sadia Faique
United Nation Population Fund (UNFPA):	Dr. Sukanta Sarkar Dr. Zibulnessa
United Nation Children’s Fund (UNICEF):	Dr. Linda Bartlett
World Health Organization (WHO):	Dr. Annie Begum Dr. Adela Mubasher
USAID/REACH:	Dr. Jeffrey Smith Dr. Abdullah Abed Ms. Miho Sato
ACCESS:	Ms. Hannah Gibson Dr. Wamta Shams Dr. Maureen Mayhew Dr. Robert Johnson Dr. Joseph de Graft-Johnson
US Centres for Disease Control:	Ms. Linda Barnes Dr. Mehran Massoudi Dr. Hamida Abadie Dr. Noriko Fujita
JICA:	Ms. Kathy Carter Lee
Aga Khan Health Services (AKHS):	Dr. Malalai Ahmadzai
Swedish Committee for Afghanistan (SCA):	Dr. Noorkhanum
Terres des Hommes:	Dr. Freshta Jamal
STEP:	Dr. Fatima Noorzada Dr. Humaira Abawie
International Medical Corps (IMC):	Dr. Mohammad Nasir Ahadi
AHDS:	Ms. Nika Saeedi

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LIST OF ACRONYMS

APHI	Afghan Public Health Institute
BCC	Behaviour change communication
BEOC	Basic essential obstetric care
BEmOC	Basic emergency obstetric care
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CEOC	Comprehensive essential obstetric care
CEmOC	Comprehensive emergency obstetric care
CHC	Comprehensive Health Centre
CHS	Community health supervisor
CHW	Community health worker
CM	Community midwife
CPR	Contraceptive prevalence rate
CYR	Couple-years protection
EOC	Essential obstetric care
EmOC	Emergency obstetric care
ENC	Essential newborn care
EPHS	Essential Package of Hospital Services
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/Acquired immuno-deficiency syndrome
HMIS	Health management information system
ICPD	International Conference on Population and Development
IDP	Internally displaced persons
IHS	Institute of Health Sciences
IMR	Infant mortality rate
INGO	International non-governmental organisation
IUD	Intra-uterine device
MCH	Maternal and child health
MMR	Maternal mortality ratio
MNH	Maternal and neonatal health
MOPH	Ministry of Public Health
NGO	Non-governmental organisation
NMR	Neonatal mortality rate
PNR	Perinatal mortality rate
PHC	Primary health care
PHD	Provincial health director
PID	Pelvic inflammatory disease
PM	Preventive medicine
PQI	Performance quality improvement
REACH	Rural Expansion of Afghanistan's Community-Based Healthcare (USAID-funded project)
RH	Reproductive health
SBM	Standards-based management
STI	Sexually transmitted infection
TFR	Total fertility rate
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1

REPRODUCTIVE HEALTH STRATEGIC FRAMEWORK

INTRODUCTION

VISION, MISSION and GOAL

In line with the *National Health Policy*, the **vision** of the National Reproductive Health Policy is the highest achievable standard of reproductive health for the families of Afghanistan.

The **mission** of the MOPH, therefore, is commitment to ensuring the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to under served areas of the country, and through working effectively with communities and other development partners.

The **goal** of this strategy is to develop the health sector to improve the health of the people of Afghanistan, especially women and children, through implementing the basic package of health services (BPHS) and the essential package of hospital services (EPHS) as the standard, agreed-upon minimum of health care to be provided at each level of the health system.

The Reproductive Health Strategy is intended to guide Afghanistan's reproductive health directorate in developing a plan that addresses reproductive health needs in the country. This includes building linkages between the different components of reproductive health in an integrated package. The following definition of reproductive health has been used in Afghanistan.

Box 1: Definition of Reproductive Health

- Reproductive Health, within the context of Primary Health Care, includes the following essential components:
- Family Planning counselling, information, education, communication and services
 - Safe Motherhood; education and services for healthy pregnancy, safe delivery and post natal care including breast-feeding
 - Care of the new born
 - Prevention and management of the complications of abortion
 - Prevention and management of RTIs/ STIs / HIV/AIDS and other reproductive health conditions
 - Information education and counselling for adolescent and young people
 - Prevention and management of sub-fertility/infertility
 - Life cycle reproductive health care including breast cancer, cancer of the reproductive system.
 - Nutrition.

In 2002, because of the destroyed health system in post-conflict Afghanistan, prioritizing certain aspects of reproductive health was necessary. Although 4 years later this scope can be broadened somewhat to include other areas, the same primary focus of safe motherhood and birth spacing/family planning exists.

Priority Areas

Based on the present condition of the health system and the high levels of maternal and neonatal mortality and morbidity, the national RH strategy prioritizes the following areas during the next four years (2006-2009):

1. Maternal and neonatal health in Chapter 2;
2. Birth spacing and family planning in Chapter 3;
3. Gender and Reproductive Rights in Chapter 4

Other areas of reproductive health that should receive some attention in the coming four years are mentioned briefly in Chapter 5.

This document provides a template to develop specific plans and to make funding decisions. It also emphasizes that ensuring the health of women and children involves a cross-sectoral approach whereby the reproductive health department must work with sectors outside of reproductive health.

Guiding Principles:

The strategy is based on the following core values and operational principles which are in line with the Ministry of Public Health's mission, vision and with the National Development Framework.

Core Values:

- **Human Rights:** based on a human rights approach, the RH strategy promotes the rights of all people, especially women and children, to life and the highest attainable standard of health.
- **Gender:** the strategy aims at promoting gender equality as the basis of RH programmes especially maternal and newborn health programmes, by addressing the lower status of women and discrimination against women.
- **Equity:** the actions promoted within the strategy aspire to contribute towards decreasing the inequities in health in the country, with priority attention to the rural areas and poor and underserved groups.
- **Culture:** the strategy aims at improving reproductive health, highlighting maternal and newborn health through working with women, families, communities and policy makers and uses a culturally-sensitive approach that takes into consideration the socio-cultural dimensions and specifics of the country.

Operational Principles

- **Quality of Care:** All interventions for Reproductive health should be made available with the highest standard of quality and safety, and services should be delivered according to evidence-based best practices. Addressing providers' needs and community views, particularly those of women, on the quality of service provision is key to ensuring improved quality and increased access and utilisation.

- **Continuum of Care:** All women have a right to the best possible care before and during pregnancy, childbirth and the postpartum period at all levels of the health system, as appropriate for each woman or newborn's needs. These levels range from the household to the first service level, and to the higher level service site. Primary care should be strongly connected to a referral system in order to effectively manage life threatening complications. This continuum of care encompasses the life-cycle of the woman, from adolescence through to the birth of her own child.
- **An Integrated Approach:** Comprehensive services are made available to all especially to women and newborns, integrating maternal and newborn care, family planning, nutrition, immunization, child survival, prevention and treatment care of malaria, sexually transmitted and HIV infections, and other aspects of primary health care. Because of the close links between the different aspects of reproductive health, interventions in one area are likely to have a positive impact on the others. Existing services will be strengthened and used as entry points for new interventions, looking for maximum synergy.
- **Ownership, Partnership and Responsibilities:** Goals, objectives and strategies are commonly agreed upon and pursued by the government and their partners, and supported by the international community through coordinated actions and activities determined by national plans. The Basic Package of Health Services - BPHS (2005) and the Essential Package of Hospital Services - EPHS (2005) are two key examples;
- **Good Governance, Peace and Security:** These elements are vital components of a sustained effort to improve the health of all people including the health and survival of mothers and their newborns, and are especially relevant to the country;
- **Sustainability through Technical And Financial Capacity Building:** Financial and technical self-reliance is a target for the government and partners working collectively, with ongoing development of infrastructure;
- **Policies and Strategies Based on Evidence and Best Practices:** The choice of policies, strategies and practices is informed by research findings, surveillance, monitoring and evaluation, need assessments, economic analysis, and by the sharing of lessons learned and other available evidence-based norms and standards.

BACKGROUND

Reproductive Health in Afghanistan

Afghanistan's population, estimated at 24 million¹, is faced with major health challenges as shown by its high maternal mortality ratio, low life expectancy and high child mortality rate. At the end of 23 years of war, it had one of the highest maternal mortality ratios in the world, estimated at 1600/100,000 live births meaning that on average 1 in 9 Afghan women will die in childbirth. Life expectancy is only 46 years² and under-five mortality rate is 230/1000³. A low contraceptive prevalence rate (6%)⁴ contributes to a high fertility rate (average of 6.6 children per woman).

Neonatal and maternal mortality are linked since neonatal health depends on maternal health. Thus, since the war ended and for the next several years after, two of the biggest challenges facing the MOPH, are reducing both maternal and newborn mortality.

Several health indicators are listed below in Table 1:

Table 1: Several Health Indicators

INDICATOR, YEAR AND SOURCE	
Maternal mortality ratio (per 100,000 live births) Source: <i>Maternal Mortality Survey 2002 MOH/CDC/UNICEF</i>	1600
BPHS facilities providing three methods of contraception Source: <i>HMIS MOPH 2005</i>	52 %
Coverage of Antenatal Care (%) Source: <i>MOPH, JHU Re-evaluation of the UNICEF MICS 2003</i>	8 %
Births attended by trained personnel (%) Source: <i>MOPH, JHU Re-evaluation of the UNICEF MICS 2003</i>	8%
Coverage of tetanus vaccination (% of pregnant women) Source: <i>MOPH, JHU Re-evaluation of the UNICEF MICS 2003</i>	33%
Total fertility rate (per woman) Source: <i>MOPH, UNICEF, MICS 2003</i>	6.6%
Contraceptive prevalence (% of women 15-49) Source: <i>MOPH, UNICEF, MICS 2005 National MNPC Study</i>	10%
Unmet need for family planning Source: <i>Herat Physicians for Human Rights, 2002</i>	23 % [€]
Unmet need for family planning Source: <i>Kabul TDH study 2002</i>	98%
Crude Birth rate Source: <i>MOPH, UNICEF, MICS 2005 National MNPC Study</i>	4.8%

¹ UNICEF/Islamic Government of Afghanistan. "Best estimates" of social indicators in Afghanistan. August 2005

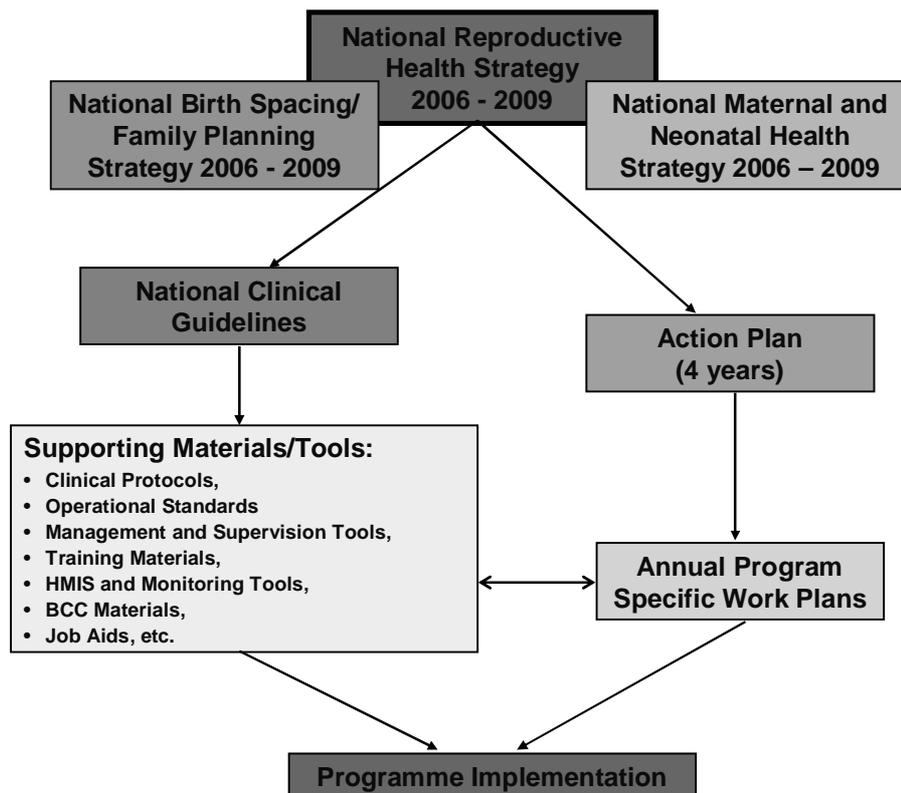
² UNICEF. *Progress of provinces: 2003 multiple indicator cluster survey*. Kabul, 2003

³ UNICEF/Islamic Government of Afghanistan. "Best estimates" of social indicators in Afghanistan. August 2005

⁴ Johns Hopkins University. *Afghanistan multiple indicator cluster survey, 2003: a re-analysis of critical health service delivery indicators*. Unpublished paper. 2005.

[€] It is likely that this statistic is much lower than the true value of unmet need since the vast majority of women in 2002 were unaware of family planning

Figure 2: Health Strategy to Implementation – The Strategic Implementation Framework



Once policies and clinical guidelines are in place, numerous tools and approaches (described below) can be developed to implement the program in a logical and consistent manner. Many of these things are already in place in Afghanistan, yet this framework is useful to guide their implementation as well as highlight areas which still need attention..

- **Operational standards** are developed which operationalize (or make “real”) the guidelines;
- **Supervision materials** are developed to monitor the correct elements of the program that will lead to improved quality, and guide supportive supervision to providers;
- **Training materials** are developed that are consistent with national guidelines, drug lists, staff competencies, etc. These training materials would include detailed case management protocols, such as the WHO *Managing Complications in Pregnancy and Childbirth* and *Managing Newborn Problems* manuals that guide providers in the care of individual patients. These reference manuals are the “content” of what we want providers to learn, while the trainer materials help teachers to teach it and the participants materials help learners to learn it;
- **HMIS tools**, such as the Obstetric Registers, are launched which measure the right elements of care, and allows for an understanding of program progress;
- **Behaviour change communication materials** are developed which give accurate messages regarding reproductive health to the community; and
- **Job aids**, such as the partograph, antenatal cards or the WHO Decision Making Tool for Family Planning, are implemented to support provider performance related to the key elements of reproductive health.

Numerous other materials can be developed to facilitate program implementation, as long as they use the *Guidelines* as the source. This ensures technical and managerial consistency within the program.

STRATEGIC APPROACH

The guiding principles of the strategy are based on those of the Ministry of Public Health's mission and vision and the National Development Framework of the Islamic Republic of Afghanistan. These include:

- Stewardship of the health sector by the Ministry of Public Health to ensure transparency, accountability, advocacy and regulation;
- Provision of service primarily through an essential package of health services designed to reduce inequalities in access to health care and address the priority causes of mortality and morbidity;
- A focus on vulnerable groups such as the displaced, disabled, and homeless; nomads; and rural women without access to midwives, doctors or hospitals;
- Community participation and involvement in order to maximize sustainability;
- Commitment to the ethical concepts of human rights, equity, solidarity and social justice and to the incorporation of a gender perspective in reproductive health;
- Capacity building of the Afghan government and civil society; and
- Intra- and inter-sectoral cooperation and active and effective participation

INCREASING SUPPLY AND DEMAND

The strategic approach to improving reproductive health encompasses efforts to improve both supply of quality reproductive health services and demand for those services.

○ *SUPPLY CREATION*

1. ***Increase the number of facilities that provide reproductive health services.*** While services are already provided at most provincial/central hospitals, efforts should be directed at increasing the number of district hospitals, CHCs and BHCs that provide services.
2. ***Increase in the number of providers*** able to provide reproductive health services. Special emphasis is given to increasing the number of midwives and female CHWs, in an effort to expand services to the periphery. Alternative providers such as pharmacists should also be trained to provide some family planning services.
3. ***Improving the quality of care*** at facilities is a major area of focus. This is accomplished through:
 - a. Widespread distribution of documents such as the BPHS and EPHS, which define facility and staff requirements,
 - b. Implementation of the clinical guidelines, through the channels defined in the introduction of this strategy,

- c. Expanding the Standards-based Management Program as a way to measurably improve quality and direct material and technical resources to address problems
- d. Enforcing the national Reproductive Health Policy and other related policies that begin a regulatory structure for health service delivery.

4. ***Improving facility management*** through the development of managerial standards and mechanisms to enforce those standards. This includes drug and supply pipelines.

○ ***DEMAND CREATION***

This Strategy emphasizes community-based interventions and community empowerment. If the community participates in their own healthcare system, they are more likely to use the expanding network of reproductive health services. Specific attention should be paid to:

1. ***Community-facility linkages*** including outreach activities from the facilities to the community as well as opportunities for influential members of the community to participate in the management of health facilities
2. ***Behaviour change communication activities*** which increase the dissemination of appropriate health messages. There should be a focus on
 - Interpersonal communication and counselling skills
 - Use of mass media, including radio announcements and radio dramas, to improve the community's awareness of key messages
 - Efforts to improve the caring behaviours of providers
3. ***Mobilization of the community to address reproductive health issues*** through the promotion of village health committees, education of women's shuras
4. ***Activities which encourage women and families to improve and maintain their own reproductive health*** such as enhanced nutrition and hygiene

MANAGEMENT OF THE NATIONAL REPRODUCTIVE HEALTH PROGRAM

Managing, monitoring, supervising and evaluating the reproductive health program are necessary components of this strategy. The 4-year action plan will be used to gauge progress. Throughout the present implementation period (2006 – 2009) all counterparts involved in the program should at all times be able to:

- describe the goals, objectives and status of the national reproductive health program
- report on the progress of key implementation activities
- discuss the achievements of the program as they relate to key process and program output indicators
- identify gaps in program inputs so as to guide partners and other donors toward meaningful participation in the MOPH's national program.

MONITORING AND EVALUATION

A **monitoring and evaluation system**, based on key indicators and fed by appropriate data from existing sources, will enable all implementing partners to remain aware of progress toward the desired performance. Firstly performance gaps will be identified and then plans that respond to these gaps will be created at both the national and local levels. Continuous assessment of the program will result in both improved outcomes for the program but also increase the ability of the MOPH to direct and manage its programs.

Data will be collected at multiple levels of the health system – from communities, facilities and provincial/central management teams – and will be evaluated at all levels. The M&E structure will allow local teams to analyse key elements of their own data and make adjustments to the program at a local level. Data will also be sent to the provincial and national levels for more detailed analysis and consideration. The information gained from analysis at the national level will be disseminated to the provinces and key facilities through all available channels.

To achieve the national RH Program at the provincial level, the **Provincial RH Officers** will be key partners for enhancing two-way communication between the national and provincial/local level. They will, according to their job description, support the implementation of this strategy in facilities and management structures (e.g. Provincial Health Coordinating Councils) at the provincial level. Capacity building of these Provincial RH Officers is a priority in the coming years.

CHAPTER 2

MATERNAL AND NEONATAL HEALTH STRATEGY

MATERNAL AND NEONATAL HEALTH STRATEGY 2006 - 2009

BACKGROUND

Maternal and Neonatal Mortality in Afghanistan

A national average maternal mortality ratio (MMR) of 1600 per 100,000 live births means that approximately 17,000 Afghan women die of pregnancy-related complications every year⁵. This rate varies markedly from province-to-province and district-to-district, depending on many factors including distance from an urban centre. A study of maternal mortality in one district in each of four provinces (urban, peri-urban, rural and remote), showed that maternal mortality was markedly higher in rural areas compared with urban sites (Table 2)⁶:

Table 2: Mortality in Rural and Urban Sites

	Urban	Semi-rural	Rural	Remote
District	Kabul	Alisheng	Maywand	Ragh
Province	Kabul	Laghman	Kandahar	Badakshan
MMR(per 100,000)	400	800	2200	6500
IMR (per 1000)	80	120	n/a	220

Verbal autopsy indicates that haemorrhage is the greatest cause of maternal death among women of reproductive age⁷. More than a third of all women who die of maternal causes bleed to death either during or shortly after delivery. Another quarter of them die because of obstructed labour. Obstructed labour, however, is the main cause of maternal death in the remote district of Ragh, Badakshan where there are very few skilled birth attendants and even fewer surgical facilities. Women die after being in labour for many days and the neonate dies in the process. This highlights a serious lack of access to health care in areas like Ragh⁸ and may be similar to other remote districts.

Overall 82% of maternal deaths are related to direct maternal causes – haemorrhage, sepsis, pregnancy-induced hypertension (pre-eclampsia and eclampsia) and unsafe abortion⁹. Seventy-eight percent of deaths in the study were considered preventable; once again, illustrating that access to appropriate medical care would have had significant impact (Fig 3).

