

**ASSESSMENT OF SERVICES AND HUMAN RESOURCE NEEDS FOR  
THE DEVELOPMENT OF THE SAFE MOTHERHOOD INITIATIVE  
IN AFGHANISTAN**

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## GLOSSARY OF TERMS

ACO	Afghanistan Country Office
AHDS	Afghan Health and Development Services
AMDD	Averting Maternal Death and Disability
AMI	Aide Medicale Internationale
BHC	Basic Health Center
BP	Blood Pressure
CBR	Crude Birth Rate
CHA	Coordination of Humanitarian Assistance
CHW	Community Health Worker
C/section	Cesarean Section
DAC	Danish Afghanistan Committee
D&C	Dilatation and Curettage
DFID	Department for International Development (UK)
DMPA	DepoProvera
DOTS	Directly Observed Treatment Short-Course
EmOC	Emergency Obstetric Care
ENT	Ear Nose and Throat
EPI	Expanded Program on Immunization
FP	Family Planning
GS	General Surgical
HBV	Hepatitis B Virus
HIS	Health Information System
HIV	Human ImmunoVirus
HNI	HealthNet International
HRS	Hewad Reconstruction Services
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IMC	International Medical Corps
IMES	Intermediate Medical Education School
IMPAC	Integrated Management of Pregnancy and Childbirth
IV	Intravenous
MgSO <sub>4</sub>	Magnesium Sulphate
MCH	Mother and Child Health
MCI	Mercy Corps International
MDM	Medecins du Monde
MOPH	Ministry of Public Health
MSF	Medecins Sans Frontieres
NGO	Non-Governmental Organization
OPD	Outpatient Department
OR	Operating Room
ORS	Oral Rehydration Solution
OT	Operating Theatre
Rh	Rhesus (factor)
RH	Reproductive Health
ROSA	Regional Office for South Asia (UNICEF-Kathmandu)
RPO	Resident Project Officer (UNICEF)

SCA	Swedish Committee for Afghanistan
SMI	Safe Motherhood Initiative
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
24/7	Twenty-four hours a day, seven days a week
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNOCHA	United Nations Office for Coordination of Humanitarian Affairs
UNOPS	United Nations Office for Project Services
USA	United States of America
VHV	Village Health Volunteer
WHO	World Health Organization

## EXECUTIVE SUMMARY

Afghanistan's maternal health indicators are among the worst in the world. During 20 years of conflict, drought, political instability and isolation, the toll on the health of women and children has been staggering. The Afghanistan Ministry of Public Health (MOPH) is strongly committed to reducing maternal and neonatal mortality. From the Ministry's perspective, immediate action is needed with a focus on extending the reach of life-saving care as close to the family as possible. UNICEF has, for several years, supported the implementation of the Safe Motherhood Initiative (SMI) in Afghanistan and many activities are currently ongoing in selected locations.

Under the new national and political conditions, the MOPH requested UNICEF to support the Ministry in developing and implementing national maternal health and safe motherhood policies and programs, as well as coordinating the interventions of donors in this subsector. To do this, UNICEF works in close partnership with WHO and UNFPA in the overall sector of reproductive health. In order to carry out its responsibilities, UNICEF organized an assessment of services and human resource needs for strengthening the SMI.

During the course of the assessment, the team identified a wide range of opportunities already existing in Afghanistan upon which actions to reduce maternal and neonatal mortality could be built. For example, in all regions visited by the assessment team, several Afghan NGOs are providing services, either independently or as part of the MOPH. While those NGOs providing the best maternal and child health (MCH), and in some cases basic EmOC, services vary from region to region, the opportunities to selectively expand access to and the quality of services through the NGO-network exists and should be vigorously pursued.

Other services exist that contribute greatly to maternal and newborn health. For example, nutrition and therapeutic feeding services are available in many clinics. NGOs and donors have helped ensure supplies of drugs and consumable supplies. The Expanded Program on Immunization (EPI) services located in MCH clinics provide access for women to tetanus toxoid to prevent deaths from postpartum and neonatal tetanus. NGOs and other organizations have developed health information systems at the local level for tracking program activity and monitoring progress, these could provide a detailed and valuable resource to healthcare programs and providers. In addition, civil society organizations, such as women's groups, have formed around the need for advocacy and improving access to health information at grassroots level. Additionally, coordination mechanisms exist at regional and local level to promote information sharing and planning.

The many regions of Afghanistan differ greatly from one another in climate, geography, culture, resources, and infrastructure. During long years of strife, out of necessity an infrastructure of communications, transportation, and local support evolved to make use of scarce resources. Coupled with a growing capacity of the MOPH to provide services and guidance to regions and provinces, this local capacity helps guarantee that priority needs are addressed and that services more rapidly extended to the periphery and to underserved populations.

## RECOMMENDATIONS FOR IMMEDIATE ACTION

- 1. Reference materials.** As a first step in updating and standardizing both refresher (in-service) and preservice training of doctors and midwives nationally, the WHO Integrated Management of Pregnancy and Childbirth (IMPAC) manuals, *Managing Complications of Pregnancy and Childbirth* and the *Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care*, should be translated into the local languages (Dari and Pashtu). These evidence-based reference standards can serve multiple purposes (e.g., developing medical and midwifery education policy, national service delivery practice guidelines, medical and midwifery curricula, and monitoring clinical performance). Because of the importance of this activity, UNICEF should take the lead with the MOPH in expediting the translation and production of these manuals in order to make them available in a timely manner.
- 2. Midwifery curriculum development and training.** The MOPH should prioritize training of midwives. The faculty of the Intermediate Medical Education School (IMES) in Kabul has requested technical assistance from UNICEF to assist in reviewing the new, 2-year midwifery curriculum and in developing the clinical practice component. International Medical Corps (IMC), HealthNet International (HNI), and IMES/Kabul have also requested UNICEF's technical assistance in developing a shorter (about one year), community-based auxiliary midwifery training program scheduled for implementation initially in Jalalabad. Subsequent and timely follow-on implementation should be considered for possibly Herat and Kandahar, depending on local context and prospects for recruitment and service delivery,.
- 3. Development of trainers.** UNICEF should take advantage of the upcoming UNICEF-ROSA/AMDD-supported regional training program on competency-based EmOC. An Afghan team comprising a doctor, anesthetist and two midwives should participate. Subsequently, this core group will return to Kabul and, with assistance from UNICEF and members of the Asia regional AMDD training team, will prepare a proper training facility in Kabul. Following site preparation, the team will need to consolidate their training skills, with support from AMDD training team, and then update and standardize clinical practices at the Malalai Hospital (Kabul). After about 6 months, the group will begin to train another team of about 10-12 medical and midwifery faculty/trainers skilled in the use of these evidence-based learning materials. After these new trainers are qualified as clinical trainers, they will then work with staff at Afghan regional and key provincial and/or district hospitals to improve and expand basic and comprehensive EmOC services.
- 4. Support to NGOs.** Management Sciences for Health (MSH) will soon begin a program to support health programs of NGOs. NGOs may submit proposals for rapid review and funding. UNICEF should contact qualified NGOs providing MCH services to alert them of this resource and facilitate proposal development consistent with the recommendations and strategy proposed in this report.
- 5. Equipment and commodities.** UNICEF has an available inventory of equipment and consumable supplies for health facilities. Based on the findings of this needs assessment, a plan should be made for distribution of this material to facilities that have services and the management capacity to put them to immediate use.

6. **Capacity building.** UNICEF should recruit and appoint a senior SMI advisor to be based in the MOPH to assist in policy development, coordination, and program planning and implementation. In addition, we recommend that a midwifery advisor (preferably with training experience) and a management advisor be placed to support implementation of the SMI. While working with the MOPH, it is important that these advisors work closely with their Afghan Ministry counterparts in order to build long-term, sustainable MOPH capacity.

## RECOMMENDATIONS FOR MEDIUM-TERM PROGRAM DEVELOPMENT

1. **Objective of the Safe Motherhood Initiative.** We recommend that the MOPH and UNICEF choose as their main objectives to:
  - increase the proportion of births attended by skilled (qualified) birth attendants (whether auxiliary midwives, midwives, or female physicians), and
  - expand access to and the quality of service.
2. **Supporting national policy development.** The MOPH, with UNICEF support, should take the lead in further refining and implementing the National Reproductive Health Policy with support and technical input from UN partners, NGOs and regional MOPH directors of maternal and child health.
3. **National clinical practice standards to improve the quality of services.** The MOPH with support from UNICEF, WHO and other partners, should assist NGOs and other service providers by developing national standards for delivery of the minimum package of the essential reproductive health services and model service delivery protocols for use by midwives and physicians. A good starting point for standards development would be the WHO, UNICEF, UNFPA, World Bank IMPAC documents *Managing Complications in Pregnancy and Childbirth* and the *Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care*.
4. **Data to support planning and monitoring.** A reproductive health survey (to be conducted by CDC/UNICEF and other partners) and a facility and human resource mapping survey (to be conducted by MSH) will soon be underway. Resulting data from these activities will be valuable in creating and implementing healthcare service delivery strategies. Particular attention is needed to the types and availability of safe motherhood and other reproductive health services that comprise the “minimum package” defined during the Joint Donor Mission to Afghanistan (18 March—4 April 2002), and the numbers and types of female personnel currently in medical and healthcare practice. In addition, agreement on a small set (perhaps two or three) of indicators is needed, and a system for monitoring progress using the vast amount of existing data already collected by MOPH facilities and NGOs.
5. **Coordination mechanisms to support implementation.** The coordination mechanisms that exist at regional/provincial level provide an excellent opportunity to build local capacity for regional planning and coordination systems, subordinated to the national MOPH. The mandate for these regional/provincial mechanisms, however, will need to move beyond local information sharing and emergency response coordination. They will need to take on longer term planning in support of the National Plan for Safe

Motherhood, as well as to identify and build managerial responsibilities and capacities for local implementation and monitoring .

6. **Improving and extending the capacity of existing comprehensive EmOC services.** Concentrating on expanding comprehensive EmOC services will not lead to improved maternal and newborn care through increased use of these “improved” services in the absence of additional, complementary strategies to improve access to basic EmOC (including postabortion care) and clean, safe delivery services and referral at community level. A more appropriate approach would be: (a) to upgrade and strengthen the quality of services and management systems at selected regional hospitals and MCH facilities already providing comprehensive EmOC and increase their capacity to respond quickly and appropriately to life-threatening obstetrical emergencies, and (b) to strengthen the linkages between referral hospitals and a network of basic EmOC and community-centered services. We recommend pairing these referral hospitals with NGOs that have the management capacity to support them.
7. **Improving and extending the capacity of existing basic EmOC services.** NGOs provide a potential network of service delivery sites that can form the backbone of the SMI. We recommend that UNICEF work with NGOs to plan how best to develop and extend an appropriate minimum package of basic safe motherhood services to NGO-supported clinics that do not currently offer such services. Planning will include detailed staffing and staff training needs, and needs for adequate equipment, pharmaceuticals and supplies for operations.
8. **Focused antenatal care and nutrition services.** NGO clinics and MOPH clinics supported by NGOs are providing a basic or full range of antenatal services. Focused antenatal care should build on these successes, extending services to communities where such services do not yet exist. Focused antenatal care should include for all women: (a) tetanus toxoid immunization (preferably at least two injections); (b) micronutrient supplementation with iron and folate and vitamin A according to WHO/UNICEF recommendations; (c) presumptive treatment for helminthes; (d) provision of insecticide treated bed nets and clean; (e) treatment of existing medical conditions; (f) health education for birth preparedness, including the danger signs that mean “Get Help Immediately”; (g) promotion of clean, safe delivery with a skilled birth attendant; (h) breastfeeding and complimentary feeding; and (i) family planning.
9. **Postnatal and newborn care.** Currently, even women who deliver in hospitals may be discharged within an hour of delivery. This practice defeats the purpose of having a skilled attendant assist at the birth since the majority of complications arise during delivery or in the immediate postpartum period. We recommend that hospitals keep women and newborns under observation for at least 24 hours after delivery. Training programs will need to give much more attention to the newborn and will need to strengthen clinical services to provide drying and warming, proper cord care, eye care, immunization, immediate contact with the mother, and early and exclusive breastfeeding (especially for the first 6 months).
10. **Improving the linkages between facilities and communities.** Successful SMI programs in Afghanistan consider TBAs an integral part of the their programs. To date they have developed: (a) a system of selecting TBAs for training from the communities where they live and practice, with community involvement in the selection process; (b) linkages