Newborns and infants are also affected by health care and represent a large proportion of childhood mortality. Sixty-one percent of the under-five mortality is represented by infant mortality (140/1000 live births)¹⁰ and neonatal mortality rate (60/1000 live births)¹¹ represents 26% of under-five mortality.

⁵ Central Statistical Office. *op. cit.*

⁶ Bartlett, L., et al. "Where Giving Birth is a Forecast of Death: Maternal Mortality in Four Districts of Afghanistan, 1999-2002". *Lancet*, vol. 365, 5 March 2005, pp. 864-870.

⁷ Bartlett, L., et al. *op. cit.*

⁸ *ibid.*

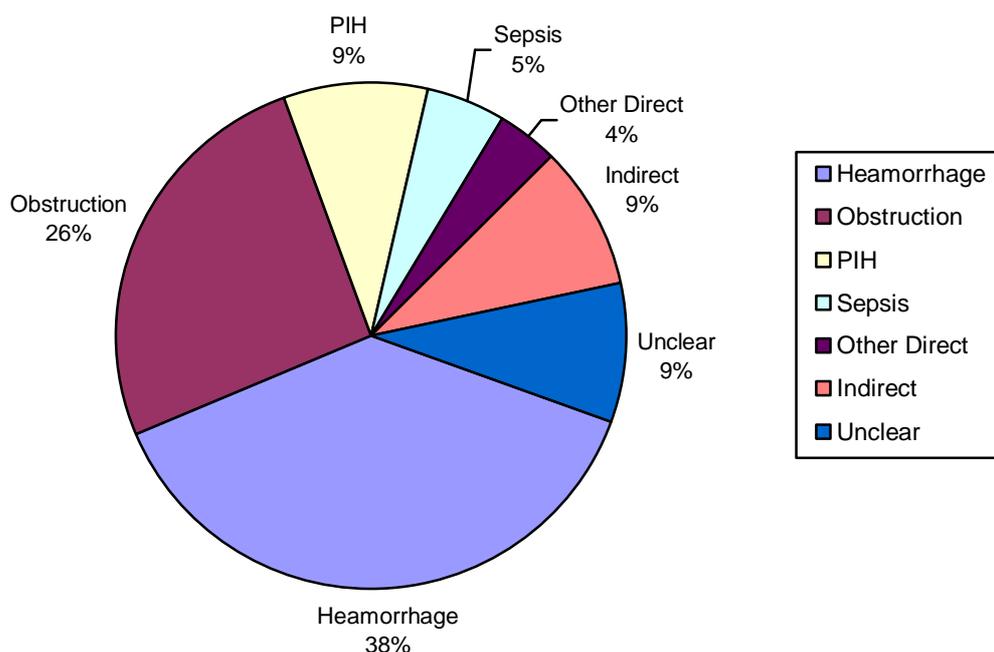
⁹ *ibid.*

¹⁰ UNICEF/Islamic Government of Afghanistan. "Best estimates" of social indicators in Afghanistan. August 2005

¹¹ World Health Organization. *World Health Report*. Geneva, 2005.

Although newborn mortality has not been studied in Afghanistan, the magnitude to which high maternal mortality affects infant mortality has been illustrated by Bartlett et al where 74% of infants died shortly after being born to women who had died during childbirth. Thus, addressing the need for improved maternal care should have the additional benefit of reducing neonatal mortality. Globally major causes of neonatal deaths include sepsis, asphyxia, neonatal tetanus, low birth weight and birth injuries. Most of these deaths can be averted by treatment or preventive measures using proven, low-tech interventions.

Figure 3: Causes of Maternal Deaths



Challenges in Service Provision

Lack of skilled birth attendants: Few Afghan women have the help of a skilled birth attendant during delivery and most skilled attendants are located in cities. Nationally only 9% of births are assisted by skilled birth attendants but this varies tremendously from urban to remote locations.¹²

Geographic disparity in health care provision: Kabul has the highest number of skilled birth attendants who aid 40% of deliveries in the city. In contrast five provinces, Hilmand, Nooristan, Saripol, Takhar and Zabul have skilled birth attendants assisting in only one percent or fewer births¹³. Surprisingly Badakshan with its notorious maternal mortality has a higher coverage of skilled birth attendants than these 5 provinces. Since a low skilled birth attendance rate is associated with a high maternal mortality, these areas may have a similar MMR to 6500/100,000 recorded for Ragh district of Badakshan province but this has not been studied (Table 3).

¹² Johns Hopkins University. *op. cit.*
¹³ *ibid.*

Table 3: Births Attended by Skilled Birth Attendants – By Province¹⁴

Province/Rural Areas	Births assisted by Skilled Birth Attendant (%)	Urban Areas	Births assisted by Skilled Birth Attendant (%)
Badakhshan	1.80	Herat city	34.43
Badghis	12.71	Jalalabad city	55.28
Baghlan	14.54	Kabul city	53.10
Balkh	3.30	Kandahar city	42.29
Bamiyan	5.85	Kunduz city	10.16
Farah	3.12	Mazar city	21.61
Faryab	2.20		
Ghazni	9.02	Urban Median	38.4
Ghor	6.08	Rural Median	6.0
Herat	17.58	National Median	9.0
Helmand	1.02		
Jawzjan	9.09		
Kabul	22.56		
Kandahar	1.75		
Kapisa	7.07		
Khost	16.89		
Kunar	9.32		
Kunduz	4.85		
Laghman	13.91		
Logar	13.36		
Nangarhar	5.84		
Nimroz	9.98		
Nooristan	0.44		
Paktika	3.41		
Paktya	14.47		
Parwan	2.45		
Samangan	29.45		
Saripul	0.43		
Takhar	0.37		
Uruzgan	3.14		
Wardak	9.88		
Zabul	0.76		

Antenatal care also varies in urban and rural area. Nationally, although 16% of pregnant women received antenatal care in 2003¹⁵ urban women were 10 times more likely to receive it than rural women¹⁶. These statistics agree with those of Bartlett et al who noted that of women who had died, those in Kabul were almost 20 times more likely to have received antenatal care than those in the most remote area studied.

Security: Lack of security or perceived poor security in certain areas as well as the restrictions applied to women to move freely outside the home, play an important role in women's ability to access to health care services. This also has an affect on recruitment, deployment and retention of female health staff such as midwives and female doctors.

¹⁴ UNICEF. *op cit.*

¹⁵ UNICEF. *op. cit.*

¹⁶ *ibid.*

Dispersed population: Afghanistan's dispersed population compounds the challenge of providing health care for all. Seventy-seven percent of the population live in rural areas¹⁷ in a combination of small towns and dispersed small villages where, in many cases, roads are non-existent and time-distances to reach health centres may represent several days travel¹⁸. It is estimated that 1.5 million nomads live in Afghanistan and are often excluded from surveys and health care planning.¹⁹

Cultural factors: The importance of having female health workers cannot be over-emphasised since most women find it culturally unacceptable to receive midwifery or obstetrical care from a man. Although this idea may change over time, for the duration of this strategy, it is likely to remain constant. Secondly, home births vastly outnumber those occurring in health facilities and most deliveries are assisted by family members.^{20 21} This means that providing education at the household level is important. Thirdly, providing health care in rural areas is difficult because educated women do not wish to practice in places where few educated women live, where life is difficult and where they have no extended family. Therefore training local rural women is crucial to providing health care in these areas. In 2002 only 40% of facilities providing the basic package of health services (BPHS) had female health workers, some of whom were skilled at managing births.²²

Literacy: Challenges to providing health care in Afghanistan are compounded by a low literacy rate. Nationally in 2003 the literacy rate in Afghan women was 14%, rendering it difficult to find female students to enrol in health worker programmes. This difference is more pronounced in rural areas where only 8% of females over 15 years of age were considered literate.²³ Literacy programmes have been linked to reproductive health worker programmes as a means to prepare students to enrol in health worker training programmes. This must continue at least for the duration of this strategy until a steady supply of literate women is provided by the public education system.

• **Barriers to Maternal Health Care**

Internationally, barriers to health care are classified into three levels:²⁴

- *Level 1:* The woman and her family do not recognise the existence of a pregnancy-related problem, or do not seek care once recognising it.
- *Level 2:* Family members decide to seek care but have difficulty obtaining it, either because it is too far away or the care or transport was unaffordable.
- *Level 3:* Family members access care but the woman does not receive quality, timely treatment from an appropriate provider when arriving at the facility.

¹⁷ UNICEF. *op cit.*

¹⁸ UNICEF. *op cit.*

¹⁹ UNICEF/Islamic Republic of Afghanistan. "Best estimates" of social indicators in Afghanistan. August 2005

²⁰ Central Statistical Office. *op cit.*

²¹ O'Connor RW. *Managing Health Systems in Developing Areas: Experiences from Afghanistan*. Boston: MSH, 1980. ISBN #: 0-913723-89-4

²² Ministry of Health. Transitional Islamic Government of Afghanistan. *Afghan National Health Resource Assessment*. Kabul, December 2002.

²³ UNICEF. *op cit.*

²⁴ Graham W. "Safe motherhood needs assessment: maternal death review". Geneva: World Health Organization, 1996. Report No. WHO/RHT/MSM/95.

Overall, Afghan women encounter substantial barriers at all three levels.

Level 1: Health care knowledge and ability to decide to seek care decline with remoteness and is compounded by the low literacy rate in the country. While families express concern about their relative's risk of maternal death, decisions to seek care are influenced by the families' perception of accessibility. Most families report that female relatives recognise pregnancy-related problems, but a male relative in consultation with the mother-in-law, makes the decision to seek care. In Ragh, 30% of families sought care whereas in Kabul, 72% did so. Women who die of maternal causes are significantly more likely to have a first-level barrier and to be illiterate than women who die of non-maternal causes²⁵.

Level 2: Families do not seek care because of lack of transportation, large time-distance between homes and services, insecure travelling conditions and inability to afford either transport or care. Of families who try to reach maternal health care, three-quarters identify level-two barriers as the most significant challenges to their ability to access care.

Level 3: Almost 70% of families who seek care indicate they encounter third-level barriers either because of cost or poor quality offered at the only accessible health facility.^{26 27}

NATIONAL HEALTH POLICY AND MATERNAL AND NEWBORN HEALTH

Improving maternal and newborn health among the Afghan people is one of the Ministry of Public Health's (MOPH) highest priorities. The *National Health Policy 2005 – 2009* emphasises women and children as well as underserved areas in its stated mission and goals:

“The mission of the Ministry of Public Health is commitment to ensuring the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to underserved areas of the country, and through working effectively with communities and other development partners.”

The National Health Policy goal is to:

“Develop the health sector to improve the health of the people of Afghanistan, especially women and children through implementing the basic package of health services and the essential package of hospital services as the minimum of health care to be provided at each level of the health system.”

Specifically regarding reproductive health, the Ministry of Public Health is:

“...committed to increase accessibility of mothers and women of childbearing age to quality reproductive health services including antenatal care, intrapartum care, routine and emergency obstetric care and postpartum care, counselling and modern family planning services through skilled birth attendants working with community and other health workers.”

²⁵ Altai Consulting. SMI. *Safe Motherhood Initiative: Formative Research Report*. June 2004

²⁶ *ibid.*

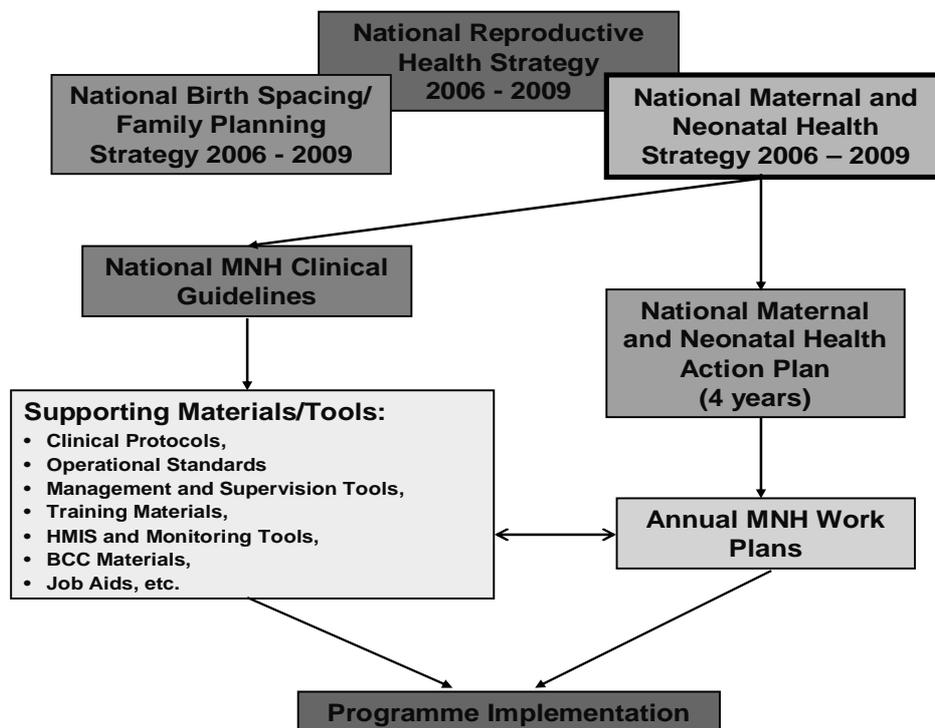
²⁷ Bartlett, L., et al. *op. cit.*

STRATEGIC PLANNING FOR PROGRAMME IMPLEMENTATION

It is imperative to do develop a plan based on strategic directions for programme implantation. Figure 4, which has been adapted from Chapter 1, describes the flow of actions leading to implementation of the MNH part of the strategy.

During this programme period it is necessary to review the existing guidelines, standards, training curricula, tools used for monitoring and supervision, BCC materials and job-aids used in the programme. Then it should be decided what documents and tools need revision or development.

Figure 4: MNH Strategy to Implementation – The Strategic Implementation Framework



OPERATIONAL PRINCIPLES FOR THE NATIONAL MNH PROGRAM

Several cross-cutting operational principles have been defined in the Chapter 1. In implementing the maternal and newborn health program, these additional principles will be followed.

- **Promotion of Skilled Attendance at Birth**

International evidence has shown that a necessary component of maternal and newborn mortality reduction is the presence of a skilled birth attendant to assist the woman at birth. The BPHS, concepts of basic and comprehensive essential obstetric care and the national job descriptions for midwives and community midwives are elements of this approach. This strategy promotes program activities that support skilled attendance at birth.

- **Emphasis on Care for Families in Rural Areas**

To address the need for reducing maternal and newborn mortality in underserved areas, this strategy focuses on developing quality MNH services and promoting access to services especially at BHCs, CHCs and DHs in rural areas. Given the fact that urban health statistics are far better than rural ones, the present strategy emphasises rural areas.

- **Balance between Supply and Demand**

The strategy emphasises improving both the supply of quality MNH services and increasing demand for those services among rural populations. While strengthening the availability and provision of quality services is essential, communities must be aware of the services and feel that they are of good quality and welcoming. As well, if demand for services is raised, the services must be available. A balance between supply and demand of services will be sought.

- **Focus on Health Workers in Clinics and Communities**

Increasing numbers and skill levels of community midwives in CHCs and BHCs and community health workers (CHWs) in communities is at the core of the strategy. Ensuring a sufficient number of midwives and physicians in hospitals is essential to provide comprehensive emergency obstetric care (CEmOC), but it is just as important for community midwives and female CHWs to be available to women and newborns in and near their homes. This provides the necessary continuum of care from the antenatal period through to the postpartum period, including care for the newborn. In addition to these services, community midwives must also be able to provide intrapartum care, basic emergency obstetric care (BEmOC) and essential newborn care (ENC). Complications must be recognised early so women and their newborns can be directed to appropriate sources of referral care.

- **Increase Use of Birth Preparedness/Complication Readiness**

Encouraging birth preparedness/complication readiness is an essential concept in this strategy, occurring at both health facility and community levels and requires improving counselling techniques of all health workers. Important aspects of this activity include building capacity of families to plan and prepare for birth by disseminating knowledge of birth preparedness and complication readiness planning. All health workers, including CHWs will be involved. Another aspect of this involves strengthening the ability of facilities to receive and manage maternal and neonatal complications received as a result of these birth plans. Facilitating the ability of families to act on their plans will be a significant challenge whether birthing occurs in the home or in a facility.

- **Involvement of the community at all levels**

Communities should be involved in all aspects of a strategy to improve maternal and newborn health. They should participate in elements of supply creation (selection of midwifery student candidates, participation in community boards at health facilities, etc.) and lead activities to increase demand for services, through advocacy, BCC activities and community mobilization.

Traditional birth attendants will continue to have a role in Afghanistan. Although further training of them as birth attendants will not occur, it is recognized that they can serve a support and advocacy role. They should be encouraged to train as community midwives or CHWs, as appropriate. Partnerships should develop between them and community midwives and CHWs. They should be viewed as key promoters of the concepts of birth planning and brought into the system in that role. The general approach to working with TBAs will be the approach as stated by WHO: “Partnership – yes; investment – no”.

STRATEGIC OBJECTIVES

The strategic approach of the National Maternal and Newborn Health Strategy is to simultaneously address issues of MNH supply and demand. The MOPH and its development partners in Afghanistan should increase the availability of high quality MNH services while partnering with communities to increase their ability to access these services.

The **objectives** to increase the **supply** of quality MNH services include:

1. Improve the provision of services within existing health facilities
2. Improve the clinical supervision of MHH workers
3. Increase the number of qualified skilled birth attendants, particularly midwives
4. Improve the distribution and deployment of skilled birth attendants
5. Promote and expand appropriate roles for CHWs
6. Expand the concepts of EOC into pre-service education of all skilled providers
7. Standardize and improve in-service training in all areas of MNH
8. Pilot and evaluate creative approaches that increase access to MNH services

The **objectives** to increase **demand** for MNH services include:

9. Increase the capacity of partners to implement demand creation activities
10. Expand the use of behaviour change communication activities
11. Improve community perception of services
12. Facilitate access to skilled attendants and MNH services
13. Advocate for the use of skilled birth attendants

Other **objectives** to improve MNH services

14. Implement appropriate costing strategies
15. Ensure linkages and coordination with other RH Initiatives

SUPPLY CREATION: Strategies to Improve the Availability of Quality Services

OBJECTIVE 1: Improve the provision of services within existing health facilities

The BPHS and the EPHS are MOPH policy documents designed to prioritize the delivery of essential health services and align the health system according to those priorities. These documents have fostered a clearer approach to the effective functioning of health facilities and the provision of high quality priority health services. There have been some notable improvements in the delivery of some reproductive health services, as noted by

the National Health Services Performance Assessment (NHSPA). The NHSPA involves an annual assessment of a random sample of health facilities throughout Afghanistan. The NHSPA is a Ministry of Public Health activity that receives technical support from the Johns Hopkins University and the Indian Institute of Health Management Research.

According to the NHSPA 55.8% of BPHS facilities provided antenatal care and 46.7% provided delivery care in 2004. In 2005, 73.1% of facilities were providing antenatal care and 53.7% were providing delivery care. Closer evaluation of the data shows that the increase in the availability of delivery services was greatest at the district hospitals (from 52.0% to 81.4%) and essentially unchanged at BHCs (from 41.6% to 40.0%). As well, the presence of some but not all elements of delivery services increased (from 52.5% to 71.4%) at CHC level.

This information suggests that more work is needed to increase the availability of maternal health services at all BPHS facilities, but especially at BHCs and CHCs. It must be noted that the NHSPA data does not provide information on the quality of those services, and therefore, efforts to increase availability should look at not only the ability to provide these services, but also the adherence to national quality standards, which exist and are derived from the national clinical guidelines. Health facility staff should be trained in evidence-based tools known to encourage the identification of gaps in quality of service and solutions that address those gaps, using the SBM-R (Standards-based Management and Recognition) and FFSPD (Fully Functional Service Delivery Point) approaches already in place.

Frequent, supportive supervision and program monitoring contributes to improving quality of care and should be a routine function at all facilities. Current approaches to supervision focus on administrative rather than clinical functions. Developing an integrated national RH supervision approach for both BPHS and EPHS facilities, based on agreed-upon standards of care and using already functioning mechanisms, is currently underway and should be supported. The Monitoring and Evaluation Working Group of the RH Task Force should coordinate this approach.

Essential Obstetrical Care is a curative health service which requires 24-hour access to care. It is necessary for facilities that provide EOC to make services accessible (by having staff on stand-by in their homes, for example) 24 hours a day. Women may be less likely to use health services during their pregnancy if they know the services will not be available at the time of delivery.

Services at all levels of the health system need to be linked through an effective referral system. Staff at BHCs and CHCs must identify which patients should be referred and to where. They should understand the services available at the DH and PH and how to ensure that women with life-threatening problems are able to be seen immediately. They should receive feedback on their referrals through documentation that returns with the patient to the more peripheral facility. Standardized referral forms should be developed for this purpose and priority referral mechanisms must be developed to ensure prompt action by providers at the higher level.

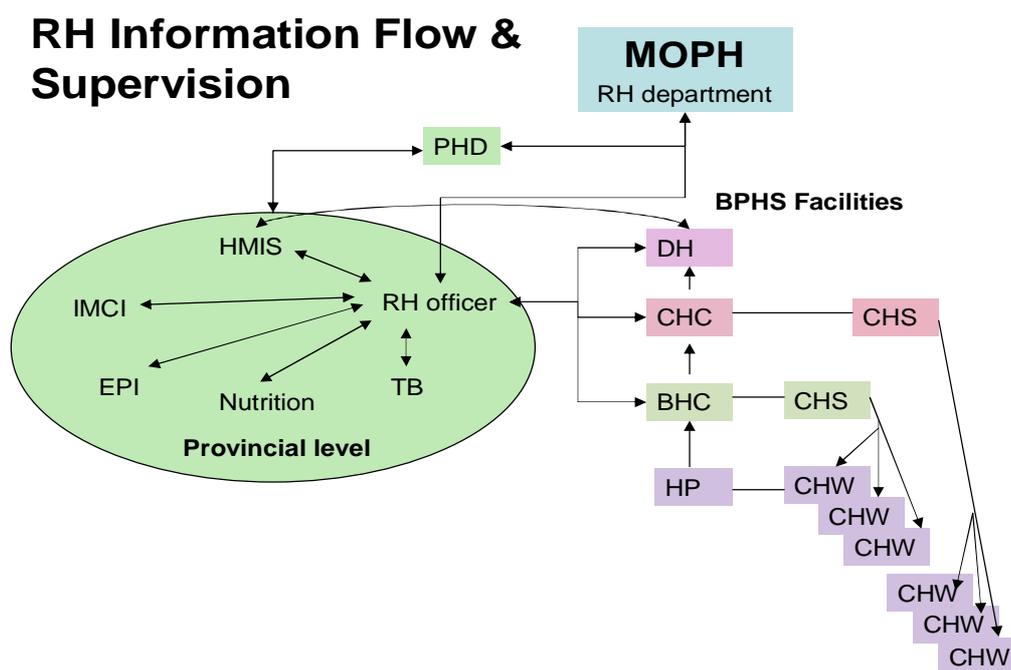
Actions to achieve objective:

- Implement maternal and newborn health components of the BPHS and EPHS in all appropriate health facilities, and monitor the service statistics

- Ensure wide distribution and clear understanding of national clinical guidelines and implementing tools
- Develop/finalize implementing tools according to the strategic implementation framework
- Implement quality improvement tools and systems, especially those already in place with the MOPH (FFSDP and SBM-R)
- Develop specific mechanisms to strengthen clinical supervision within health facilities using standardized clinical supervision materials
- Develop referral systems including referral forms and a mechanism to alter attendants and providers at the referral site so that the patient can receive priority care

Figure 5 (below) suggests how information may flow up from communities through CHWs, all the way to the RH officer and ultimately to the RH Department of the MOPH. This information, if analyzed in a timely manner, can provide supervisors with data to support suggested improvements to employees who provide health care, thus improving quality of care. Direct observation is another facet of supervision that is extremely important for verifying that standards of care are being practiced and it must be done on a regular basis.

Figure 5: Network of Information and Supervision



OBJECTIVE 2: Improve clinical supervision of MNH workers

Adequate management and allocation of resources is necessary at all levels of health facilities including health posts. Techniques and tools will be identified and used to strengthen management, logistics and supply distribution at all health facilities and health posts so that quality care reaches those who need it.

Clinical supervision should be based on the National Clinical Guidelines and should focus on delivery of services according to standards. An integrated clinical supervision approach should be used to assess adherence to standards in an objective and supportive manner. The Standards-based Management and Recognition (SBM-R) materials have clinical standards that can be used to supervise clinical staff and provide feedback. These tools provide specific mechanisms for monitoring services and can provide a quantitative measure of quality of care. They are designed so that service providers are aware of the goals of care and specific gaps can be worked on by the service provision teams after supervisors have departed. This also promotes internal ownership of quality concepts rather than promoting a model which is external and top-down. These standards can be used by hospital managers as well as provincial RH Officers for supervision, support and monitoring.

Community Health Supervisors are the designated workers responsible for providing clinical support to CHWs. At present their supervision tools do not have sufficient clinical specificity to allow them to provide clinical support to CHWs. These CHSs should be trained in the use of appropriate tools that will enhance the provision of selected MNH services at the community level.

In addition to strengthening approaches for monitoring and evaluation of public sector services, the MOPH should also explore ways to monitor private sector services. Private practitioners should be appropriately licensed and required to periodically participate in continuing education courses and consistently display professional conduct in order to maintain licensure. Systems should be considered to record the data from services provided in the private sector. In certain situations it may be necessary to train private practitioners in HMIS data collection.

Actions to achieve objective:

- Agreement on the content of supervision tools
- Implementation of SBM-R and FFSDP as clinical supervision tools at all appropriate levels
- Development of additional tools for improved supervision of CHWs.
- Train NGO health facility and management staff in evidence-based management tools, especially SBM-R and FFSDP
- Develop tools and techniques to strengthen management skills of implementing organisations

OBJECTIVE 3: Increase the number of qualified skilled birth attendants, particularly midwives

Testing and Certification of midwives and nurses has been undertaken by the MOPH starting in 2004. This process has identified those mid level providers who possess the required knowledge to be licensed in their profession. Unfortunately, pass rates for this exam have been low. The MOPH, however, has appropriately preferred to take a strategy that increases the capacity of those who have failed the exam, rather than lower the passing mark simply to increase numbers. Thus, appropriate refresher training programs need to be targeted to those providers, identified through this process, who need additional training to be licensed in their field according to the current MOPH job descriptions and competencies. These efforts will appropriately determine how many

qualified midwives there are in Afghanistan. It is certain, however, that there are not enough and that efforts to educate more women to become midwives will continue to be necessary.

In order to logically and strategically determine how many midwives will be necessary in Afghanistan, it is important to review certain assumptions in health workforce planning.

Model 1: Population-based	Population: 27 million Crude Birth Rate: 45/1000 Work load: 150 births / year Assume 50% of birth in next 10 years by Skilled Attendant Assume Midwives are the SBA in 80% of births
	$27,000,000 \times 45/1000 \div 150 \times 0.5 \times 0.8$ = 3240 midwives needed

In the above model, Afghanistan needs more than 3200 midwives to provide 50% coverage by a skilled attendant, which is a reasonable goal for the next ten years. An alternate set of assumptions based on distribution of BPHS facilities gives a slightly different estimate of the number of skilled attendants needed. According to the BPHS each BHC employs one community midwife, each CHC employs two community/hospital midwives and each DH employs 4 hospital midwives. So based on the number of health facilities to be staffed, 1600 community midwives and 1800 hospital midwives are needed to meet the requirements of the BPHS²⁸.

These are different models of workforce planning, each based on certain assumptions. There are other models which give different figures. Today, what is known is that the country needs many more midwives than it has and therefore education of new midwives is a priority.

By June 2006 a total of approximately 200 community midwives will graduate from the first classes of the newly established CME programs throughout the country and another 600 hospital midwives will have graduated from the Institute of Health Sciences (IHS) programs. Starting in 2007 approximately 400 new midwives will graduate annually from all of the 20 midwifery schools in the country. The MOPH must keep close watch on the rate of production of these midwives, and work to ensure close to 100% deployment of new graduates.

It may appear that increasing the number of schools in the country would be an easy way to increase the annual number of midwife graduates. However, opening new schools requires a large investment, and new schools must be established according to established national standards and under the auspices of the National Midwifery Education Accreditation Board. Qualified faculty have to be recruited and may need refresher training in essential obstetric care skills and training methods. Each school requires a substantial amount of basic equipment and must be attached to a health facility that guarantees adequate case load for clinical learning.

Judiciously increasing the number of students enrolled at a school could be done if the number of deliveries and maternity cases in the school's teaching facilities are sufficient. Thus, the maximum number of enrolled students must be determined by each school

²⁸ Islamic Government of Afghanistan, Ministry of Public Health. *A Basic Package of Health Services for Afghanistan, 2005/1384 (revised version)*. 2005

according to case load and criteria of educational quality, in conversation with the Human Resources Department of the MOPH. Establishment of maternity waiting homes close to community midwife schools could increase case loads as well as provide opportunities for simulated home birth and the management of home birth.

Actions to achieve objective:

- Accelerate activities to upgrade those midwives who have failed the T&C exam and give them priority for training.
- Conduct appropriate workforce planning activities to determine the number of midwives, nurses and doctors needed and where they are needed
- Increase number of MNH health workers, especially midwives
- Accelerate production of hospital and community midwives according to accepted standards within the existing community midwife education programs
- Accelerate production of CHWs and evaluate the possibility of reducing the household coverage per CHW
- Promote a health workforce planning approach in human resources and create more detailed deployment plans for all health workers

OBJECTIVE 4: Improve the distribution and deployment of skilled birth attendants

Improve the distribution of skilled birth attendants, especially to BPHS facilities in rural areas

There is great disparity between the density of health workers in urban areas and rural areas. More skilled birth attendants are needed in the rural areas to staff the BPHS facilities that are functional and planned. The placement of community midwife programs in the provinces is one mechanism of increasing staffing of more peripheral facilities because it specifically recruits from near those facilities and keeps the educational process closer to them.

The National Salary Policy also makes allowances for the salary of staff that go to more rural areas, through incentives based on health worker density, girls enrolment in primary school and facility conditions. Implementers of the BPHS should be supported to understand and apply the National Salary Policy as a mechanism to increase equitable distribution of SBAs.

Improve recruitment and deployment

Strategic recruitment and deployment of all health workers to rural areas of the provinces is a key element of this strategy. Many educated men and women are unable to accept an assignment in districts outside their home. One option is to recruit hospital midwifery students and medical students from specific targeted rural communities, as is being done with community midwifery students, and admitting them to professional programs on the condition that they return to their villages. The Guidelines for Selection of Students to Community Midwife Education Programs have been finalized by the HR Task Force and adopted by the MOPH. These need to be followed to help in rational planning.

A health workforce planning approach should be used whereby students are recruited based on planned deployment, and newly trained and deployed midwives are supervised

by those previously trained or updated. Mentorship and peer support are part of the current job descriptions of midwives and community midwives and these skills are taught in their curriculum. Clinical skills will then be maintained as demand for services is generated in communities. Incentives and retention strategies to encourage health workers to relocate to rural areas must be explored and will probably require pilot testing.

Actions to achieve objective:

- Finalize approaches to promote appropriate health worker recruitment and deployment, using the Guidelines for Selection of Students to CME Programs
- Support the implementation of the National Salary Policy
- Evaluate and test various incentive schemes that encourage health workers of all levels to work in rural areas
- Participate in activities of the Human Resources Task Force for the appropriate determination of health worker needs and rational selection and deployment of new skilled birth attendants

OBJECTIVE 5: Promote and expand appropriate roles for CHWs

Current CHW training must be evaluated and supported to ensure that CHWs are successfully providing the desired set of MNH services. The maternal and newborn health component of CHW training is focused on identifying pregnant women (through community mapping), providing counselling and support for birth planning, providing selected elements of antenatal care and referring those women with pregnancy complications to community midwives at BPHS facilities. A community health supervisor (CHS), a paid position based at BPHS facilities, is being used in some provinces to help monitor and train CHWs. This will be expanded and further developed over the next four years. The MNH Working Group should participate in defining the role of the CHW and the CHS.

The case load of a CHW is currently set by the BPHS at 100 – 150 households but this can vary depending upon geographic conditions, difficulty of travel and population dispersion. Using the flexibility inherent in this statistic it may be more realistic for a female CHW to cover fewer households and male CHWs to cover more. Although both male and female CHWs will be involved in MNH, the men will work with shuras and through mosques while the women will deal directly with women in the households. The end result would be a higher female to male CHW ratio, perhaps 3:1. How to effectively cover the population but remain within the parameters set by the BPHS will be explored during the coming four years. The total number of CHWs (female and male) trained to date is over 8500²⁹, representing 25% of the target of the BPHS.

CHW motivation is a concern. Since CHWs are not employees of the MOPH, motivating influences from the community must be encouraged. Free education, community recognition and some type of payment by the community may be options. Preferential participation in vaccination campaigns and health education campaigns are possible sources of income for them. Implementing organisations can pay for their travel costs to the BPHS facility on a monthly basis when they bring reports.

²⁹ Personal communication with HMIS Office, MoPH.

Actions to achieve objective:

- Institute CHSs in all provinces and participate in review and revision of CHS job description
- Strengthen supervision of CHWs especially in relation to MNH services
- Support evaluations of CHW practices and revision of their scope of work, supervision and compensation, as appropriate
- Provide technical support to the PHC Task Force of the MOPH to strengthen the performance of CHWs related to MNH services.

OBJECTIVE 6: Expand concepts of EOC into pre-service education of all skilled providers

In order to ensure uniformly high quality services, all midwives are currently being educated according to the agreed MOPH curriculum which gives them the competencies of a skilled provider. They must be supported to take up their posts and fulfil their duties as identified in the MOPH job description. The curricula of pre-service education programs must remain consistent with the BPHS and EPHS and use competency-based, participatory teaching methodologies to encourage all students to actively learn.

Although a sufficient number of doctors have been trained in Afghanistan the content of their education and the distribution of physicians once they have graduated does not fully meet the health needs of the population. Pre-service medical education should reflect the principles of primary care and the components of the BPHS, with appropriate focus on specific surgical and anaesthetic techniques important for rural practice. Doctors must have been appropriately trained in up-to-date obstetrical care to be deployed to rural areas. Since this involves creating a well-followed deployment plan and a revised medical curriculum that highlights primary care and CEmOC, close coordination and collaboration with the Ministry of Higher Education is necessary. As an incentive, further specialisation could be provided free of charge if the doctor has fulfilled his/her duty of serving in a rural area for a minimum of two or three years.

At present, all doctors should be updated in current concepts of basic and comprehensive EOC. This is urgent if we are to achieve the desired effect of pre-service midwifery education since midwives have been taught to provide some services (e.g., active management of third stage of labor, use of magnesium sulphate) that may be new to doctors. These concepts should be urgently integrated into pre-service medical education.

Actions to achieve objective:

- Work with the HR Task Force to identify areas where medical education can be improved
- Work with and encourage the Ministry of Higher Education to revise medical curriculum to include, at a minimum, the concepts of Basic and Comprehensive EOC
- Design and implement a series of Technology Updates in EOC to be provided to all doctors providing or supervising the provision of MNH services

OBJECTIVE 7: Standardize and improve in-service training in all areas of MNH

In-service training programs have been taking place in Afghanistan for many years. They provide some of the necessary information and skills that doctors and midwives need in order to provide services according to the National Clinical Guidelines for Reproductive Health. These training packages need to be standardized at the national level and a strategy for training providers in the appropriate concepts of antenatal, intrapartum, postnatal and newborn care should be developed. Much work has already been done on this and a National Training Package for Basic Essential Obstetric Care has been adopted. This package predominantly focuses on intrapartum care and immediate newborn care. Draft training packages exist for antenatal, postnatal and newborn care, however, these have not been reviewed or approved at the national level.

At present all in-service training efforts are managed by projects or NGOs. The training of providers is on an as-needed basis and does not follow training standards set out by the MOPH. The development of standardized national in-service training packages in all areas of RH is a necessary first step. This should be followed by a standardized approach to the preparation of MNH trainers and training sites. A logical training approach should be developed which organizes training according to priority topics and geographic areas. This training program should be guided centrally so that guidelines are established for selection of training sites and participants and to ensure quality of the process.

Actions to achieve objective:

- Review and finalize training packages in antenatal, postnatal and newborn care.
- Identify appropriate training sites in the regions so that adequate numbers of courses can be conducted throughout the country
- Ensure that those trainers identified to provide MNH training are up-to-date and prepared as trainers
- Develop a strategy for rolling out MNH training to priority areas and priority personnel
- Develop in-service training guidelines that allow for an organized implementation of the training plan
- Establish the capacity in the MOPH to manage the national training program

OBJECTIVE 8: Pilot and evaluate creative approaches that increase access to MNH services

Numerous different activities are either on-going or proposed to demonstrate the appropriateness of evidence based approaches to increasing the availability of MNH services. The piloting of these activities should be coordinated with the MNH Working Group and should be monitored for their effectiveness and feasibility. Once adequate information is available, these initiatives should be scaled up nationally. These initiatives include:

- PPH Reduction Demonstration Project: this is ongoing in Jawzjan and Kabul Provinces. Results to date are promising and the project should be followed carefully by the Safe Motherhood Unit of the MOPH.
- Maternity Waiting Homes: the feasibility study was completed in 2006 and recommended piloting of this in Badakhshan and possibly Bamiyan Provinces. Donor support should be sought and this concept piloted urgently.

- Integrated Postpartum Care Visit: International evidence has suggested that an integrated immediate visit (within the first 3 days postpartum) has benefits for both mother and newborn. The CHW program should be reviewed to see how a targeted and comprehensive postpartum visit might be incorporated into their activities.
- Community-based Management of Newborn Sepsis: The majority of newborn deaths occur in the first week of life, with sepsis being a leading cause of death. In response to this, programs have been implemented in South Asia to address this problem. Success has been substantial and Afghanistan should look into piloting this approach to assess its feasibility.

Actions to achieve objective:

- Evaluate results of PPH Reduction Demonstration Project and scale up nationally as appropriate
- Pilot the idea of maternity waiting homes in selected provinces using appropriately designed guidelines
- Review international evidence for integrated postpartum care visits and community-based management of newborn sepsis and consider pilot testing these initiatives in Afghanistan

DEMAND CREATION: Strategies to Increase Demand for and Use of MNH Services

The purpose of increasing demand for quality healthcare is to elevate the perceived value of maternal and neonatal health services in villages so that services will more frequently be used by communities. There are five major “demand generation” areas on which the MNH strategy focuses: 1) capacity building, 2) behaviour change communication, 3) improving the community’s perception of the service being provided, 4) facilitating use of the services, and 5) social mobilisation and advocacy.

OBJECTIVE 9: Increase the capacity of partners to implement demand creation activities

Community mobilisation, participatory methods, community leadership skills and encouraging caring attitudes in healthcare providers are topics in which many implementing organizations require further training. Improving their capacities will enable them to disseminate these ideas to communities, helping community members to plan and become involved in health care. Involving and adapting to traditional village structures are important in gaining village support and ownership. Shuras and village elders are decision-makers in communities and engaging them in decision making at the community level is essential. Female shuras have been developed in some areas of the country, although male and female shuras thus far have different roles. Further leadership training is necessary in both groups to improve function in the future.

Actions to achieve objective:

- Ensure provision of leadership training to community groups and implementing NGOs
- Ensure that implementing agencies use accepted techniques for demand creation

strategies

- Disseminate widely all materials that have been developed for capacity building

OBJECTIVE 10: Expand the use of behaviour change communication activities

Since CHWs are communication and education agents who provide a crucial link between households and health facilities, their communication skills are of great importance. Focused training on how to counsel effectively is a very important aspect of their education. Similarly, all other healthcare workers should be trained in counselling since health professionals often have more influence on stimulating behaviour change than family members and are role models for CHWs.

Men and women are both involved in recognising pregnancy complications and taking decisions for pregnant women, so both genders will be the targets of behaviour change communication strategies (BCC). Behaviour change education will be done initially through direct contact with CHWs and other healthcare workers and then reinforced through broader communication strategies such as radio messages, pamphlets linked to BCC materials and posters. CHWs should also provide BCC in schools because school children are a receptive audience.