between TBAs and healthcare facilities so that TBAs do not work in isolation; (c) ongoing supervisory and support programs for TBAs; (d) supply systems for TBA kits and replenishment of stock supplies at regular intervals; (e) clear expectations of the role of the TBA within a larger system of care and referral; (f) training and refresher programs at regular intervals; and (g) appropriate reporting systems for monitoring TBA activity. The effectiveness of these efforts to help extend clean, safe delivery services to communities, to increase use of antenatal care, and to assist in referral and transfer of women experiencing complications to facilities with EmOC services has not been evaluated. We recommend that the MOPH, NGOs, UNICEF and other stakeholders assess TBA performance against these criteria in order to better define their role before investing more resources in TBA training.

11. **Mobilizing civil society.** Women's groups exist in some parts of the country we visited. Women's groups can have an important role to play in house-to-house health information/education/ communication for safe motherhood and child survival—a particularly important strategy to reach women in seclusion. Topics should be focused on birth preparedness: clean, safe delivery and immediate newborn care; the danger signs that mean get help immediately; the importance of having a skilled attendant at the birth to assist; exclusive breastfeeding and complimentary feeding; family planning for birth spacing; and the importance of antenatal care. We recommend that UNICEF field offices locate and facilitate local women's groups to implement IEC activities.
12. **Policy for human resource development.** The MOPH is in the process of clarifying and finalizing policy on categories of health workers and determining the approximate total size of the workforce. Based on limited, qualitative assessment, it is clear that (a) the quality of physician, nursing and midwifery training is very low, especially in the regional medical schools and the various IMES sites; (b) the country has a substantial excess of unemployed male physicians and too few female physicians, midwives, and female nurses to meet the needs of an expanded SMI; and (c) with the possible exception of the Northeast Region and perhaps, one or two other areas, few women are sufficiently well educated to meet the entrance requirements for medical or midwifery school. Therefore, to improve the quality of medical education, class size should be dramatically reduced (50-75 per class). For the IMES midwifery program, which recently has been reduced in length from three to two years, class size should be kept small (20-25 per class), especially in the regional IMES programs.
13. **Improving training capacity and resources.** Midwives and auxiliary midwives need up-to-date information provided in a simple format, preferably with an emphasis on effective (and interactive) audiovisual learning materials, and practical, competency-based skills training. Efforts must be made to effectively integrate training and service delivery to reinforce learning and provide improved health service. In addition, the curriculum should be limited to only essential, up-to-date knowledge in easily incorporated packages so that graduates have the basic skills to conduct normal deliveries and manage complications of pregnancy and childbirth. Teachers and trainers with new knowledge, evidence-based practices, and standardized skills need to be trained, service delivery/training sites need to have their services improved (especially infection prevention and biohazardous waste handling and disposal), and the IMES will need considerable administrative and management support.

14. **Commodities and logistics.** Currently commodities are being supplied to SMI sites by NGOs, WHO, ICRC, UNICEF and donors. For the most part, in NGO-supported clinics and hospitals, supplies are available. In many instances, however, sound systems are lacking for forecasting stock needs, reordering, proper storage, and monitoring of consumption. It may be possible to increase efficiencies in the system by sharing best practices and local expertise. Facility-level assessment of practices and support to improving the management of pharmaceuticals, disposable commodities, and logistics management systems will be an important aspect of strengthening SMI service delivery sites.

# GENERAL REPORT

## SPECIFIC OBJECTIVES

The Afghanistan Ministry of Public Health (MOPH) requested UNICEF to develop and implement maternal/newborn health policies and programs and to be the focal agency in Afghanistan responsible for coordinating and monitoring donor activities in safe motherhood. Toward this end, UNICEF organized an external team of consultants to conduct an assessment of services and human resource needs for developing the Safe Motherhood Initiative (SMI) in Afghanistan. Specifically, the team was asked to:

1. Assess the accessibility, quality and utilization of emergency obstetric care services and identify immediate and medium-term needs to be addressed in order to improve coverage and quality of care.
2. Assess the current status of staffing for Emergency Obstetric Care (EmOC), identify immediate and medium-term needs, and suggest short-, medium- and long-term strategies for human resource development, including proposals for curricula reform, with special attention to midwifery development.
3. Identify specific and critical points for the implementation of the Averting Maternal Death and Disability (AMDD) project in Afghanistan, particularly focusing on blood transfusion and transport services.
4. Assess the EmOC training program being implemented currently and check how it fits in the proposed strategy and in the forecasted implementation of the AMDD project.
5. Identify key implementation partners such as national non-governmental organizations (NGOs) and donors to support service delivery and training.
6. Liaise with the Centers for Disease Control and Prevention (CDC)/UNICEF maternal mortality study team to ensure both assessments contribute to our overall understanding of factors contributing to maternal mortality and morbidity.

## METHODS

The external needs assessment team comprised Dr. Noel McIntosh, Mr. Mark Fritzler, Ms. Judith O’Heir, and Dr. Patricia Stephenson. Health section staff from UNICEF/Kabul, Drs. Suraya Dalil and Denisa-Elena Ionete, and field office staff joined the team for field visits.