Because roughly half of rural families have radios³⁰, mass media approaches will be supplemented by interpersonal methods of communication. Interpersonal communication flip cards have been prepared in 4 areas: antenatal care, birth planning, preparing for home birth and postnatal/newborn care. All promote the concept of skilled attendance but take a pragmatic approach recognizing the reality of home birth for many women in the current Afghan situation. The flip cards concentrate on birth preparedness and complication readiness counselling directed toward all family members, decision makers and community leaders. Documents for these activities have been developed by REACH and are to be made available to all provinces. Radio messages have also been developed but have thus far been disseminated in a limited manner.³¹ Having a set of nationally accepted maternal and newborn health messages will enable NGOs to provide technically sound, consistent information on maternal and newborn care by all health workers, including CHWs.

BCC is not only applicable in communities. It can also be used throughout the health care system. An example of this is the infection prevention programs set up in some hospitals and how slowly all levels of health care workers are changing their behaviour towards infection prevention. BCC materials and job aids have been developed to facilitate appropriate behaviour change.

Actions to achieve objective:

- Ensure that all health professionals and CHWs are adequately trained in BCC skills
- Ensure wide distribution and availability of national BCC materials
- Ensure that radio messages are disseminated and broadcast

³⁰ Central Statistical Office. *op. cit.*

³¹ De Graft-Johnson, J. *Recommendations for improving demand creation for utilization of maternal and newborn health services in Afghanistan*. Unpublished report from ACCESS.

- Promote health education campaigns done both by CHWs and by mobile teams of BHC staff

OBJECTIVE 11: Improve community perception of services

Strategies to address the community's perception of healthcare involve improving the caring attitude of the all healthcare workers towards patients, including doctors, nurses and midwives. Ensuring that privacy and confidentiality exists in the health worker–patient interaction is part of this. Facilitating links between CHWs and BHC staff can in part be accomplished by the new position of CHS and through CHW training opportunities. In addition, mobilising the BHC staff to reach out to communities through mobile clinics and health education campaigns, using the nationally accepted MNH messages will reduce cultural barriers to MNH services. Using group discussions to facilitate community dialogue about this issue can be an effective way of changing perceptions.

Actions to achieve objective:

- Provide training to all health care workers and CHWs/CHSs on the incorporation of caring behaviours
- Promote the participation of community leaders and opinion leaders in facility-based community boards
- Develop approaches to inform CHWs and TBAs of the services provided in facilities and their role in improving these services

OBJECTIVE 12: Facilitate access to skilled attendants and MNH services

Efforts should be directed at facilitating access to the care provided by skilled birth attendants and mobilising communities through participatory approaches and discussions. Some strategies that may be useful require evaluation through pilot projects to determine effectiveness and cultural acceptability. These include the establishment of maternity waiting homes in rural areas, community financing for emergency care and community transport initiatives.

The option of maternity waiting homes has been successful in other countries and is currently being evaluated in Afghanistan. If they are found acceptable and cost-effective, they will be implemented here in specific locations where access to health facilities is particularly difficult and the community is supportive to the idea. Strategically placing maternity waiting homes near designated teaching hospitals that have CEOC capacity could potentially increase the case load at the hospitals associated with midwifery schools.

Community financing options are being studied by Johns Hopkins University but the current study does not look at options for emergency transportation. Tools and approaches for developing emergency transport schemes should be developed and implemented by partners who are working directly with the community.

Actions to achieve objective:

- Promote pilot projects to determine feasibility, acceptability and effectiveness of demand-generation strategies including maternity waiting homes and community financing options

OBJECTIVE 13: Advocate for the use of skilled birth attendants

Advocacy is a process of planned actions designed to influence national policies and cultural norms with the goal of ensuring a more equitable distribution and utilisation of quality MNH services. Multiple stakeholders use data collected through monitoring and evaluation strategies to raise awareness of disparities that exist. The goal is to determine how policies and planning can be changed to create more equity in MNH care. Uniting together under the promotion of maternal and newborn health, NGOs, various departments at the MOPH, community representatives and others can work together to ensure that MNH remains a priority at the MOPH and the various funding agencies.

The Afghan Midwives Association is leading an advocacy campaign around the use of skilled attendants and increasing the awareness of the community about danger signs of pregnancy. A broad based alliance has been formed and will lead efforts related to appropriate advocacy.

Actions to achieve objective:

- Maintain focus on the development of appropriate advocacy approaches for skilled attendance and danger signs
- Develop advocacy packets for providers and policy makers/parliamentarians to increase their understanding of priority areas
- Link with HMIS Department to secure data useful for the selected advocacy initiatives

OTHER STRATEGIES: Supportive Activities to Improve MNH Services

OBJECTIVE 14: Implement appropriate costing strategies

All interventions to improve maternal and neonatal outcomes have both a potential impact and a cost. In 2005, the Maternal Neonatal Program Index was carried out in Afghanistan and demonstrated the level of effort being given to various programmatic inputs. This was followed by the costing study which showed real costs of implementing certain activities. In developing the action plan from this strategy, the costing tools will be used to improve planners' understanding of how changes in maternal and neonatal health services can prevent maternal and newborn deaths and at what cost. Thus cost analysis and cost/benefit data will be used in planning and decision-making for strategy implementation. Using tools of this kind will help determine where effort can be focused to yield the greatest reduction in maternal and neonatal mortality with the most efficient investment of resources, an important effort as donor funding becomes less available and the MOPH gradually takes on more and more financial commitment. It will also help in setting realistic targets in maternal and neonatal mortality reduction.

Actions to achieve objective:

- Orient planners to the use of cost analysis tools
- Ensure that cost factors are included in the planning process

OBJECTIVE 15: Ensure linkages and coordination with other RH Initiatives

○ Coordination with other elements of the reproductive health strategy

Of the other elements of the reproductive health strategy (birth spacing and family planning, gender and reproductive health rights, prevention and management of other RH conditions), the link with birth spacing and family planning will be especially critical. Delay before the first pregnancy and optimal birth spacing between pregnancies have been shown to improve maternal, newborn and child health. Maternal and newborn health is closely associated with reproductive health rights; management of STIs/HIV is an essential part of antenatal care and non-infectious RH conditions can occur during pregnancy and compromise it. All of these areas will be linked to MNH through joint planning, collaborative monitoring and evaluation, and coordination meetings at central, provincial and district levels.

○ Coordination with other parts of the health sector

To be effective the maternal and neonatal health strategy needs to coordinate with portions of the health sector that fall outside the responsibilities of the Directorate of Reproductive Health. Links with other directorates, such as Adolescent Health, Primary Health Care (PHC) and Preventive Medicine (PM) will be established through joint coordination meetings. Adolescent health is a particularly important for MNH because marriage and childbearing in Afghanistan often start in early adolescence. Finally, MNH will maintain close ties with the Institute of Health Sciences (IHS) regarding hospital midwife, nurse and community midwife training, participating with IHS in the curriculum revision process when necessary, among other things.

○ Coordination with other sectors

There are many other sectors whose efforts will have a positive effect on maternal and neonatal health. Improvement of women's status and increased educational levels of women have been shown globally to reduce maternal mortality. Maternal and newborn health will improve if there is concerted effort to communicate with the Ministry of Higher Education since the curriculum, accreditation and selection and deployment of university-level health science students is determined by this sector.

Access to clean water and sanitation alleviate a woman's work load and lead to better health of both mother and newborn. Easier access to health care facilities (BHCs, CHCs and hospitals) from rural areas reduces the delay in getting to health care once a complication is recognised. MOPH will initiate and institutionalise dialog with these other ministries to ensure that their efforts complement those of MOPH in bringing down the high levels of maternal and neonatal mortality.

Recommended actions to achieve linking strategies

- Institutionalise cross-sector team work by:
 - Establishing joint task forces
 - Establishing joint planning groups
 - Utilise brainstorming or other group techniques to improve cooperative planning and coordination

CHAPTER 3

BIRTH SPACING AND FAMILY PLANNING STRATEGY

BIRTH SPACING AND FAMILY PLANNING STRATEGY 2006 - 2009

INTRODUCTION

Family Planning in the Context of ICPD

ICPD promotes **human rights** of every woman, man and child to enjoy a life of health and equal opportunity. In many parts of the world, extreme **poverty** limits choices available to women and men and is an obstacle for them to access basic services needed to improve their situations. Women often suffer disproportionately, due to violence, discrimination and the burden of poor **reproductive health**, which is the leading cause of death and disability for women in their reproductive years.

We must step up efforts for **family planning**, which has a direct impact on maternal health. When couples can choose the number, timing and spacing of their children, they are better able to ensure there are enough resources for each family member to prosper and thrive. Worldwide, families are having half as many children today as they did in the 1960s, but fertility remains high in the poorest countries. Some 350 million couples still do not have access to a range of effective and affordable family planning services, and demand for these services is expected to increase by 40 per cent in the next 15 years.

- **Reproductive Rights**

Attaining the goals of sustainable, equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the right to:

- Reproductive and sexual health as a component of overall health, throughout the life cycle, for both men and women
- Reproductive decision-making, including voluntary choice in marriage and determination of the number, timing and spacing of one's children
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

Defining Reproductive Rights

...reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

—ICPD Programme of Action, paragraph 7.3

Family Planning Situation in Afghanistan

The estimated total fertility rate (TFR) is 6.6 per woman, a statistic that contributes to high maternal and neonatal morbidity and mortality. Weather problems, cultural norms and security restrictions limit access of women to health services resulting low usage levels of birth spacing technology and inadequate information contribute.

In Afghanistan, contraceptive prevalence rate ranges from 2-12% depending on the province. Oral contraceptive and progesterone injections represent the most common methods.³² Even though birth spacing technology exists, little is known about the knowledge level and competency of trained family planning service providers. According to Afghanistan Reproductive Health Resources Assessment (2002), only at 29% of facilities offered three modern family planning methods. Among those facilities, only 7% had female service providers. In the same survey it was found that only 12% pharmacies stocked condoms, varying significantly per province. For example, in some provinces no pharmacies had condoms but in Herat 40% of pharmacies dispensed condoms.

Only one third of married women are aware of one or more methods to delay pregnancy. Awareness is greater in urban areas (45%) than in rural areas (22%). Of those who are aware, less than half are practicing some method of delaying pregnancy³³. And the rate of consistent use of birth spacing methods is unknown. Low literacy rates contribute to this lack of awareness.

Table 4: Selected Family Planning Related Indicators

Total fertility rate ³⁴	6.6 per woman
CPR (modern method) ²	10 percent
Proportion of unmet need for FP ³⁵	22.6 percent
CPR among married girls 15-19 years ²	3 percent
Knowledge about contraception among ever married women ²	28 percent
Desired number of children ³⁶	4 per family

- **Family planning needs for special populations**

In this document special population refers to populations living in underserved areas, Kuchi population, people living in geographical areas where access becomes difficult especially in winter, people affected by natural disasters, internally displaced population (IDPs) and returnees.

In the National Multisectoral Assessment of Kuchi the definition of Kuchi used was ‘A Kuchi is either migratory, or has settled recently due to loss of livestock during the last drought’³⁷. In Afghanistan, the Kuchi population is approximately 2.4 million living in an estimated 240,000 households. Most Kuchi (52%) travel long distances and are called “long range migratory Kuchi”. Short-range migratory Kuchi represent 33% of Kuchis and only 15% of the Kuchi are settled. According to the study, the Kuchi place their trust predominantly in the

³² Multiple Indicator Cluster Survey (MICS), Transitional Islamic Government of Afghanistan and UNICEF, 2003

³³ Multiple Indicator Cluster Survey (MICS), Islamic State of Afghanistan and UNICEF, 2003

³⁴ MICS Unicef 2003 and Best Estimates, Unicef 2005

³⁵ PSI 2002

³⁶ Strategic Family Planning Assessment, WHO 2005 (unpublished)

³⁷ National Multisectoral Assessment on Kuchi, MRRD & WFP, May 2005

religious leaders and shrines. However, the traditional birth attendant, the private doctor and hospital are also used relatively often.

Afghans comprise the second largest number of refugees and IDPs in the world³⁸. Since 2002, millions of refugees have returned to Afghanistan but many remain as internally displaced persons within the country, living in poor conditions. In many cases, these groups have particular needs.

2.2 Barriers to contraceptive use:

Globally many countries have been facing different barriers to contraceptive use. The eight barriers below are the most common.

- Lack of accessible services, and shortage of equipment, commodities and personnel;
- Lack of method choice appropriate to the situation of the woman and her family;
- Lack of knowledge about safety, effectiveness and availability of choices;
- Poor client-provider interaction;
- Lack of community or spousal support;
- Misinformation and rumours;
- Side-effect for some, and insufficient follow-up or ensure proper use and dosage;
- Financial constraints

In Afghanistan empirical evidences show that several of these barriers exist. In-depth analysis of knowledge, attitude, behaviour, and practices of communities might reveal many other barriers.

OBJECTIVES OF THE FAMILY PLANNING/BIRTH SPACING STRATEGY

There are five specific objectives of the strategic framework of family planning³⁹ programme that relate to supply, demand and access to family planning services.

Objective 1: Increase availability of high quality family planning by strengthening the capacity of providers to counsel, provide services and manage side effects and complications, especially for people in rural and hard-to-reach areas, and nomad populations

Objective 2: Improving the enabling environment for the provision of high quality family planning services

Objective 3: Promote involvement of males, religious and community leaders and communities to achieve higher demand for and use of family planning services by couples

Objective 4: Strengthening behavioural change communication (BCC) to increase demand for and use of family planning, and social mobilization among different sectors and populations to support a rapid demographic transition

Objective 5: Expanding the variety of ways that couples can access family planning services both within and outside of the health sector

³⁸ Afghanistan National Human Development Report 2004, UNDP

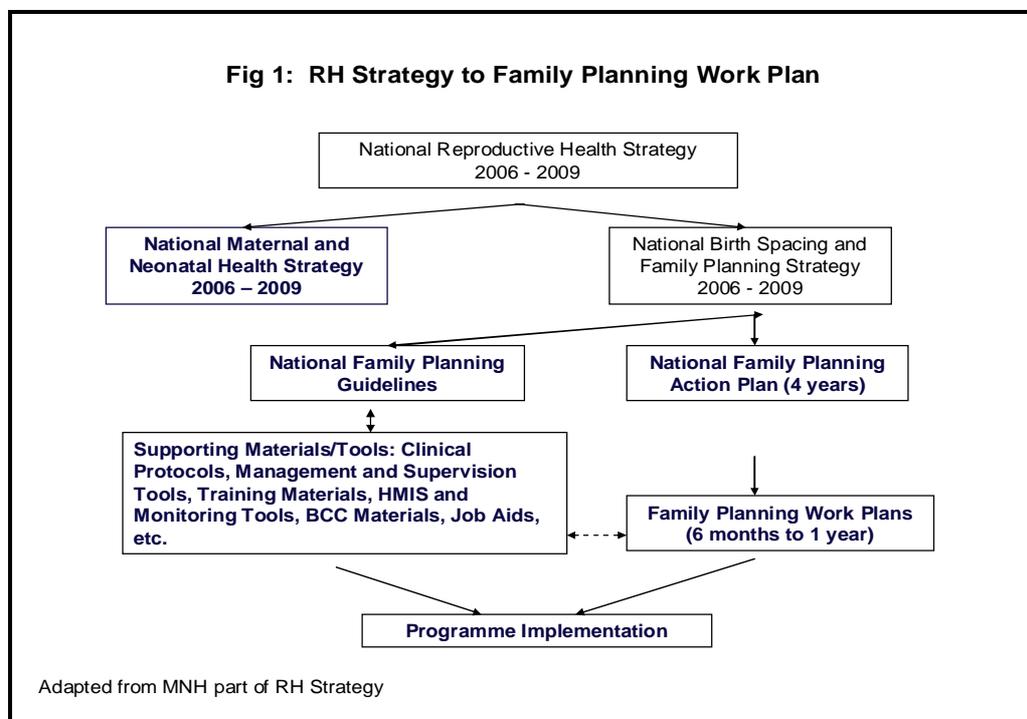
³⁹ Adapted from the National Reproductive Health Strategy for Afghanistan 2003-2005

- **Strategic plan for programme implementation**

It is imperative to develop a plan based on strategic directions for programme implantation. Figure 6, which has been adapted from Chapter 1, describes the flow of actions leading to implementation of the family planning part of the strategy.

During this programme period it is necessary to review the existing guidelines, standards and guidelines, training curricula, different tools used for monitoring and supervision, different BCC materials and job-aids used in the programme. Then it should be decided what documents/tools need revision and what is needed to be developed. Emphasis should be given to complete the stock-taking at the beginning of programme implementation and incorporate all revisions and development of documents/tools in the four-year plan.

Figure 6: RH Strategy to Family Planning Work Plan



- **Operational Principles**

Operational principles for family planning/Birth Spacing strategy include the following:

- Family planning service is an integral part of reproductive health services
- Family planning activities will be emphasized, but will not be developed as a vertical programme.
- For sustainable family planning demand creation a long-term social mobilization plan should be developed. For this activity political commitment, participation of different civil societies and professional bodies are essential.
- Community participation and support from the religious perspective is also necessary.
- Long-term funding commitment especially for commodity security should be ensured.

Supply Creation

The first objective of the strategy is to increase availability of high quality family planning by strengthening the capacity of providers to counsel, provide services and manage side effects and complications, especially for people in rural and hard-to-reach areas, and nomad populations.

- **Family planning services as part of BPHS**

The Ministry of Public health (MOPH) will ensure that women and men have access to quality family planning services through providing birth spacing services as a part of BPHS. Family planning services should be available at all level as part of BPHS. MOPH and PHDs, in collaboration with BPHS implementing NGOs, should ensure that all the service delivery sites provide these services maintaining a set standard. To provide these services level-appropriate training will be necessary to refresh service providers who received training long ago and currently are out-of-date. Also, it is important to develop skills of service providers who have never provided family planning. Table 4 indicates availability of different methods at different levels.

In Afghanistan CPR is low. There is no information about client satisfaction, discontinuation rate or knowledge of family planning methods. Anecdotal information suggests that the use contraceptive injections is rising and that there are IUD acceptors where IUD services are available. Generally, male sterilization is not accepted with the exception of a few cases in areas bordering Iran and Pakistan. Female sterilization service is available in some specialized urban hospitals.

The national programme will ensure that each individual and couple gets adequate and correct information enabling them to choose appropriate methods. As demand for injectable contraceptives and IUDs is increasing, the programme should ensure that supplies of these methods meets the growing demand. Quality IUD services could be as efficient as permanent methods. At the same time, sterilization services should be available from the specialized hospitals in selected areas.

- **Family planning services from district, provincial and specialized hospitals**

Family planning services should be available from all district, provincial and specialized hospitals that provide maternal care. Family planning services should be strengthened at these facilities and should have linkages with the maternity ward of the hospital.

Table 5: Family Planning Methods at Different Service Delivery Level

	Condom	Pills	Inject able	IUD	Female sterilization	Male sterilization
Community level (Health Post)	✓	✓	✓			
Basic Health Center	✓	✓	✓	✓		
Comprehensive Health Center	✓	✓	✓	✓		
District Hospital	✓	✓	✓	✓	✓	
Provincial/specialized Hospital	✓	✓	✓	✓	✓	✓

- **Emergency Contraception**

Emergency contraception in the form of hormone tablets should be available in all facilities from BHCs to Provincial and Specialized hospitals. However, it should not be used as a regular family planning method. Adequate training and supplies should be ensured.

Recommended actions:

- Ensure family planning services are available as recommended in BPHS Guidelines
- Database should be developed indicating availability of skilled service providers at the site level. This will help the NGOs, PHDs and MOPH in developing training plan, facilitating training and monitoring.
- Ensure required logistics especially stock-out of contraceptives at the site level.
- Develop a plan of action for reduction of unmet need
- Train service providers on emergency contraception including those who have already received family planning training.
- Ensure supply of emergency contraception in all health facilities.

- **Family Planning Services Provided by Private Physicians/Clinics**

Large numbers of people visit private physicians and clinics, many of whom are family planning clients so involving them is likely to improve family planning services. MOPH in collaboration with NGOs should identify private physicians who will be interested in providing family planning services in different geographical locations. These physicians will get training on service delivery and supply logistics. MOPH and NGOs will conduct supportive supervision to those physicians.

Recommended actions:

- MOPH will take the leadership in developing a demonstration project
- Mobilize funds for the activity

The second objective of the strategy is to enhance the enabling environment for the provision of high quality family planning services.

- **Quality of care**

The ICPD Programme of Action recognized that in addition to making reproductive health services universal, “family planning programmes must make significant efforts to improve quality of care” (para.7.23). The aim should be to “ensure informed choices and make available a full range of safe and effective methods” (para.7.12). The national programme should improve quality of family planning services in order to meet client satisfaction.

Recommended actions:

- Review existing standards, guidelines and tools etc. and update those documents.
- Develop, as necessary, additional service delivery and other guidelines.
- Increase effectiveness of a functional supervision system throughout the programme.
- Ensure adequate supplies and equipment.

- **Human Resource Development**

- **Community Health Workers (CHW):** The training situation and case load dilemma of CHWs has been discussed in the MNH part of the strategy. Interpersonal communication and community-based distribution CHW is and will play a vital role in family planning services. Careful attention should be given so that CHWs gain skills in interpersonal communication and important messages about different methods including advantages and disadvantages. They should also be able to provide family planning supplies (pills, condoms and injectable contraceptives) to the community.
- **Service Providers at Facility Level:** Community Midwives, Midwives and physicians, located in health facilities would be able to counsel clients on family planning and prevention of STIs including HIV/AIDS. Female service providers would also be able to provide IUD and injectable contraceptives. Permanent methods should be available in selected sites according to the BPHS Guidelines. At least one service provider from each selected service delivery site should be able to provide female and male sterilization.
- **Long-term strategy:** Pre-service education on family planning including STIs and HIV/AIDS should be provided in Community Midwifery, Midwifery and undergraduate medical education. The curricula of Community and Midwifery education and medical school curricula will be kept up to date and a competency-based, participatory teaching methodology should be followed. For undergraduate medical education, MOPH should work with the Ministry of Higher Education and ensure that these topics are appropriately included in medical curricula.

Recommended actions:

- Establish family planning training centre as part of developing national capacity. The national programme should develop family planning Learning Centers for training in Kabul and other major cities.
- Compile and update, if necessary, family planning curricula, have it endorsed by MOPH and ensure that all the NGOs use approved curricula.
- In collaboration with the Ministry of High Education facilitate development of pre-service training curricula for graduate medical course.
- Coordinate with the Community Midwifery and Midwifery school authority for continuation of family planning training as part of overall training.

- **Commodity security**

Family planning programmes are supply-based programmes. Their success relies on women and men having access to a continuous availability of contraceptives. Therefore, the major stakeholders and supporters of sustainable FP programmes are obliged to assure long term commitment for contraceptives and other RH supplies.

The varied strategies for implementing the BPHS programme result in health facilities with non-standardized supplies and contraceptives⁴⁰. Facilities managed by USAID funding through MSH receive contraceptives sourced from the U.S., while other facilities receiving direct grants or supplies from NGOs receive contraceptives and medicines from Pakistan, Iran, China or from wherever supplies are at the lowest cost.

The warehouse system for drug and supplies management is a 30 year old manual “PUSH” system that appears to be still followed very closely. MOPH, neither at central level nor at regional level, have information of procured contraceptives, storage facilities and conditions, stock situation and future procurement plan. This may lead to stock-out and commodity crisis.

Family planning commodity management is part of Reproductive Health Commodity Management which include maternal and neonatal health, family planning, management of STIs, adolescents health etc.

Commodity management is based on four major components:

1. Increased capacity of the Ministry of Public Health (MOPH) so that they take a leadership role in management of RHCS.
2. Standardized procurement system in place.
3. Effective supply system is in place.
4. Monitoring and Evaluation system for RH Commodity Security is in place

○ **Capacity Building**

At present, the Directorate of Logistics has been managing commodities related to RH. The Family Planning Unit of MOPH has been engaged in managing contraceptive logistics. Several donors have been providing support for logistics procurement. Some of the donors are directly providing commodities to their respective programs run by NGOs. Several sub-systems have been developed by different stakeholders. Those sub-systems have been working as stand-alone systems. There are opportunities to coordinate among all the partners.

There is shortage of skilled staff both at the national and provincial level in managing commodities. There is need for finding required staff and train them. One standardized system should be in place and proper equipment would be made available to run the programme.

Recommended actions:

- **Develop a long-term national RHCS plan** through participatory process of different stakeholders.
- **Increase number of experienced staff in the Family Planning Unit, if necessary in the Directorate of Logistics and also at the Regional level.** The MOPH will identify the needs and facilitate this process. At present human resource capacity in terms of commodity management is very limited. For that

⁴⁰ Reproductive Health Commodity Security Assessment in Afghanistan, Schuler-Repp J, August 2005

reason staff members would be identified to work on RHCS at the Family Planning Unit and if necessary, at the Directorate of Logistics. Same time, efforts would be given to identify staff at the Regional level that will be responsible for RHCS management.

- **Identify persons who would be responsible for managing commodity security at the provincial level.** At the provincial level there is a need to identify persons who will be responsible for managing RH commodities. This need substantial negotiation with the Ministry and will be completed in first two quarters in year 2.
- **Skills development of staff members.** There is a need to develop skills of the identified staff members. This includes level- appropriate orientation and skill building. After training there is a need for follow-up of the trainees at their workplace. However, this activity will be covered in monitoring and supervision.
- **Introduction of LMIS.** Information about commodities is fragmented and not available at the MOPH. Different BPHS implementing partners have their own information; sometimes that information is also not adequate to take a decision. So, there is a need to develop a logistic management system.

○ **Procurement of commodities:**

There is a national procurement policy; however, implementation of that policy is weak. There are several partners procuring RH commodities; there is a great need of coordination among the partners and MOPH would take lead role of coordination. There is no provision of quality check or control for RH commodities.

Recommended actions:

- **Strengthen role of Contraceptives Logistics Working Group.**
- **Develop Quality Control System for Family Planning Commodities.** Identify staff for quality control; develop protocols and guidelines on quality control. Provide appropriate training of the staff on this.
- **Procurement of commodities.** Required RH commodities will be procured through the project period in right time.

○ **Storage and supply of commodities:**

Storage for commodities has been an issue. The central warehouse has insufficient space and the storage facility is not up to standard. There are limited or inadequate storage facilities at the regional level and there is no transportation system for the commodities in place.

Recommended actions:

- **Construct or refurbish warehouse.** Based on anecdotal information there is a need for construction or extension of a central warehouse and five more regional warehouses. Donors should be approached for funding for this activity.

- **Develop transportation system for RH Commodity Security.** Over the strategic plan period a transportation system will be developed integrating other transportation mechanisms of MOPH.

- **Supervision, Monitoring and Evaluation of Commodity Management:**

A well defined monitoring and supervision system on RHCS should be in place. Different categories of staff, as appropriate, will be trained to carry out these activities. Major activities will include Develop protocols and checklists for supervision and monitoring, training of supervisors, conduction of supervisory visits and evaluation.

Recommended actions:

- Develop protocols and tools
- Provide training for the supervisors
- Evaluate the supervision system

Demand Creation

The third objective of the strategy is to promote involvement of males, religious and community leaders and communities to achieve higher demand for and use of family planning services by couples

- **Male Involvement**

Some of the most innovative work since the ICPD has aimed to involve men in protecting their partners' reproductive health as well as their own. Through their greater access to resources and power, men often determine the timing and conditions of sexual relations, family size and access to health care. Prior to the ICPD, the population field tended to focus almost exclusively on the fertility behaviour of women, paying little attention to men's roles in its study of the macro dimensions and implications of population growth and fertility rates. As a consequence, basic family planning programmes served women almost exclusively.

Research has long shown that men want to know more about reproductive health and want to support their partners more actively. Men's desire to limit their family size often makes it possible for women who want to use contraception to do so. Research on male attitudes and practices suggests that views of men and women on contraception and family size are much closer than many in the field once believed. Men generally want more and better information and access to services. Those aged 15-24 want fewer children than men 25-34, who in turn want fewer than men in their 50s.

Recommended actions:

- Focuses on men as facilitators to women's contraceptive use and as an untapped group of potential users themselves.
- Programmes emphasis should be given to provide men with sexual and reproductive health care. Programmes can improve men's access to family planning services by making existing services more receptive: welcoming men, both as clients and as supportive partners or fathers, retraining staff, providing information and services for men, and even altering clinic decoration.

- Focus on men as supportive partners of women and seeks opportunities to address the ways that social positions constrain the sexual and reproductive roles of women and men. Addresses inequitable gender norms that harm the health of both men and women. Work to educate men about the ways in which control over family resources, violence at home, or views of male or female sexuality, for example, can inhibit good reproductive health.
- Programme on Mobilizing Young Men to transform the values that underlie harmful behaviours. Encourage men to discuss their beliefs, encourage them to question harmful elements of traditional masculinity and encourage them to promote positive changes. Promote communication and respect between men and women on reproductive health issues.

The fourth objective of the strategy is to strengthen behavioural change communication (BCC) to increase demand for and use of family planning, and social mobilization among different sectors and populations to support a rapid demographic transition

- **Interpersonal Communication and Counselling**

The clients must obtain adequate, accurate information on different family planning methods, enabling an informed decision. The information should be available at the community level as well as at the service delivery sites. All service delivery sites should have informational materials for the clients including for illiterate ones.

Often individuals or couples need details about different family planning options, advantages and disadvantages of different methods, explanation on side-effects or complications etc. For these reasons counselling services should be available at least at the service delivery sites starting from Basic Health Center.

Recommended actions:

- CHWs should receive training to develop communication skills and service content areas;
- Communication materials should be available in all communities;
- Service providers at the clinic level should be trained on family planning counselling using job-aids;
- Job-aids should be available to the service providers; and
- Periodical supervision should support the service providers in developing competency in interpersonal communication and family planning information.

- **Behavioural Change Communication (BCC)**

Awareness of reproductive health issues such as family planning and STIs is very limited. A comprehensive approach for BCC activities is necessary to achieve goal for reduction of maternal mortality. There should be strong linkages in terms of approaches and interventions for BCC among all components of reproductive health. BCC activities of one RH component will complement others. The IEC Department of MOPH has drafted a communication strategy and has a plan to finalize the strategy as soon as possible. During finalization attention should be given so that BCC activities for reproductive health bring quick and lasting impact.

The following approaches will be considered to bring positive behavioural change in target audiences.

- Information transmission or propagation aims at changing the level of awareness;
- Reinforcement of information through instructions, explanations etc. for development or improvement of knowledge and skills, where applicable;
- Persuasion or influence to change norms and attitudes; and
- Create an enabling environment aimed at changing awareness, knowledge, behaviour etc.

Recommended actions:

Though there are opportunities for harmonized BCC activities for all RH components, specific family planning BCC activities will include following:

- Conduct a national campaign focusing on family planning. A medium-term plan should be developed for this campaign. Careful attention should be given for opportunities to collaborate with other ministries and institutions.
 - Develop national capacity both at the central and provincial level in developing and implementing BCC activities.
 - Develop capacity of the media especially in radio, television and print media so that they themselves supplement BCC activities.
 - Conduct advocacy as part of social mobilization for the policy makers, managers and senior officials working in different ministries, government offices, private organizations, teachers and other professional groups to raise support for family planning programme.
 - Help the religious and community leaders at different levels to increase awareness about family planning and support the programme activities.
 - Create awareness on family wellbeing to the school children as part of long-term strategy.
- **BCC Programme for Adolescents and Young couples**

This is a part of BCC activities that underscores the importance of delaying the age of marriage especially for girls and addressing needs of family planning information and services for young couples. There is a need for advocacy with the political, religious and community leaders encouraging an increase in age of marriage. Strong coordination between organizations is necessary.

Increasing Access

The fifth objective of the strategy is to expand the variety of ways that couples can access family planning services both within and outside of the health sector

- **Social Marketing**

Social Marketing will continue to play a key role in increasing access to family planning commodities in Afghanistan, especially in the private sector. A stronger coordination between the National Programme and Social Marketing should be developed.

Recommended actions:

- Develop working relationship with the organization working on social marketing and determine areas of cooperation

- **Family Planning Services for Special Populations**

Special populations referred to previously, Kuchis, IDPs and returnees and people living in isolated areas, require family planning services. A well-defined programme that targets these groups should be lead by the MOPH.

Recommended actions:

- A special programme should be developed in consultation with different stakeholders
- Financial resources should be mobilized
- Gradual implementation should be done under guidance of MOPH

- **Community Linkages**

So far few initiatives have been taken to develop a strong linkage between community and service delivery sites. Health care providers are not used to collaborating and coordinating with communities for service improvement⁴¹. CHWs and TBAs appeared to be main link between communities and service delivery sites. Religious and community leaders, according to that study, have not been involved in support of family planning activities. Activities should be undertaken to develop strong linkages between communities and the service delivery sites. This will increase number of new acceptors, increase continuation rate and service utilization rate for other RH conditions.

Recommended actions:

- Discuss with the stakeholders and provide emphasis on this intervention

⁴¹ Strategic Family Planning Assessment, WHO 2005

CHAPTER 4

GENDER AND REPRODUCTIVE HEALTH RIGHTS STRATEGY

GENDER AND REPRODUCTIVE HEALTH RIGHTS STRATEGY

BACKGROUND:

The term gender refers to social roles that men and women play, because of the way their society is organized. Unlike sex, which is universal, biological, and unchanging, gender roles and relationships are learned, vary among cultures (as well as among social groups within the same culture), and change over time. Gender is often misunderstood to mean *women*, when, in reality, gender refers to the roles and relationships of both women and men in a given cultural context. Although gender roles limit both women and men, they generally have had a more repressive impact on women.

Issues concerning gender discrimination, inequities, and stereotypes often hinder behaviour change and put people's reproductive health at risk. For example, low literacy rate among women leaves them without proper information on ante- and post-natal care, the roles and responsibilities of men within the family affect their acceptance of contraceptives, and the ways in which the cultural norms regarding sexual behaviour for men and for women affect the spread of sexually transmitted diseases.

Improving reproductive health status of people is more complex than just making reproductive health services more accessible. A comprehensive approach is required to address the underlying contextual factors, including illiteracy, early marriage, and gender based violence. Reproductive health services, while it is essential, must be provided in combination with complementary efforts in education, income generation, and community mobilization to enable women and their families to develop to their full potentials.

POLICIES ENHANCING GENDER EQUALITY AND EQUITY

The International Conference on Population and Development (ICPD), which Afghanistan has also made commitments to institutionalize its Programme of Action at the national level, states that:

“Advancing gender equality and equity and empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes”.

- ICPD Programme of Action, Chapter 2, Principles

The government of Afghanistan has committed itself to the principle of gender mainstreaming.

“All programmes must pay special attention to the respective roles and responsibilities of women and men, and not merely attempt to include women as an afterthought. This leads in to our second approach. We will need to undertake a process of re-assessment in all sectors to see where we can newly promote the inclusion of women as well as men in order to increase their role in all walks of life. This should include the political, the economic and the social.”

- the National Development Framework, page 13

The Ministry of Public Health (MOPH) had a major breakthrough in establishing Gender and Reproductive Rights Unit (GRRU) within the Reproductive Health Department structure in

December 2004. The GRRU will continue to play a key role in addressing gender equality and equity in the national health policies and guidelines.

KEY STRATEGIC AREAS:

Advancement of gender equality and equity and empowerment of women should not be an isolated policy goal. Its achievement is closely related to the integration of gender perspectives into national health goals, in particular reproductive health policies and programs.

1. Increase the general awareness of gender, reproductive health and rights

Gender, Reproductive Health, Reproductive Rights, all these concepts and approaches in health can be new to most of the healthcare workers in Afghanistan. It is necessary for them to understand these concepts before putting them into practice.

Training materials are already in place, which needs to be officially endorsed by the MOPH. The training, which will create awareness about gender issues in the framework of reproductive health and rights, will be incorporated into program planning and implementation at the facility level. The results of the past gender training activities show that the close monitoring after the implementation of the training is critical in putting the visions into action. Detail plan for training, indicators to measure the impact, and monitoring checklist need to be developed separately.

Coordination with the Ministry of Women's Affairs on this activity will also enhance the quality and impact of the training at provincial levels.

2. Enhance women's decision making role in relation to health seeking practices

The evidence in Afghanistan shows that the fact that female CHWs comprise more than half of all CHWs has increased access to health services for rural women. The establishment of women's community health committees at health post and health facility levels in some parts of Afghan communities also has facilitated more women to seek health care services. In conjunction with the MOPH's continued effort in the deployment of female CHWs and female health facility staff and existence of female community health committee members, empowerment of women in making decisions regarding their and their family's health need to be strengthened continuously.

Learning for Life, an integrated health and literacy program, which was implemented in 12 provinces of Afghanistan, is a good model in empowering women in providing not only literacy skills but also basic health messages, math, social studies, and skills in communication, negotiation, and conflict resolution, which eventually enabled them to make decisions on healthier behaviour for their own and their family's health.

Again, this will not be an isolated strategy. In order to achieve this goal this message and these activities must be integrated within the BCC components of the Reproductive Health Strategy.

3. *Involve men in activities of reproductive health and rights*

After the ICPD in 1994, more attention has been paid to the role of men in women's reproductive health due to growing recognition that men's attitudes, knowledge, and behaviour can strongly influence women's health choices. This is particularly true in male dominant society such as Afghanistan.

Men, as fathers and husbands, are to be more intimately involved in their wife's pregnancy and childbirths than are other male family members. Besides, they are often the decision-makers, the *mahrms* who accompany their wives to a clinic and the ones who pay for care (including the transportation).⁴²

As partners of women, men should be encouraged to learn birth preparedness, antenatal, delivery and postnatal care. In addition, they can play a supporting role which no one else can play. For example, he can encourage the wife to rest and help her reduce her workload, encourage a nutritious diet, and follow-up on care as prescribed. He can be a positive mediator between his parents and his wife since parents may put pressure on the couple to have many children soon after marriage.

It is worth noting that increasing male involvement could potentially intrude on women's empowerment by allowing men to interfere with the domain which has traditionally been managed by women.^{43 44} Balancing the involvement of men with the empowerment of women is a challenge that must be defined by Afghan communities. A community survey involving both men and women, looking at antenatal, delivery and postnatal care would enlighten the MOPH regarding the next steps in the strategy to enhance men's involvement in maternal health.

42 Baura, Alka et al (2004): 'Caring Men? Husbands' Involvement in Maternal Care of Young Wives', Economic and Political Weekly: 5661-5668.

43 Helzner, Judith Frye (1996): 'Men's Involvement in Family Planning', Reproductive Health Matters (7): 146-53.

44 Ransom, Elizabeth (2000): 'What Role Do Men Have in Making Motherhood Safer? Questions Researchers Can Ask', PAA: 18.

CHAPTER 5

STRATEGY FOR OTHER AREAS OF REPRODUCTIVE HEALTH

STRATEGY FOR OTHER AREAS OF REPRODUCTIVE HEALTH 2006 - 2009

INTRODUCTION

As mentioned at the outset of this strategy, reproductive health is a comprehensive package of services which together lead to an overall greater sense of reproductive and sexual wellbeing. While the major focus for Afghanistan for the coming years will be maternal/newborn health and family planning, all people would benefit from initial activities to put in place other components of reproductive health.

PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

The ICPD called for screening and treatment for sexually transmitted infections (STI), along with information and counseling, to become 'integral components of all reproductive and sexual health services. The national reproductive health programme should include guidance on the implementation of activities to reduce and manage STIs. Integration of prevention and treatment of STIs within a package of reproductive health services would be the focus for addressing STIs.

Initial steps to lay the foundations of a national program should include:

- Linkages with the National AIDS Control Program to identify areas of programmatic responsibility and to prevent duplication, gaps and inconsistencies
- Review of current activity related to management of STIs and experience of MOPH/NGOs implementing STI services
- Prevalence studies on STIs in Afghanistan to understand the extent of the situation
- Development of clinical guidelines for the diagnosis and management of sexually transmitted infections (as part of the package)
- Review and adoption of clinical protocols (clinical protocols appropriate to limited resource settings are available from the WHO. The WHO manual *Sexually Transmitted and Other Reproductive Tract Infections - A Guide to Essential Practice* would be appropriate for this purpose)
- Training of providers in the early diagnosis and treatment of STIs for clients and their partners
- Integration of screening approaches in antenatal care settings, as appropriate

Additional activities might include:

- Making "youth-friendly" reproductive health information and services readily accessible to young people
- Condom promotion and distribution
- Providing specific services for populations at risk - such as long-distance truck drivers, military personnel and prisoners etc.

INFERTILITY

Inability to have children is a tragedy for the couple and the family, which unfortunately often has its greatest impact on the woman. Millions of couples around the world have been

facing this harsh reality and their private agony is compounded by social stigma, which can have serious and far reaching consequences⁴⁵. Basic information and treatment is feasible in Afghanistan, however, provision of advanced and highly technical interventions is neither possible nor advisable at this time. Programs should consider both interventions for management of primary infertility as well as identification of opportunities for the prevention of secondary infertility.