In the short (one month) timeframe available, the team visited five regions of the country and Kabul. In each region we visited regional health directors and MCH directors, NGO partners involved in providing safe motherhood services, facilities offering basic and comprehensive EmOC services, and intermediate medical education schools (IMES). Additionally, when time permitted, we attempted to identify and meet with service providers for internally displaced persons (IDP) and women’s organizations involved in community mobilization activities and advocacy. Security considerations and complex logistics associated with current air and road travel between points in Afghanistan limited travel to some extent.

The team visited the following places and organizations:

**Central Region: Kabul**

Ministry of Public Health

Malalai Hospital

Intermediate Medical Educational School

**Eastern Region: Nangarhar and Laghman Provinces**

HealthNet International (HNI) and IbnSina

Nangarhar Hospital (Provincial hospital/ University Teaching Hospital supported by HNI)

Intermediate Medical Education School (supported by Ibn Sina)

Mehtarlam Hospital, Laghman Province (supported by AMI)

**Northeast Region: Badakhshan Province**

World Health Organization Representative for Badakhshan

Swedish Committee for Afghanistan (SCA)

Medecins sans Frontieres (MSF)

Badakhshan Voluntary Women's Association

MOPH Provincial Hospital, Faizabad

Basic Health Center, Baharak District (supported by MSF)

Basic Health Center, Jurm District (supported by SCA)

**Northern Region: Balkh and Jowzjan Provinces**

Mazar-e-Sharif Regional Hospital

Code Barq Hospital, Ministry of Mines

Andkhoy District Hospital

Sherberghan Provincial Hospital

Basic Health Center, Balkh District (supported by SCA)

Basic Health Center, Andkhoy District (supported by Save the Children/USA)

**Southern Region: Kandahar and Helmand Provinces**

Mir Wais Provincial Hospital, Kandahar (supported by ICRC)

Lashkar Gah Provincial Hospital

Grishk District Hospital

Basic Health Center, Kandahar District (supported by AHDS)

Basic Health Center, Grishk District (supported by IbnSina)

Basic Health Center, Lashkar Gah (supported by Mercy Corps)

**Western Region: Herat Province**

Maternity Ward, Heart Regional Hospital

Intermediate Medical Educational School

Shindand District Health Center (supported by CHA)

Maslakh IDP camp near Herat (5 clinics supported by NGOS)

Detailed facility assessment forms developed by WHO and adapted for the purpose of this needs assessment guided the data collection and discussions. The team assessed: (a) services offered and hours of operation; (b) staffing (especially availability of female staff); pharmaceuticals, equipment and supplies available; (c) water, sanitation and infection prevention; (d) training programs and facilities available; and (d) types of support provided by NGOs. Beyond this formal approach, the team sought to learn from the experiences and perspectives of Government officials, regional coordination teams, NGOs, service providers

and educators. Likewise, we reviewed a number of documents containing useful data to help in our understanding of the situation of women and newborns (**Annex A**).

## **ISSUES AND OPPORTUNITIES**

Afghanistan's maternal health indicators are among the worst in the world (**Annex B**). During 20 years of conflict, drought, political instability and isolation, the toll on the health of women and children has been staggering. A relatively small proportion of the population has access to basic health services, clean water, sanitation, education and health information that could help save their lives. Food insecurity, malnutrition and high fertility remain significant problems. All this is exacerbated by the low status of women.

The MOPH is strongly committed to reducing maternal and neonatal mortality. They recognize that all women and their families have a right to health and thus have adopted "Health for All" as their policy, with particular attention to reducing inequalities in health (**Annex C**). From the Ministry's perspective, immediate action is needed, with a focus on extending the reach of life-saving care as close to the family as possible. Thus, we endeavored not to spend too much time detailing the many problems encountered, except as required for understanding the rationale for our recommendations. Rather, we sought to identify viable platforms and opportunities to improve access and quality of care for rapid implementation.

Many opportunities exist for strengthening the SMI in Afghanistan. For example, in all regions visited by the assessment team, several Afghan NGOs are providing services, either independently or as part of the MOPH. While those NGOs providing the best MCH care, and in some cases basic EmOC services, vary from region to region, opportunities to selectively improve the quality of services and expand access to these services through the NGO-network exists and should be vigorously pursued. (**See region-specific reports for findings and recommendations.**)

NGOs have continued to operate in past years under very difficult circumstances and have developed a wealth of experience. They have entrée to communities and have successfully developed partnerships with local government and traditional leaders. Moreover, they have leveraged resources from donors for the continuing operation of services. In some instances, NGOs have developed the local capacity for sound management of commodities and logistics systems. These and other best practices can be shared with other NGOs and with providers working in the public system to raise the quality and efficiency of health services.

Other services exist that contribute greatly to maternal and newborn health. For example, nutrition and therapeutic/supplementary feeding services are available in many clinics. NGOs and donors have helped ensure the availability of drugs and consumable supplies. The Expanded Program of Immunization (EPI) services located in MCH clinics provide access for women to tetanus toxoid to prevent deaths from postpartum and neonatal tetanus. Health information systems (HIS) have been developed to track program activity and monitor progress. Newer indigenous NGOs or civil society organizations have come on the scene that could also contribute to the SMI. For example, women's groups have sprung up to address the recognized need for advocacy and improving access to health information and services at grassroots level.

Primary health services, including MCH services, have been *de facto* decentralized as consequence of the prolonged strife in Afghanistan. Coordination mechanisms have evolved at regional and local level to promote information sharing and planning. The regions of Afghanistan differ vastly from one another in climate, geography and culture. Infrastructure for communications and transportation are minimal at best. Local adaptations during more difficult times helped guarantee that local priority needs were addressed using limited resources. Now, in the changed political environment the MOPH is increasingly able take on a national perspective and tackle the task of developing national standards in healthcare and service delivery. With support from UNICEF, WHO, UNFPA and other collaborating UN and non-UN organisations, the MOPH is gaining in its ability to reach out to the whole country with services and resources. Coupled with the strengths and capacities developed at the local level, the MOPH and regional/provincial bodies can insure that services are extended rapidly to the periphery and underserved populations.