In Afghanistan information on infertility is virtually non-existent. Efforts should focus on basic information for both providers and the public.

Initial steps to lay the foundations of a national program should include:

- Prevalence survey to understand the extent of the problem in Afghanistan
- Development of national clinical guidelines for the diagnosis and management of infertility
- Training of providers in fertility awareness, simple diagnostic approaches and basic management techniques for infertility, including the avoidance of certain interventions
- Program communication regarding fertility awareness
- Intervention strategies to reduce the possibility of secondary infertility due to post partum infection

Additional activities might include:

- Program communication activities to disseminate appropriate information about infertility and intervention strategies
- Advocacy to reduce social stigma about infertility

PREVENTION AND MANAGEMENT OF NON-INFECTIOUS REPRODUCTIVE HEALTH CONDITIONS

Obstetric fistula

Little is known about obstetric fistula in Afghanistan. Initial efforts should include the following:

- Prevalence assessment of morbidity related to obstetric fistula
- Situation analysis related to the development of a program or specialty surgical centre for the repair of obstetric fistula

Cervical cancer

Recent evidence and programmatic activity has demonstrated the effectiveness and efficiency of large scale interventions to detect pre-invasive cervical cancer and prevent progression from pre-invasive disease to invasive disease, which is exceedingly more difficult to manage. Initial efforts in Afghanistan should include:

- Prevalence assessment of cervical carcinoma

⁴⁵ Progress in Reproductive Health Research, Vol no. 63, 2003

- Situation analysis related to the development of a cervical cancer prevention program which incorporates “See and Treat” technology such as visual inspection with acetic acid (VIA), ideally suited for a low resource settings such as Afghanistan.

Genital prolapse

Women in countries with high fertility and low socio-economic conditions are often plagued with genital prolapse and go to extreme measures to alleviate their suffering. These efforts are sometime more harmful than helpful, and simple, inexpensive options are available to reduce the morbidity of the situation. Initial program approaches might include:

- Basic clinical guidelines for the assessment and management of genital prolapse
- Situation analysis related to the development of a program or specialty surgical centre for the repair of genital prolapse.

CHAPTER 6

MONITORING AND EVALUATION

MONITORING AND EVALUATION STRATEGY

A **monitoring and evaluation system**, based on key indicators and fed by appropriate data from existing sources, will enable all implementing partners to remain aware of progress toward the desired performance. Firstly performance gaps will be identified and then plans that respond to these gaps will be created at both the national and local levels. Continuous assessment of the program will result in both improved outcomes for the program but also increase the ability of the MOPH to direct and manage its programs.

For this strategy some aspects of monitoring and evaluation have been completed but more effort and time are required to develop this further – selecting indicators and setting targets, improving quality and collection rates and following trends over time and geographically. Effective advocacy requires appropriate use and dissemination of data to key partners in an easily understood way. Monitoring and evaluation is an on-going activity that will be occurring on a quarterly basis for at least five indicators, and on an annual or twice yearly basis for other indicators.

o **Select key indicators and set targets**

Data is currently being collected in several data bases at different frequencies. These allow calculation of numerous reproductive health indicators. The purpose of following these is to compare the trends in these indicators both across provinces and over time. In addition, the indicators should be compared with specific targets or standards so that programmes and policies can be changed and resources allocated based on sound, scientific data. Selected indicators are listed in Table 5. The RH Monitoring and Evaluation Working Group in consultation with the M&E Department of the MOPH has prioritized these indicators based on quality of current data being collected, importance of the indicator for program design and global recommendations on frequency of data collection for each indicator. Coordination with the Monitoring and Evaluation Department of the MOPH must continue in the future to keep abreast of the availability of data sets and the information they offer.

The first 5 indicators in Table 5 will be followed on a quarterly basis from HMIS data. Trends will be important to note from these data since the information collected is predominantly from health facilities. The indicators from HMIS data will be compared with household surveys that occur on a less frequent basis. These household surveys are noted in the last column – “Alternative Sources of Data”. This comparison will illustrate what proportion of community health characteristics are represented by health facility data. Additional indicators we are unable to calculate from HMIS data can be calculated from community based data. Targets have yet to be set.

Several months were spent to achieve a consensus of indicators that the RH department viewed as priorities for surveillance on a quarterly basis. The choice of indicators was limited due to availability and reliability of existing data. As the health system improves and the quality of data in the HMIS database becomes more reliable, the prioritized indicators will change.

Table 6: RH Indicators for RH Department

#	Indicators (per province)	Definition	Regular Collection (quarterly)	Alternative Data Sources
Indicators - Monitored Quarterly, Displayed and Distributed				
1	% births attended by skilled attendants per province	# births attended by SBA / # expected births in province ⁴⁶	HMIS (quarterly)	NRVA (2005/07) MICS 2003
2	Availability of Basic EOC ⁴⁷	# BPHS facilities with BEOC / # BPHS facilities	HMIS - FSR	JHU – NHPA (annually)
3	Availability of modern contraceptives in BPHS facilities	# BPHS facilities providing 2 modern methods / # BPHS facilities	HMIS - FSR	JHU – NHPA (annually)
4	Rate of vaccination of pregnant women with two TT doses	# pregnant women who received ≥ 2 TT / # expected births in province	HMIS - MIAR EPI (quarterly)	NRVA MICS
5	Availability of female skilled birth attendants ⁴⁸	# facilities with ≥ 1 female MD or midwife / total # facilities	HMIS (quarterly)	JHU – NHPA (annually) HR database (eventually)

Indicators Monitored Annually or Less Frequently – Household Surveys				
6	Antenatal care coverage	#women who have had ≥1 antenatal visit by SBA / # expected births in province ⁴⁹	HMIS over-estimates -issues in record keeping	NRVA MICS
7	Availability of CEOC ⁵⁰	# BPHS facilities with CEOC / population	HMIS (quarterly) data quality varies	JHU – NHPA (annually)
8	Early neonatal mortality rate	# newborn deaths / total live births per 1000		NRVA
9	Contraceptive prevalence rate	# women using modern contraception from CHW or HF / # women 15-49y		NRVA
10	Proportion of all births in BEOC and CEOC facilities	# births in BPHS facilities / # expected births in province		NRVA MICS
11	Total fertility rate (TFR)	Sum of age specific fertility rates		HHS (Every 3 years)
12	Maternal mortality ratio (MMR)	# maternal deaths / 100,000 live births		NRVA 2007 (Every 8 years)
13	Unmet demand for contraceptives	# women wanting contraception but don't use it / # women wanting contraception		HHS (Every 5 years)

⁴⁶ Expected births = crude birth rate X population

⁴⁷ To be compared with 1/30,000 recommended by BPHS; includes IV antibiotics, oxytocics, sedation, manual removal of placenta & qualified assisted delivery

⁴⁸ In Afghanistan, female MDs + midwives

⁴⁹ Expected births = crude birth rate X population

⁵⁰ To compare with desired coverage 1/200,000; comprehensive EOC includes basic EOC (IV antibiotics, oxytocics, sedation, manual removal of placenta & qualified assisted delivery) + surgery, anaesthesia and blood transfusions

14	Exclusive breast-feeding for 6 months	# children 0-181 days exclusively breastfed / total number of children 0-181 days		HHS (Every 2 years)
15	Knowledge about danger signs in pregnancy and childbirth	# adults who know 3 danger signs / total # adults		HHS (Annually)

Other Indicators Requiring Improved Quality and Collection				
16	Perinatal mortality rate	# of perinatal deaths/total births per 1000	HMIS	
17	Combined case fatality rate of 5 common causes of maternal mortality ⁵¹	Sum of case specific mortality rates	HMIS	
18	Met need for emergency obstetric care	# women with obstetric complications treated at BPHS facilities / expected # complications ⁵²	HMIS	
19	Prevalence of low-birth-weight (LBW)	# births < 2500g / # infants delivered	HMIS	
20	Effective referral system	# ob pts referred into BHC+CHC+DH/ # ob pts seen in these health facilities ⁵³	HMIS	
21	Rate of postpartum visits	# mothers with infant <1yr and postpartum visit < 7d after birth / # mothers with infants <1y	HMIS	
22	Population based caesarean section rate ⁵⁴	# C-sections/# expected births in province	Obstetrical monthly delivery report (eventually)	
23	Perinatal mortality rate	# of perinatal deaths/total births per 1000	HMIS	
24	Combined case fatality rate of 5 common causes of maternal mortality ⁵⁵	Sum of case specific mortality rates ⁵¹	HMIS	

○ **Improvement in quality of data and frequency of collection**

There is some inherent difficulty in calculating all RH indicators in Afghanistan because the accuracy of the denominators (population characteristics) requires improvement. In many cases numerators need to be more accurate as well. Several indicators although desirable to have, must be improved before they can be selected (indicators 16-24 in Table 5). Constant monitoring of HMIS data must occur to improve reporting accuracy and collection. Quality improvement in HMIS data will occur as it is used since with use, people will rectify inaccuracies.

The community component of the national HMIS data is currently weak and must be strengthened through improved CHW reporting so that the information describes

⁵¹Haemorrhage, obstructed labour, pregnancy induced hypertension, postpartum sepsis and complications of abortion

⁵² Expected # of complications = 15% of expected births

⁵³ To compare with 15%

⁵⁴ 5-15% is an acceptable international standard

⁵⁵Haemorrhage, obstructed labour, pregnancy induced hypertension, postpartum sepsis and complications of abortion

programmes both in communities *and* in health facilities. Combining these sources will provide a broader image of the health of the nation as well as specific data related to geographic areas. Until this occurs, ad hoc household surveys will be used to provide the majority of community data. The new position, community health supervisor, can improve the quality of data being collected by the community through supervision of CHWs.

○ **Timely analysis of data**

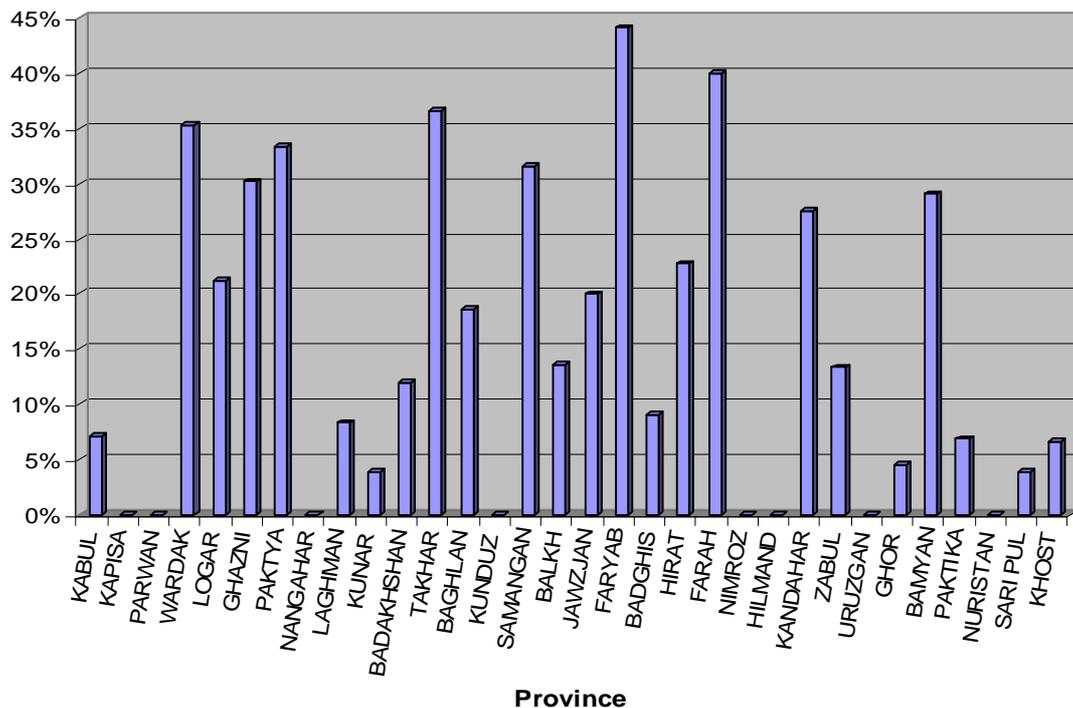
Quarterly analysis of indicators is important in order that gaps can be identified and changes can be implemented. Data can be analyzed for a given quarter for all provinces (Fig 7-11), looking for particularly weak or strong provinces for the designated characteristic. It is also done for one province over several quarters (Fig 12a-f), looking for progress, tracked over time. This is done for each province by analyzing separately each of the 5 indicators. When results of household surveys become available, the information should be compared. Because the HMIS data base has gradually been developed over the past 3 years, the bar charts of data over time are unreliable before the year 1383 (Shamsi calendar).

○ **Presentation and use of data**

Several indicators are presented graphically here. The data are taken from HMIS reporting and represent a sample of those indicators which could be used routinely to monitor the National Reproductive Health Program.

Figure 7: Proportion of Total Provincial BPHS Facilities Providing Basic Essential Obstetric Care

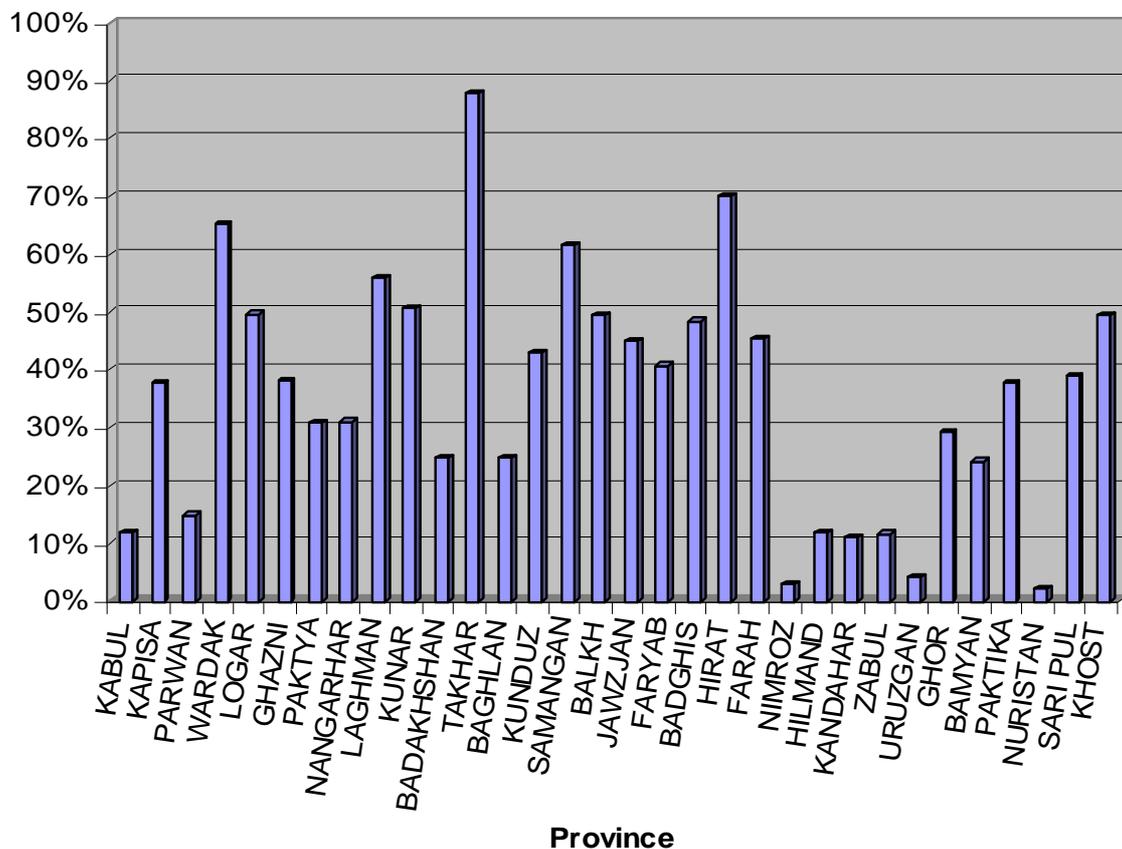
Proportion of Total Provincial BPHS Facilities Providing Basic Essential Obstetric Care



Note that BPHS facilities offering BEOC were determined from HMIS data using the “Services provided” portion of the Facility Status Report (FSR). For a facility to be counted as providing BEOC it had to offer all of the following services: delivery offered by a trained attendant, assisted delivery, and manual removal of placenta, removal of retained products, IV anticonvulsants, IV antibiotics and IV oxytocin. In addition, only BPHS facilities were included in data collection so that specialty hospitals, provincial hospitals and private facilities do not appear in the calculation. Future analysis could be done to include provincial and specialty hospitals in a summarized figure once data from those facilities is available.

Figure 8: Proportion of Expected Births Per Province Where Mothers Have Received Two or More Tetanus Vaccinations

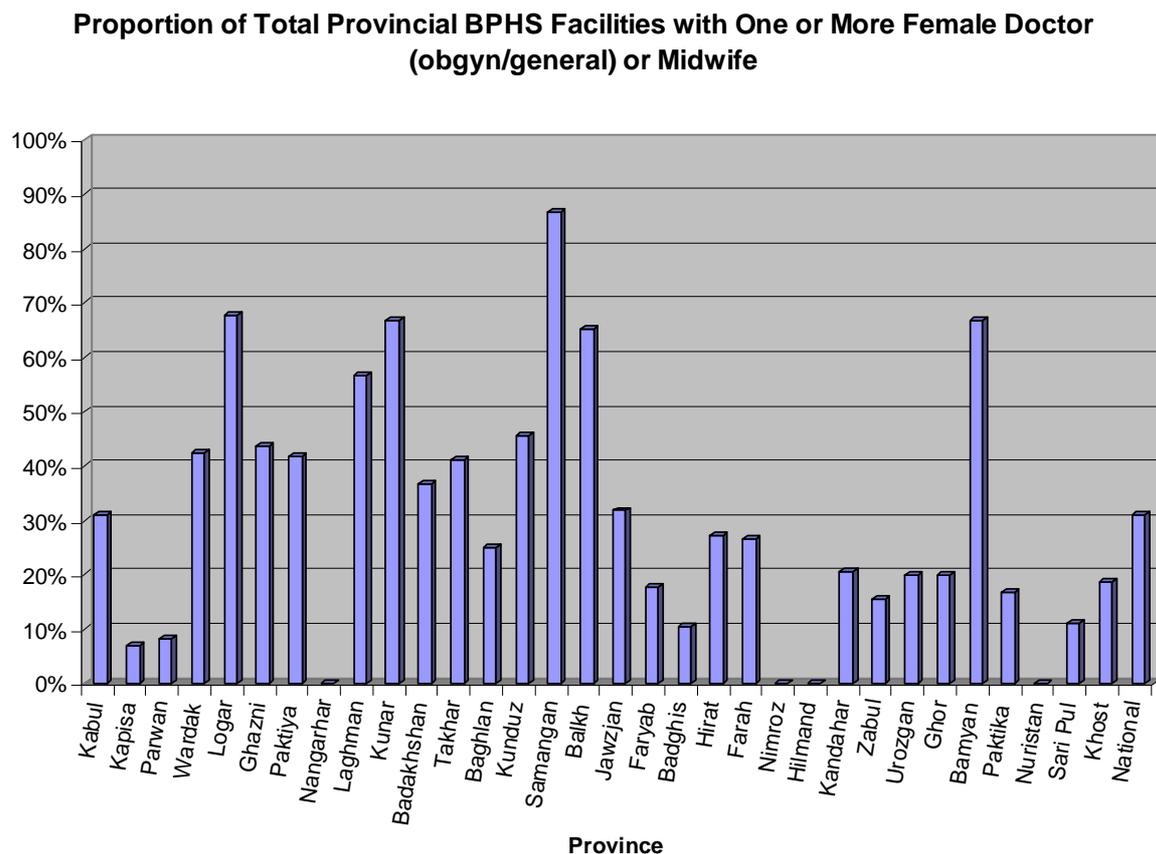
Proportion of Expected Births Per Province Where Mothers Have Received Two or More Tetanus Vaccinations



HMIS data was used to calculate the number of women in the first two quarters of 1384 (Shamsi). Note that Takhar has the highest rate of TT vaccination and Kabul, Nimroz, Hilmand, Kandahar, Zabul, Uruzgan and Nuristan are all very low. Whether this is because vaccination have occurred elsewhere, women cannot get to where vaccinations are provided or because there are no vaccinations offered, differs province to province. Of course there may be some errors in the system of data collection or in calculation of the indicator. Although the criterion for filling in the form is to count the woman only after two TT vaccinations, there may be errors since it is easier to count a woman each time she is vaccinated. This results in double counting. In this graph “expected births” were used as the

denominator in calculating this indicator, not number of women age 15-49 years of age. Geographic trends and changes over time can be measured but exact comparisons with other countries would be inadvisable. There is some error in the denominators since provincial populations are from pre-census CSO data and a national estimate for crude birth rate (45/1000) was used. It is important to note that birth rates may differ from province to province.