## RECOMMENDATIONS FOR IMMEDIATE ACTION

Several actions may be taken immediately to address the urgent needs of women and newborns:

1. **Reference materials.** As a first step in updating and standardizing both refresher (in-service) and preservice training of doctors and midwives the WHO (IMPAC) manual, *Managing Complications of Pregnancy and Childbirth*, should be translated into the local languages (Dari and Pashtu) and distributed widely throughout the country. The availability of this manual and other WHO/IMPAC manuals, such as the *Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care*, can serve multiple purposes, such as evidence-based reference standards for:
  - Medical education policy,
  - National service delivery practice guidelines,
  - Medical and midwifery curricula, and
  - Monitoring clinical performance.

Because of the importance of this activity, UNICEF should take the lead in coordinating it with the MOPH in order to make these manuals available in a timely manner.

2. **Midwifery curriculum development and training.** A key recommendation of the recent Joint Donor Mission (March/April 2002) is that the MOPH should prioritize training of midwives (**Annex D**). In response, the MOPH has reduced the length of midwife training from three to two years and requested that the IMES in Kabul review, revise, and standardize the curriculum. A key feature of the new curriculum will be maximizing clinical practice opportunities so that graduates will have the essential knowledge and skills to conduct normal labor and delivery and manage complications of pregnancy, abortion, labor and delivery and the newborn period. The Kabul IMES and International Medical Corps (IMC), which has been given responsibility by the MOPH to revise the overall curriculum for the IMES system, has requested technical assistance from UNICEF in updating the curriculum and developing the clinical practice component. Once the new 2-year program is operating it planned to roll the program out to the regional IMES centers.

UNICEF technical assistance also has been requested to work with HealthNet International (HNI) to design and finalize the new auxiliary midwifery training program. This training program will be of shorter duration (approximately 1-year), conducted as a satellite program close to the community and use low-literacy learning approaches because most of the students will have only basic reading skills. It is expected that during the next 3-5 years, the capacity to develop significant numbers of community-based auxiliary midwives through this program will be key factor in improving maternal and newborn care. Because of the shortage in female maternal and newborn health healthcare providers, the gap can be partially met by fielding a cadre of auxiliary midwives trained specifically in a minimum package of essential skills, with an emphasis on hands-on abilities. Presently only HNI is pursuing this initiative, but it should be examined for inclusion in an appropriate way into the broader structure of MOPH midwifery training for the country.

The program will be first implemented in Jalalabad, under supervision of HNI. Two other areas, possibly Herat and Kandahar, will be considered for subsequent (and, it is hoped, rapid) implementation, depending on local context of site selection, community involvement, participant recruitment environment, and service delivery. While all programs will share a common, evidence-based curriculum, the learning approach used in each region will be tailored to the qualifications of potential students, cultural differences and community practices (e.g., in some regions, recruitment of husband and wife teams from the community, where the husband may be trained in care for the newborn, may be preferable to training just female auxiliary midwives alone.)

As both programs are critical to expanding and strengthening the SMI, and both are already well into the planning process, UNICEF should provide an appropriate midwifery consultants to work with the MOPH to assist both activities in a timely manner.

- 3. Development of trainers.** Based on the preliminary assessment of the recently completed EmOC training course held in March 2002 in Kabul, we recommend that UNICEF take advantage of the upcoming UNICEF-ROSA/AMDD-supported regional training program on competency-based EmOC, which is tentatively scheduled for July/August 2002. Space will be provided for an Afghan team comprising a doctor, anesthetist and two midwives to participate. UNICEF and the MOPH should begin the process for selecting appropriate participants as soon as possible.

After returning to Kabul, this core group will work with members of the AMDD Asia regional training team to prepare an appropriate training site in Kabul, consolidate their own training skills, and update and standardize clinical practices at the Malalai Hospital (Kabul) over the ensuing 3-6 months. They will then select another team of 10-12 medical and midwifery teacher /trainers, skilled in the use of these evidence-based learning materials, to be trained as trainers.

Once trained, this expanded group of clinical trainers then could work with staff at Afghan regional and key provincial and/or district hospitals to improve and expand basic and comprehensive EmOC services at these institutions and facilitate linking with community-level MCH centers where basic EmOC services are available. Additionally, once teachers/trainers are available at the regional level in Afghanistan, they can also assist in revising the maternal and newborn curricular components at regional medical and midwifery schools and help implant best practices.

4. **Support to NGOs.** Management Sciences for Health (MSH) will soon begin a program to support health programs of NGOs. NGOs may submit proposals for rapid review and funding. This may be an important opportunity for the NGOs identified in this report as capable of expanding safe motherhood services to access needed funding for expansion of services. UNICEF should contact NGOs providing MCH services to alert them of this resource and facilitate proposal development consistent with the recommendations and strategy proposed in this report.
5. **Equipment and commodities.** UNICEF has available inventory of equipment and consumable supplies for health facilities (sterilizers, delivery kits, essential drug kits). Based on the findings of this needs assessment, a plan should be made for distribution of this inventory to facilities that have services and the management capacity to put them to immediate use.
6. **Capacity building.** As soon as feasible UNICEF should recruit and appoint the senior SMI advisor to be based in the MOPH to assist in policy development, coordination, and program planning and implementation. In addition, we recommend that a midwifery advisor (preferably with training experience) and a management advisor be placed to support implementation of the SMI. While working with the MOPH, it is important that these advisors work closely with Afghan Ministry counterparts in order to build long-term, sustainable MOPH capacity.

## RECOMMENDATIONS FOR MEDIUM-TERM PROGRAM DEVELOPMENT

1. **Objective of the Safe Motherhood Initiative.** All stakeholders should agree that the goal of the Afghanistan SMI is to:
  - increase the numbers/proportion of births with a skilled attendant, and
  - increase access to and the quality of service.

Given the current situation in Afghanistan, including: (a) cultural preferences for homebirth; (b) the experience of NGOs in developing workable, acceptable community-based and owned systems; (c) the available resources; and (d) the time horizon for reconstruction of health systems for SMI, we recommend that the MOPH and UNICEF, as the focal agency for SMI activities in Afghanistan, choose as its main objectives to increase the proportion of births attended by a skilled birth attendant (auxiliary midwives, midwives, or female physicians). Improving access to clean, safe delivery and referral services at the community-level, and basic and emergency obstetric care at the facility-level would accomplish this.

2. **Supporting national policy development.** The Afghanistan SMI should be seen in the context of reconstruction. While Afghanistan may still be in the midst of a complex emergency, and immediate, concrete action is needed to improve conditions in the short-term; nevertheless, strategic planning for the transition to reconstruction needs to begin now. We recognize a need for the MOPH to begin the process of developing a National Plan for Safe Motherhood that will identify priority interventions and appropriate technical approaches to address them. The Ministry's leadership, coupled with support from UNICEF as the agency responsible for coordination, will help channel external assistance as it becomes available toward priority problems, underserved areas in

Afghanistan and it will help ensure that the assistance offered is appropriate for the national interests. The Ministry, with UNICEF support, should take the lead in developing the national strategy with support and technical input from UN partners, NGOs and regional MOPH directors of MCH. Particular attention also should be paid to including Afghan NGOs in the planning process because they have a wealth of experience in implementation under difficult circumstances.

Continued high level advocacy and public statements by government officials in support of Safe Motherhood will go a long way toward increasing awareness of the need for improved services for mothers and newborns.

3. **National clinical practice standards to improve the quality of services.** The MOPH with support from UNICEF, WHO and other partners should agree on a minimum package of essential reproductive health services. The MOPH and collaborative support groups should assist NGOs and other service providers by defining national standards for delivery of the minimum package and model service delivery protocols for use by midwives and physicians.

A good starting point for standards development would be the WHO, UNICEF, UNFPA, World Bank IMPAC documents *Managing Complications in Pregnancy and Childbirth* and the *Essential Care Practice Guide for Pregnancy, Childbirth and Newborn Care*. These reference documents define what specific services should be offered in antenatal, delivery, postnatal and newborn care. They would also assist in changing practices routine in Afghanistan that are no longer recommended, such as routine episiotomy for primigravidas, and in promoting new practices such as active management of the third stage of labor that significantly reduce the incidence of postpartum hemorrhage.

National standards assist NGOs and other providers assess how well their services measure up and serve as a guide for curriculum development, monitoring and supervision. For family planning, we recommend the WHO evidence-based document detailing selection and continuation criteria for use of contraceptive methods (1998) and the about to be released “best practices” document (2002) as well as the JHPIEGO *Pocket Guide for Family Planning Service Providers*.

4. **Data to support planning and monitoring.** Apropos data needs for strategic planning, a reproductive health survey (to be conducted by CDC) and a facility and human resource mapping survey (to be conducted by MSH) will soon be underway. Particular attention is needed to the types and availability of safe motherhood and other reproductive health services that comprise the “minimum package” defined during the World Bank Joint Donor Mission to Afghanistan, and the numbers and types of female personnel currently in practice. Likewise, it would be helpful to have additional information on the current plans of donors and international NGOs to maintain a presence in Afghanistan once the emergency has past.

A small set (perhaps two or three) agreed upon indicators are needed, and a system for monitoring progress using the vast amount of existing data already collected by MOPH facilities and NGOs put in place. For example, the EPI stations routinely record the numbers of pregnant women receiving tetanus toxoid; hospitals maintain delivery logs and records of the numbers of deliveries, live births, stillbirths, maternal deaths and cesarean deliveries; and NGOs routinely report the numbers of deliveries in basic health

centers and the numbers of antenatal care clients served. NGOs sometimes collect information about the numbers of deliveries conducted by TBAs. These data could form the basis of a routine, provincial-, regional- and national-level health information system (HIS) system.

5. **Coordination mechanisms to support implementation.** The coordination mechanisms that exist at regional and provincial levels provide an excellent opportunity to build a decentralized regional planning and coordination system subordinated to the National MOPH. Existing mechanisms that support emergency response at regional levels should continue during the transition and reconstruction. Their mandate, however, will need to move beyond information sharing and coordination of emergency response, to take on planning with a longer time horizon in support of the National Plan for Safe Motherhood, as well as managerial responsibilities for local level implementation and monitoring.
6. **Improving and extending the capacity of existing comprehensive EmOC services.** Concentrating on expanding comprehensive EmOC services will not lead to improved maternal and newborn care through increased use of these “better” services in the absence of additional, complementary strategies to improve access to basic EmOC (including postabortion care) and clean, safe delivery services and referral at community level. A variety of factors conspire to limit women’s access to care and utilization of facilities for delivery care.

Women have strong preferences for home birth, usually without a skilled birth attendant or TBA. EmOC services exist only in a relatively few urban areas, consequently access to care is extremely limited in rural, low population density areas. Women and their families often do not recognize the danger signs that mean “Get Help Immediately” and even when they do, they may not have the resources to pay for transport and the costs of care. Even those women fortunate enough to overcome these obstacles often face considerable delays after being admitted to a hospital in receiving appropriate treatment. Moreover, at this time it is not clear whether hospitals already overcrowded and stretched to capacity in some areas could handle an increased patient load.

Women do not choose hospitals for normal delivery. Women with complications arrive at referral facilities in very poor condition—if they do not die in transit. A more appropriate approach, therefore, would be: (a) to upgrade and strengthen the quality of services and management systems at selected regional hospitals already providing comprehensive EmOC services and improve their capacity to respond quickly and appropriately to life-threatening obstetrical emergencies, and (b) to strengthen the linkages between referral hospitals and a network of basic EmOC and community services. We recommend pairing these referral hospitals with NGOs that have the management capacity to support them and developing these sites as models of excellence.