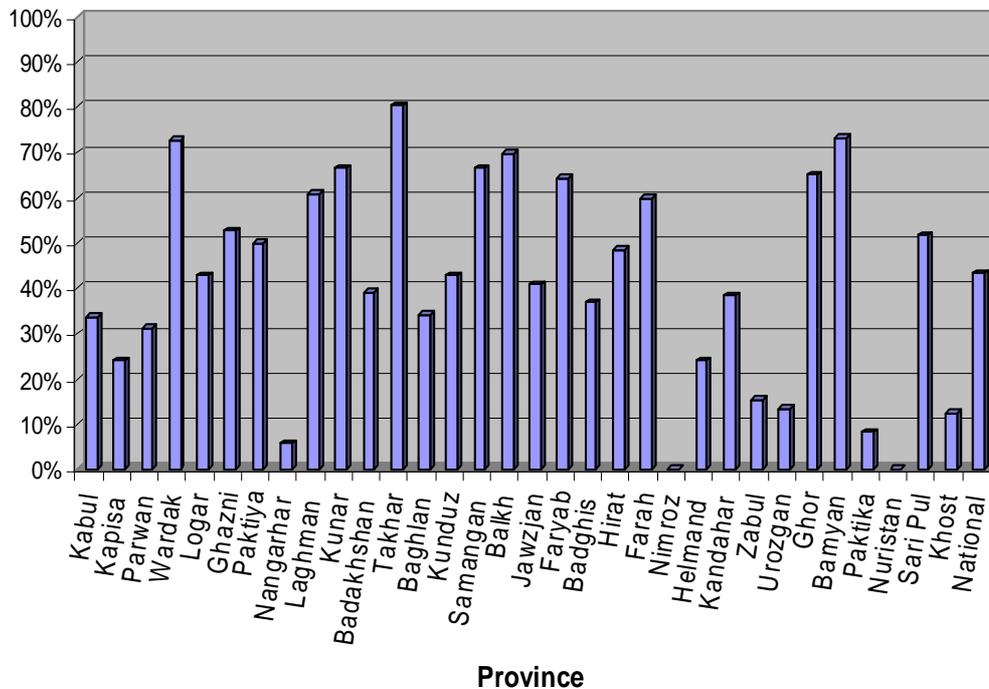
Figure 9: Proportion of Total Provincial BPHS Facilities with One or More Female Doctor (bogy n/general) or Midwife



The data for BPHS facilities with skilled birth attendants was obtained from HMIS FSR data for the first two quarters of years 1384. Several provinces still have no female skilled birth attendants. Surprisingly, Kabul’s BPHS facilities that have female skilled birth attendants appears low, only 30%. But in looking more closely at the data for Kabul, 97% of the facilities that returned their HMIS forms had female skilled birth attendants but only 30% of the facilities in Kabul returned HMIS forms. This highlights the need to encourage greater compliance with HMIS reporting.

Figure 10: Proportion of Total Provincial BPHS Facilities Providing Two or More Birth Spacing Methods

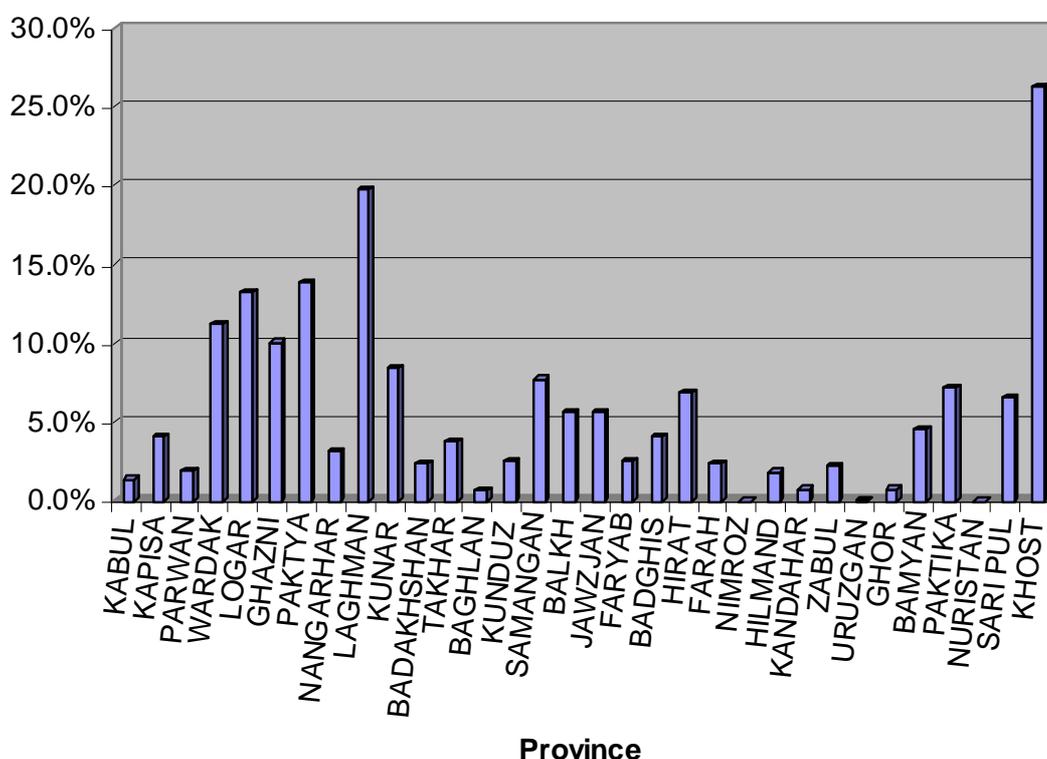
Proportion of Total Provincial BPHS Facilities Providing Two or More Birth Spacing Methods



The availability of two or more birth spacing methods was calculated by choosing those facilities that have treated one or more clients with two different modern methods of contraception in the first and fourth months of 1384 (Shamsi). Once again, this indicator is influenced by the number of BPHS facilities that have returned HMIS forms. For example, Nimruz and Nuristan have the lowest measured percentages in this figure but they have only returned forms from 1 facility.

Figure 11: Proportion of Expected Births Per Province Occurring at BPHS Facilities

Proportion of Expected Births Per Province Occurring at BPHS Facilities



The proportion of BPHS facility births is low, surprisingly low in Kabul as well as in several other provinces. The ratio is highest in Khost and Laghman (26% and 19% respectively). It's important to note that as with all indicators, only BPHS facilities are included and that in facilities not submitting forms falsely low numbers may be assigned to the corresponding province. Future analysis could be done to include provincial and specialty hospitals in a summarized figure representing "Births in Public Facilities". This is a more inclusive statistic to monitor over time. But again, this would not account for deliveries by skilled attendants in private facilities. An overall assessment of "Proportion of Births Attended by a Skilled Attendant" can be achieved through household surveys, on a less frequent basis and should be used to compliment the information from the HMIS system.

In the following 6 figures (Fig 12a-f), provinces have been grouped geographically and one indicator (proportion of expected births where mothers have received TT vaccination) has been followed quarterly starting in 1383, continuing to 1384. In general the trend is upwards, but this is not true in all provinces. The high vaccination rate indicates that over-estimation may be occurring through double counting. Alternatively, the denominator may not correspond with the numerator. For example, "expected births" falsely under-estimate the number of women who should be vaccinated. A preferred denominator is women between the ages of 15-49 years old because the numerator of the indicator is women of child-bearing age who have been vaccinated during that quarter.

Figure 12 a: Central Provinces: Proportion of Expected Births Where Mothers Have Received Two or More TT Vaccinations

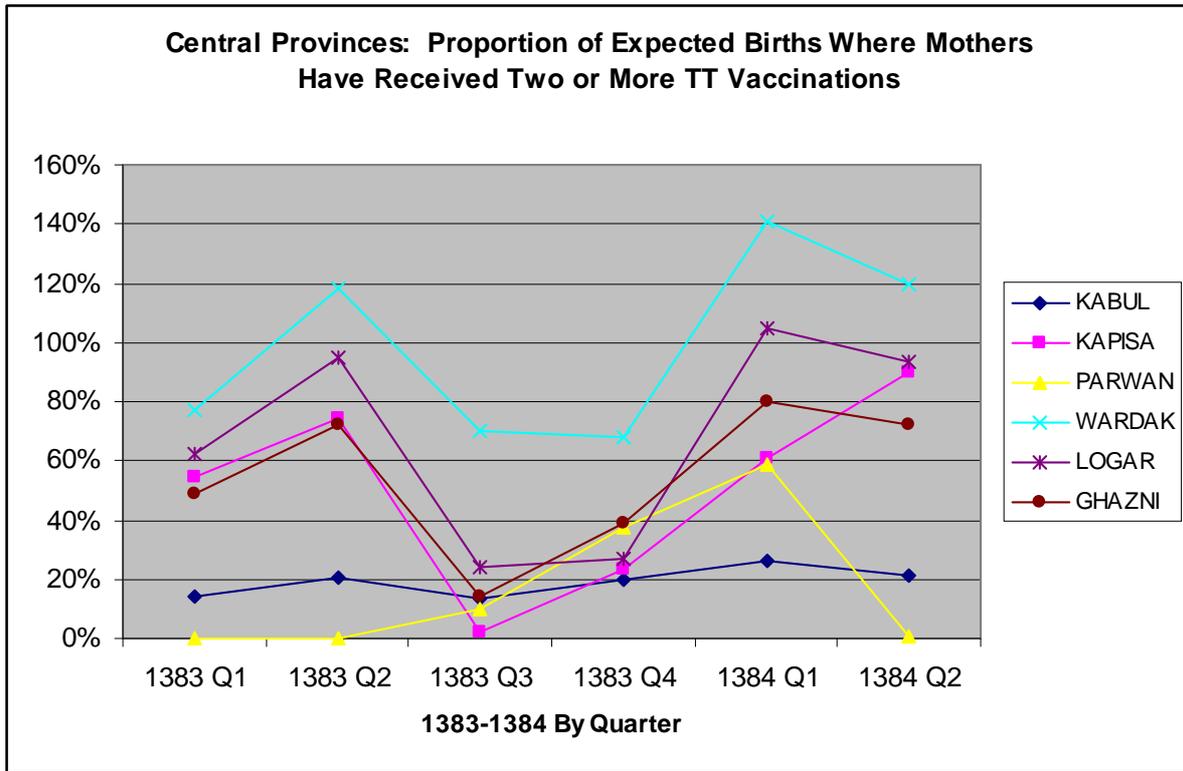


Figure 12 b: Eastern Provinces: Proportion of Expected Births Where Mothers Have Received Two or More TT Vaccinations

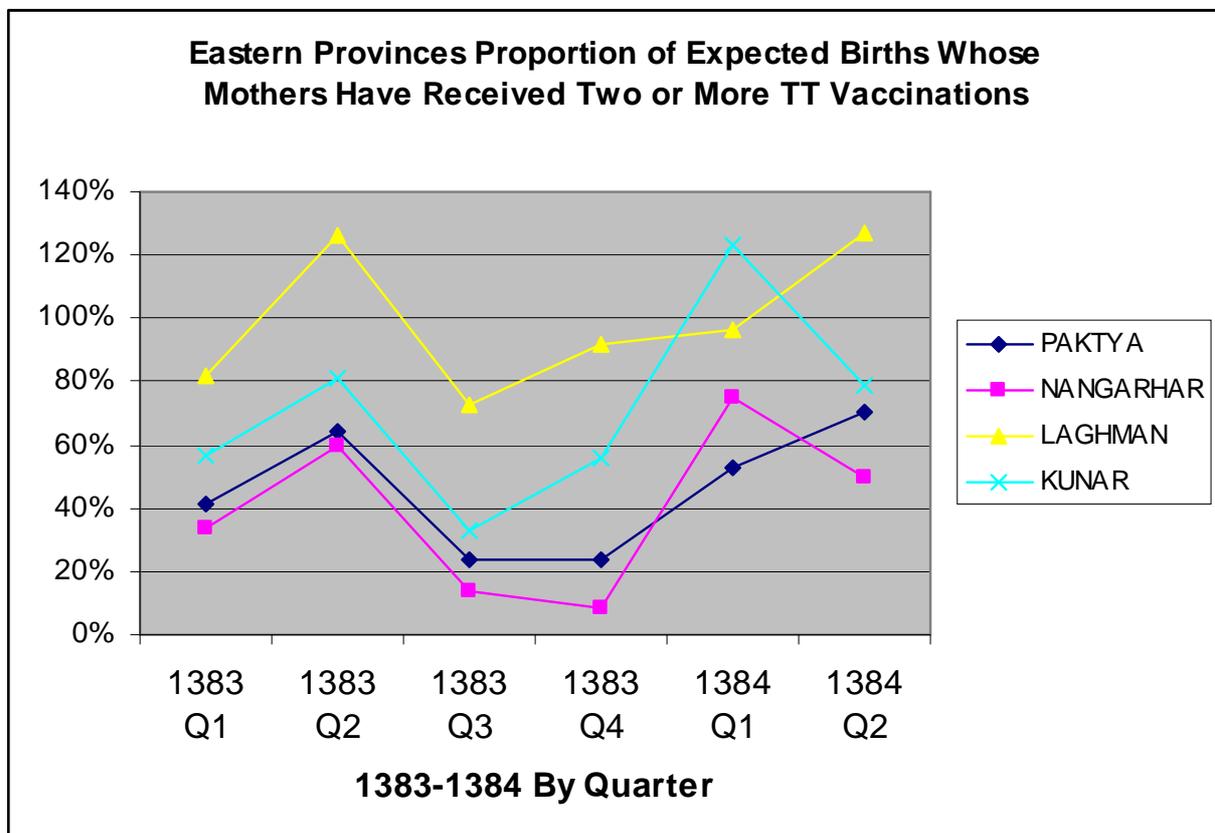


Figure 12 c: Northern Provinces: Proportion of Expected Births Where Mothers Have Received Two or More TT Vaccinations

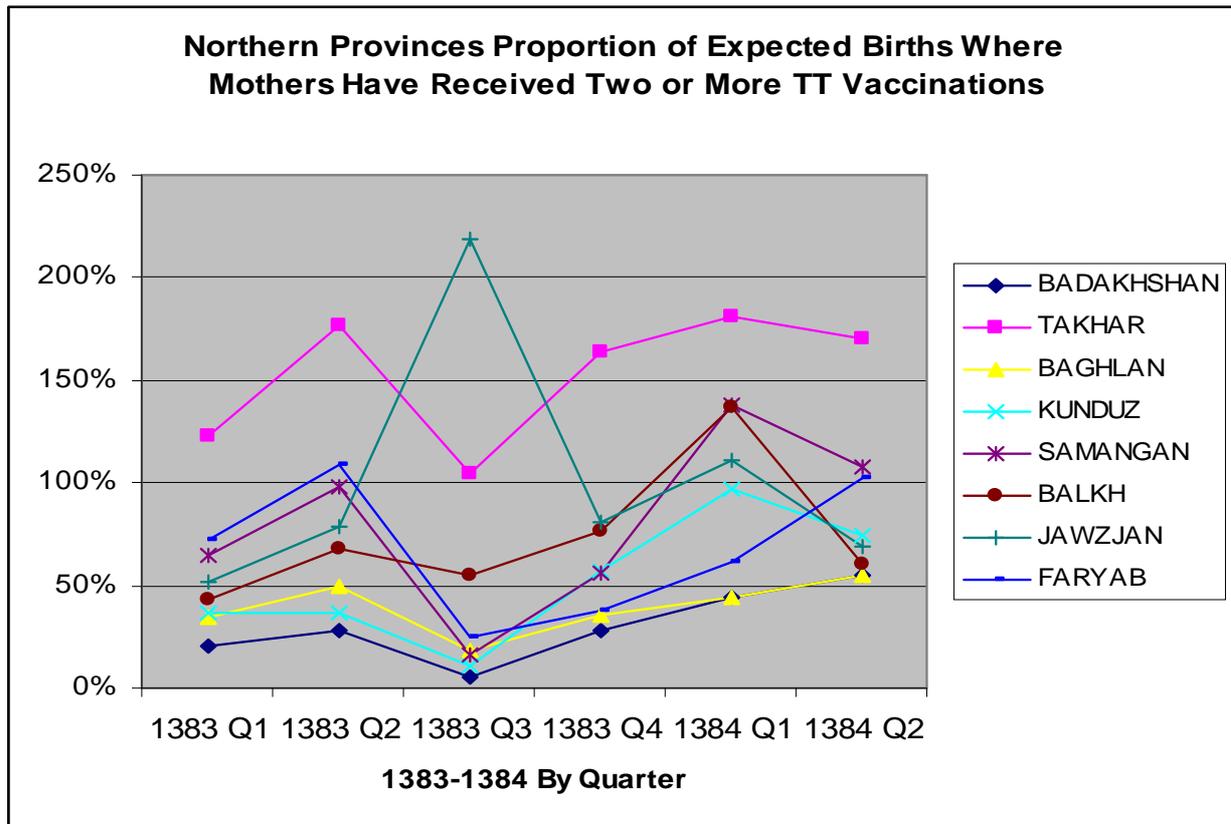


Figure 12 d: Western Provinces: Proportion of Expected Births Where Mothers Have Received Two or More TT Vaccinations

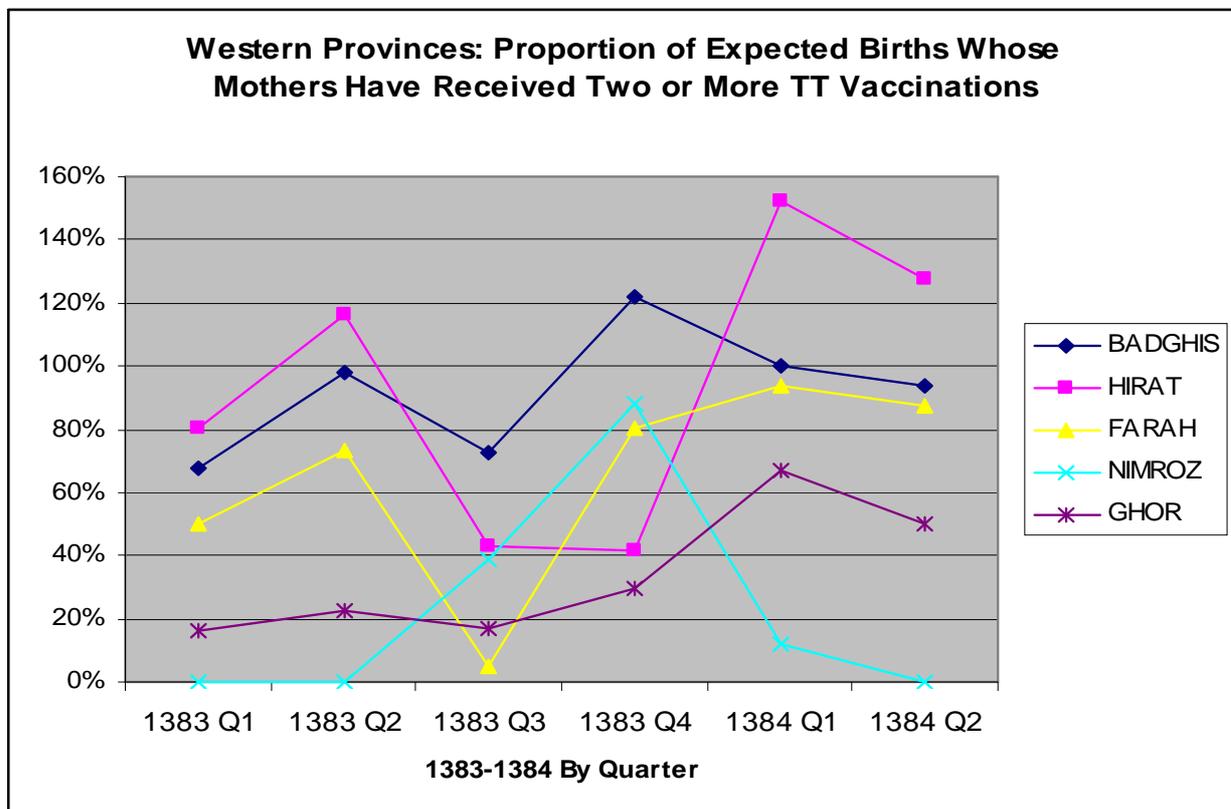


Figure 12 e: Southern Provinces: Proportion of Expected Births Whose Mothers Have Received Two or More TT Vaccinations

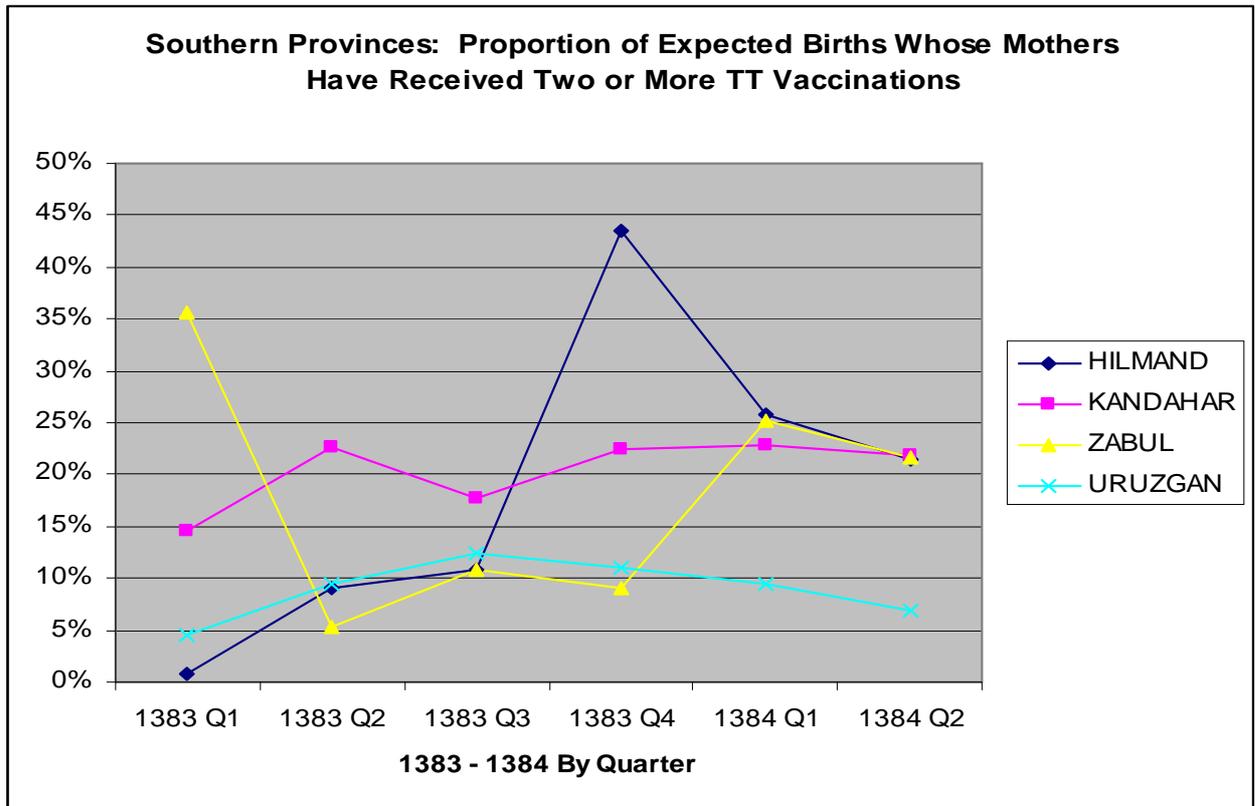
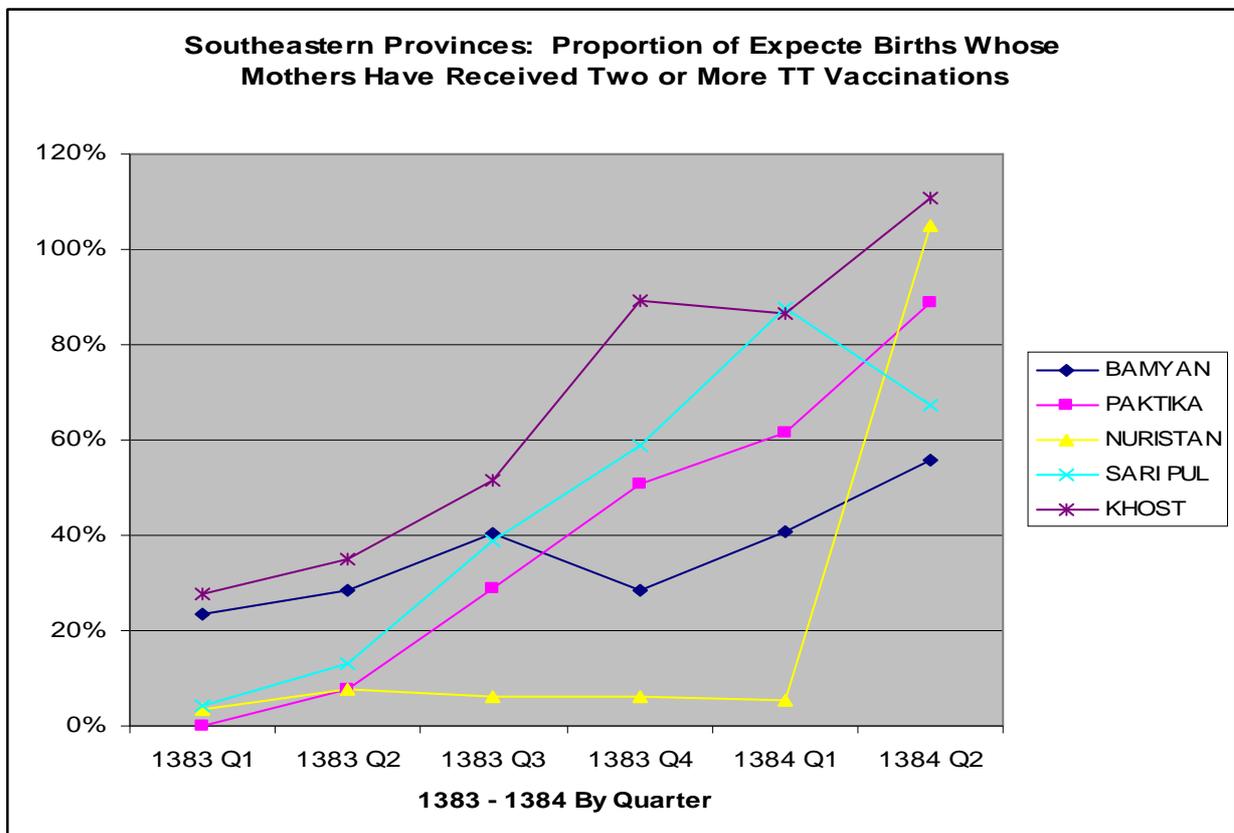


Figure 12 f: Southeastern Provinces: Proportion of Expected Births Whose Mothers Have Received Two or More TT Vaccinations



○ **Ensure effective use of indicators**

As seen in the previous paragraph, timely analysis of indicators is an important part of using the data for identifying particular strengths or weaknesses in programs. In addition, well displayed data are easily disseminated and are powerful in showing trends for advocacy. Strategic selection of key departments, organizations and media sources for dissemination are an important part of advocating for RH.

Establishing a link with the newly re-instituted Afghan Public Health Institute (APHI) will be important for technical assistance. This institute is an independent organization under the direction of the Ministry of Planning and Preventive Care and will receive technical advice from UNICEF and CDC.

Recommended actions to achieve monitoring and evaluation strategies

- Select targets for the 5 indicators to be monitored quarterly
- Analyse and display selected indicators on a quarterly basis
- Disseminate selected indicator displays on a quarterly basis
- Compare indicators from household surveys when they become available
- Use indicators to compare with standards, define gaps and allocate resources accordingly
- Encourage continuous data quality improvement especially for HMIS
- Encourage awareness of all databases including HMIS
- Ensure that RH Officers and CHSs understand quality data and can do some basic data analysis
- Train MOPH and NGO HMIS staff in data analysis and data quality improvement
- Develop a link with APHI and HMIS

CHAPTER 7

NEXT STEPS...

NEXT STEPS

The development of this strategy provides a useful road map for the National Reproductive Health Program. Further implementation will require specific attention to several areas, as outlined in the Program Implementation Framework.

Development of a National RH Action Plan

This strategy will guide the development of a national action plan for reproductive health. The

- Key Output
- Activities to achieve output
- Timeframe (expressed by year and quarter)
- Lead Implementing Partner to MOPH
- Other Partners
- Requirements/Conditions

Key Output	Activities to achieve output	Timeframe				Lead implementor	Other Partners	Requirements/ Conditions
		2006	2007	2008	2009			

Development of Program Area Specific Annual Workplans

The Reproductive Health Directorate of the MOPH will convene selected task forces and working groups to assist it in developing and implementing this national strategy. At present the following groups exist to support the RH Directorate:

- Reproductive Health Task Force
- Maternal and Neonatal Health Working Group
- Family Planning Working Group
- RH Monitoring and Evaluation Working Group

Each group has an appropriate Terms of Reference and list of members.

Each group will develop an appropriate annual (12 month) work plan by calendar year which is consistent with the 4-year RH Action Plan. This work plan will be expressed by month and outline the activity through the year for achieving the goals of the strategy. Times for reviewing monitoring indicators will be noted on this work plan. It will follow the same outline as the RH Action Plan, but with more specificity.

#	Activity	2006												Lead Partner for MOPH	Notes
		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
1															

ANNEXES

ANNEX 1: GLOSSARY OF TERMS RELATED TO REPRODUCTIVE HEALTH

REPRODUCTIVE HEALTH DEFINITIONS

Reproductive Health	<p>Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive Health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.</p> <p>Reproductive Health includes the following essential components:</p> <ul style="list-style-type: none"> • Family Planning counselling, information, education, communication and services • Safe Motherhood; education and services for healthy pregnancy, safe delivery and post natal care including breast-feeding • Care of the new born • Prevention and management of the complications of abortion • Prevention and management of RTIs/ STIs / HIV/AIDS and other reproductive health conditions • Information education and counselling for adolescent and young people • Prevention and management of sub-fertility/infertility • Life cycle reproductive health care including breast cancer, cancer of the reproductive system, genital fistula, genital prolapse and reproductive health problems associated with menopause, • Nutrition • Reduction of harmful practices such as early marriage and violence against women
Abortion	Loss of a pregnancy before fetal viability (22 weeks gestation). It can be either spontaneous or induced. Spontaneous abortion is further classified as below:
Threatened abortion	Vaginal bleeding; cervical os is closed; cramping may be present Pregnancy may continue
Inevitable abortion	Vaginal bleeding; cervical os is open; cramping may be present Pregnancy will not continue and will proceed to incomplete/complete abortion
Incomplete abortion	Vaginal bleeding; cervical os is open; cramping is usually present Products of conception are partially expelled

Complete abortion	Vaginal bleeding; cervical os is open or closed; cramping may be present Products of conception are completely expelled.
Septic abortion	An abortion complicated by infection. Sepsis may result from infection if organisms rise from the lower genital tract following either spontaneous or unsafe abortion. Sepsis is more likely to occur if there are retained products of conception and evacuation has been delayed. Sepsis is a frequent complication of unsafe abortion involving instrumentation
Gender	Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular point in time.
Genital prolapse	A condition where the uterus descends from its normal anatomic position into the vagina
Infertility/subfertility	The inability of a couple to become pregnant after 1 year of unprotected intercourse
Obstetric Fistula	A medical condition resulting from prolonged obstructed labour in which an abnormal passage develops between either the vagina and the rectum or the vagina and the urinary bladder

FAMILY PLANNING DEFINITIONS

Contraceptive prevalence rate (CPR)	The percentage of woman in union aged 15-49 years currently using contraception ¹ .
Emergency Contraception	The prevention of pregnancy after unprotected vaginal intercourse. Emergency contraception may use progesterone alone or progesterone combined with estrogen. The EC pills are similar to birth control pills but generally contain higher hormone doses and are used in a different manner and schedule. Another form of emergency contraception uses an intrauterine device (IUD) inserted within 5 days after intercourse. As stated by WHO, "Emergency contraceptive pills do not interrupt pregnancy and thus are no form of abortion."
Sexually Transmitted Infections (STI)	Any infection that is communicated primarily or exclusively through intimate sexual contact. Commonly transmitted STIs include chlamydia, gonorrhoea, syphilis, genital herpes, and HIV infection. STIs are a common cause of infertility.
Total fertility rate	The number of children that would be born per woman if she were to live to the end of her child bearing years and bear children at each age in accordance with prevailing age-specific fertility rate ⁵⁶
Unmet need for Family Planning	Refers to women and couples who do not want another birth within the next two years, or ever, but are not using a method of contraception. Unmet need result from growing demand, service delivery constraints, lack of support from communities and spouses, misinformation, financial costs and transportation restrictions.

⁵⁶ The State of World's Children 2005

MATERNAL AND NEONATAL HEALTH DEFINITIONS

Essential Obstetric Care (EOC) and Essential Newborn Care (ENC)

Basic essential obstetric care (BEOC)	The obstetric care needed for managing pregnancy, labour, childbirth and the postpartum period both in normal situations and when certain complications arise. BEOC includes use of parenteral antibiotics, oxytocic drugs, treatment of eclampsia, manual removal of the placenta and of retained products of conception.
Basic emergency obstetric care (BEmOC)	The portion of BEOC dealing with the treatment of complications
Comprehensive essential obstetric care (CEOC)	Contains all the elements of BEOC, plus definitive care of more complicated emergencies including surgery, anaesthesia and blood transfusion
Comprehensive emergency obstetric care (CEmOC)	The portion of CEOC dealing with the advanced treatment of complications (includes all BEmOC)
Essential newborn care (ENC)	Includes care of the normal newborn and management of frequently-encountered complications such as sepsis, asphyxia, neonatal tetanus and low birth weight
Skilled birth attendant	A healthcare provider (midwife, doctor, or nurse with midwifery and life-saving skills) who has the knowledge and skills necessary to give safe and effective care during pregnancy and childbirth to mothers and their newborns, in a variety of settings. Safe and effective care requires that the skilled attendant is able to manage normal pregnancy, labor, and childbirth; recognize the onset of complications; perform essential emergency interventions; and safely refer the mother and/or her baby, when necessary

Maternal/Perinatal Epidemiology and Monitoring

Maternal Death	A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal deaths should be divided into two groups: <ul style="list-style-type: none"> • Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labor, and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. • Indirect maternal deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but was aggravated by physiologic effects of pregnancy.
Maternal mortality ratio (MMR)	Number of deaths of women from all causes from the onset of pregnancy through six weeks postpartum divided by number of live births and multiplied by 100,000 (per year)

Infant mortality rate (IMR)	Number of infant deaths from birth to one year of age per 1000 live births (per year)
Neonatal mortality rate (NMR)	Number of infant deaths from birth to 28 days per 1000 live births (per year)
Perinatal mortality rate (PNR)	Number of early neonatal deaths (first week of life) added to the number of stillbirths per 1000 births, including stillbirths (per year)

Obstetric Clinical Conditions

Abruptio placentae	The detachment of a normally located placenta from the uterus before the fetus is delivered, characterized by bleeding after 22 weeks gestation and intermittent or constant abdominal pain
Breech presentation	Occurs when the buttocks and/or the feet are the presenting parts. Complete (flexed) breech presentation occurs when both legs are flexed at the hips and knees. Frank (extended) breech presentation occurs when both legs are flexed at the hips and extended at the knees. Footling breech presentation occurs when a leg is extended at the hip and the knee
Brow presentation	Partial extension of the fetal head so that the occiput is higher than the sinciput. In brow presentation, engagement is usually impossible and arrested labor is common
Cephalopelvic disproportion	The fetus is too large or the maternal pelvis is too small to allow passage of the fetus through the birth canal
Compound presentation	Occurs when an arm prolapses alongside the presenting part. Both the prolapsed arm and the presenting part present in the pelvis simultaneously
Ectopic pregnancy	A pregnancy in which implantation occurs outside the uterine cavity. The fallopian tube is the most common site of implantation
Face presentation	Hyper-extension of the fetal head occurs so that neither the occiput nor the sinciput are palpable on vaginal examination. The chin serves as the reference point in describing the position of the head
Fetal distress	Fetal distress in labor is characterized by abnormal fetal heart rate (less than 100 or more than 180 beats per minute) and thick meconium-stained amniotic fluid
First stage of labor, active phase	Dilatation of the cervix is 4–10 cm (rate of approximately 1 cm per hour), contractions are regular with increasing frequency and duration, and fetal descent begins
First stage of labor, latent phase	Dilatation of the cervix is 1–3 cm, contractions are irregular, and descent is not progressive
Fourth stage of labor	The first two hours after childbirth
Hypertension	Diastolic BP of 90 mmHg or more on two consecutive readings taken 4 hours or more apart. If hypertension occurs after 20

	weeks of gestation, during labor, and/or within 48 hours of childbirth it is classified as pregnancy-induced hypertension. If hypertension occurs before 20 weeks of gestation, it is classified as chronic hypertension
Induced abortion	A process by which pregnancy is terminated before fetal viability
Malpositions	Abnormal positions of the vertex of the fetal head (with the occiput as the reference point) relative to the maternal pelvis
Malpresentations	All presentations of the fetus other than vertex. The most common presentation is the vertex of the fetal head
Occiput posterior position	Occurs when the fetal occiput is posterior in relation to the maternal pelvis.
Occiput transverse position	Occurs when the fetal occiput is transverse to the maternal pelvis. If an occiput transverse position persists into the later part of the first stage of labor, it should be managed as an occiput posterior position
Partograph	A chart for recording information about the progress of labor and the condition of the mother and fetus, which provides objective data on which to base clinical decisions during the 1 st stage/active phase of labor. Skilled management of labor using a partograph is key to the appropriate prevention and management of prolonged labor and its complications. The partograph should be used for all women during labor
Placenta previa	Implantation of the placenta at or near the cervix, characterized by bleeding after 22 weeks gestation
Postpartum hemorrhage (PPH)	Vaginal bleeding in excess of 500 mL after childbirth. PPH can be immediate (within the first 24 hours after childbirth) or delayed/ secondary (from days 2 to 42 postpartum)
Pre-eclampsia	Hypertension after 20 weeks of gestation, during labor, and/or within 48 hours of childbirth, with proteinuria
Prelabor rupture of membranes (PROM)	Rupture of the membranes before labor has begun. PROM can occur either when the fetus is immature (preterm or before 37 weeks) or when mature (term)
Prolapsed cord	The cord is said to have prolapsed when it lies in the birth canal below the fetal presenting part or it is visible at the vagina following rupture of membranes
Prolonged active phase	When cervical dilatation moves to the right of the alert line on the partograph
Prolonged latent phase	The cervix has not dilated beyond 4 cm after 8 hours of regular contractions
Ruptured uterus	Separation of the uterine wall with passage of intrauterine contents into the abdominal cavity. It is characterized by intra-abdominal and/or vaginal bleeding and severe abdominal pain that may decrease after rupture
Second stage of labor	Dilatation of the cervix is 10 cm, the urge to push becomes

	progressively stronger with each contraction, and descent progresses until the presenting part reaches the pelvic floor
Shoulder dystocia	Occurs when the fetal head has been delivered but the shoulders are stuck and cannot be delivered. It is a condition that cannot be predicted. The diagnostic characteristics are: fetal head is delivered but remains tightly applied to the vulva; the chin retracts and depresses the perineum; and traction on head fails to deliver the shoulder, which is caught behind the symphysis pubis
Spontaneous abortion	The loss of pregnancy before fetal viability (22 weeks gestation)
Third stage of labor	Begins with the birth of the baby and ends with the delivery of the placenta
Transverse lie and shoulder presentation	Occur when the long axis of the fetus is transverse. The shoulder is typically the presenting part
Unsafe abortion	A procedure performed either by persons lacking necessary skills or in an environment lacking minimal medical standards, or both
Vaginal bleeding in early pregnancy	Bleeding that occurs during the first 22 weeks of pregnancy
Vaginal bleeding in later pregnancy	Bleeding that occurs after 22 weeks of pregnancy. The probable causes are abruptio placentae, ruptured uterus, and placenta previa; all three of these conditions may be accompanied by shock