Blood transfusion services require particular attention. In many communities, people are very reluctant to donate blood. Hospitals keep lists of donors willing to sell blood (going rate approximately US\$50-\$60 per unit). Not only is this expense far beyond the reach of most families, the practice may expose the population to HIV and other blood borne infections, especially in those areas where blood is not adequately screened. Likewise, other practices such as using health providers and older women in the family as “safe” blood donors should be discouraged. We recommend that an improved blood transfusion system be put in place as soon as possible, not as a stand-alone but as integral part of

comprehensive EmOC service and facilities. Laboratory facilities will need to be strengthened for blood testing and storage and practices will need to be in line with international standards of collection, testing (serology, syphilis, HBV, HIV/IDS, et al.), and storage should be thoroughly taught, routinely practiced, and carefully monitored and supervised. Community education will also be important to encourage blood donation and to overcome traditional beliefs that militate against giving blood.

Selected regional hospitals may also serve as clinical training sites linked to midwifery and auxiliary midwifery educational programs. Among the hospitals visited during this assessment, the initial focal sites that could be strengthened to serve as referral sites for comprehensive EmOC and would be: (a) Malalai Hospital, Kabul; (b) Mir Wais Regional Hospital, Kandahar; (c) Maternity Ward, Western Regional Hospital, Herat; (d) Provincial Hospitals in Faizabad and Mehtarlam; and (e) the Nangarhar University Teaching Hospital in Jalalabad.

- 7. Improving and extending the capacity of existing basic EmOC services.** NGOs constitute the largest numbers of service providers in the country, whether they operate their own clinics or whether they provide support to MOPH clinics and hospitals. Thus, they provide a “network” of service delivery sites that can form the backbone of the SMI. However, within these networks of service delivery sites, only a fraction of clinics provide MCH and basic EmOC services. Several factors limit NGO capacity to extend basic EmOC services: (a) lack of qualified, well-trained female staff confident in their skills to manage obstetrical and newborn complications; (b) resources to equip and supply existing clinics; and (c) in some cases, especially MOPH regional and provincial hospitals, the need to strengthen management systems to bring services up to an appropriate standard.

We recommend that UNICEF work with NGOs to plan how best to extend EmOC services to NGO-supported clinics that do not currently offer such services. Planning will include detailed staffing and staff training needs; needs for adequate equipment, pharmaceuticals and supplies for operations; and appropriate monitoring and supervision systems to ensure quality services.

- 8. Focused antenatal care and nutrition services.** We were told that only a small proportion of pregnant women seek antenatal care. Indeed, we visited several clinics where only a few women sought services, primarily because little was offered of any benefit. In contrast, in other clinics we visited, we found that many serve 40-50 antenatal patients per day. The increased use of antenatal and other SMI services is encouraged by: (a) the presence of female staff, (b) payment of incentives to staff, (c) training and other non-financial incentives for staff, (d) therapeutic supplementary feeding programs, if available on site for mothers and children<sup>1</sup>, (e) the availability of drugs and supplies on site, and (f) other services, such as health education and delivery care.

NGO and MOPH clinics supported by NGOs are providing antenatal services and many clinics provide a full range of services. Focused antenatal care should build on these successes, extending services to communities where such services do not yet exist. Focused antenatal care should include for all women: (a) tetanus toxoid (TT)

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<sup>1</sup> This seems to serve as a magnet for bringing women into care. After receiving nutritional services pregnant women can then receive TT and other ANC services during the same clinic visit.

immunization (preferably at least two); (b) micronutrient supplementation<sup>2</sup> with iron and folate and vitamin A according to WHO/UNICEF recommendations; (c) presumptive treatment for helminthes (UNICEF should determine the need for presumptive treatment – routine laboratory screening is not recommended); (d) provision of insecticide treated bed nets and clean; (e) treatment of existing medical conditions; (f) health education for birth preparedness, including the danger signs that mean “Get Help Immediately”; (g) promotion of clean, safe delivery with a skilled attendant; and (h) breastfeeding and complimentary feeding; and (i) family planning.

In the absence of data on drug resistance, the prevalence of placental parasitemia, and statistics on use of antenatal care, we cannot recommend intermittent presumptive treatment in pregnancy as a part of routine antenatal care at this time. We can, however, strongly recommend that the WHO “Roll Back Malaria” program examine these issues as soon as possible and propose rational drug policy based on their findings. Likewise, we strongly recommend that the MOPH with WHO, UNICEF and other partners immediately begin designing a viable program for bed net distribution for prevention of malaria and leishmaniasis.

Special attention will need to be given to developing guidelines and materials to promote birth preparedness. Birth preparedness counseling should be an integral part of antenatal care. All women should be given information on clean, safe delivery and the danger signs and have a plan of how to respond—where to go, what to bring, how to get there, and what it costs. Women should also be offered a small clean, safe delivery kit<sup>3</sup>. Men and other family members have an important role to play, so involvement of traditional community governance (*shuras*) in developing a community response to public health emergencies, including obstetrical and pediatric emergencies, should be considered.

Many other opportunities exist to convey important health information. Reportedly, a high proportion of Afghan households have access to radios. Radio dramas, music, and songs are effective ways of communicating simple health and preparedness messages. Community festivals and “street” theatre have proven effective as ways to communicate health messages in other settings. We recommend that UNICEF explore methods of using these sorts of channels to increase community awareness.

9. **Postnatal and newborn care.** Few women receive any postnatal care. Even women who deliver in hospitals may be discharged within an hour of delivery. This practice defeats the purpose of having a skilled attendant assist at the birth since the majority of complications arise during delivery or in the immediate postpartum period. We recommend that hospitals keep women and newborns under observation for at least 24 hours after delivery – longer if the woman has any complication, operative delivery, or repair of a vaginal laceration or perineal tear (3<sup>rd</sup> or 4<sup>th</sup> degree).

Much more attention to the newborn will need to be given in training programs and in efforts to strengthen clinical services. Essential newborn care includes drying and warming, proper cord care, eye care, immunization, immediate contact with the mother, and early and exclusive breastfeeding (especially for the first 6 months).

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<sup>2</sup> Iodine deficiency seems to also be a significant problem. Several cases of cretinism were observed among clinic users as well as goiter. Specific technical recommendations on supplementation in pregnancy may be considered. A micronutrient assessment is currently underway sponsored by UNICEF.

<sup>3</sup> Containing plastic sheeting, a piece of soap, a nailbrush, clean cord ties and a clean razor blade.

10. **Improving the linkages between facilities and communities.** NGOs and WHO have recognized the critical importance of extending safe motherhood services to communities through the use of TBAs. Given the cultural preference for homebirths and the fact that more than 90 percent of births occur at home, one must not assume that a program concentrated solely on extending EmOC to facilities will, in the short-term, have an impact on maternal or neonatal mortality.

Information and knowledge and understanding of services must be extended to community level through a number of mechanisms, including mobilization of community-based health workers, increasing the flow of information through broadcasting of simple health messages by radio, and involving civil society associations in spreading health education knowledge house-to-house, family-to-family, and woman-to-woman regarding to safe motherhood.

To date, many NGO-supported safe motherhood programs in Afghanistan consider TBAs an integral part of the services delivery system and have developed: (a) a system of selecting TBAs for training from the communities where they live and practice and with community involvement in the selection process; (b) linkages between TBAs and facilities so that TBAs do not work in isolation; (c) supervisory programs for TBAs; (d) supply systems for TBA kits and replenishment of stock supplies at regular intervals; (e) clear expectations of the role of the TBA within a larger system of care and referral; (f) training and refresher programs at regular intervals; and (g) appropriate reporting systems for monitoring TBA activity. These efforts, however, have not been evaluated in their effectiveness to help extend clean, safe delivery services to communities, to increase utilization of antenatal care, and to assist in referral and transport of women experiencing complications to facilities with EmOC services.

We recommend that the MOPH, NGOs, UNICEF and other stakeholders assess TBA performance against the above criteria in order to better define the future role of TBAs. TBAs could be considered as providers of information, education and communication, especially regarding the danger signs that mean, “*Get Help Immediately!*”. Finally, more information is needed to understand traditional practices (especially harmful practices) so that these can also be addressed in training programs.

Currently, several TBA training programs exist—one developed by WHO and several others developed by NGOs. The MOPH and other stakeholders should consider reviewing these curricula to ensure that they provide TBAs with adequate confidence and skills before continuing to invest in TBA training. UNICEF can facilitate this as well as the learning and sharing of best practices among stakeholders supporting TBA programs.

Transportation difficulties repeatedly arose in visits to communities. This is a serious problem for women with complications—the second of the Three Delays—and for many areas, may always be a problem for women living in the remoter areas. One partial solution is to move effective antenatal services and information and basic EmOC services closer to where the women live. With good information and early recognition of the danger signs, families can take action to move women to appropriate facilities earlier, using the existing transport means, when the journey is less likely to kill the woman. Another solution, one that has worked well in similar settings, is for communities to work collectively and take ownership of solutions to the problem of transporting women to

suitable facilities. These solutions can include road and trail improvements, standing arrangements for taxis, ambulances, or private vehicles to meet the patient's party at the roadhead, and radios. Solutions to the problem of transporting women with pregnancy complications can benefit the whole community's transport problems.

11. **Mobilizing civil society.** Women's groups exist in some parts of the country we visited. Most are purely locally focused and many were formed for political reasons. Some, however, have focused primarily on advocacy for women's rights, development and skills training, and community service. Women's groups can play important roles in house-to-house health information/education/ communication for safe motherhood and child survival—a particularly important strategy to reach women in seclusion. These groups should focus on birth preparedness; clean, safe delivery and immediate newborn care; the danger signs that mean "*Get Help Immediately!*"; the importance of having a skilled attendant at the birth to assist; exclusive breastfeeding for at least the first 6 months and complimentary feeding; family planning for birth spacing; and the importance of antenatal care. In women's group health education programs, certain harmful practices could be addressed and discouraged (e.g., women sometimes reduce food intake in order to have a smaller baby).

We recommend that UNICEF field offices locate and facilitate local women's groups or other civil society associations to replicate the interventions carried out by the UNICEF and WHO-supported Badakhshan Voluntary Women's Association. UNICEF and other partners should also explore how to link health education to female adult literacy and income generation activities.

12. **Policy for human resource development.** The MOPH is in the process of clarifying and finalizing policy on categories of health workers and determining the approximate total size of the workforce. While it is beyond the scope of this assessment to critically comment on the workforce size needed to improve and expand SMI services (detailed data soon should be forthcoming from the MSH facility and human resource mapping survey), it is clear that: (a) the quality of physician, nursing and midwifery training is very low, especially in the regional medical schools and Intermediate Medical Education Schools; (b) the country has an excess of unemployed male physicians and too few female physicians, midwives, and female nurses to meet the needs of an expanded SMI; and (c) with the possible exception of the Northeast Region and perhaps one or two other areas, few women are sufficiently well educated to meet the entrance requirements for medical or even midwifery school.

To improve the quality of medical education, class size should be reduced to 50-75 per class for medical schools to permit more clinical practice opportunities and should be highly weighted toward accepting qualified women. Similarly, class size in the IMES midwifery program, which recently has been reduced in length from three to two years, should be kept small (20-25 per class), especially in the regional IMES programs, until the quality of educational and practical training experience can be significantly improved. (See **Improving training capacity** and resources below for details.)

Particular attention also is needed to address the types and availability of safe motherhood and other reproductive health services that comprise the "minimum package" and the numbers and types of female health and medical personnel currently in practice. Likewise, it would be helpful to have additional information on the current plans of

donors and international NGOs to maintain a presence in Afghanistan once the emergency has past.

As efforts are underway to develop a new category of health worker—the auxiliary midwife—the MOPH and the IMES system should begin as soon as possible to discuss human resource and staffing policies in order to recognize auxiliary midwives as a legitimate healthcare provider. The MOPH will need to address certification issues for auxiliary midwives and be an active partner in curriculum development. The MOPH will also need to plan on integrating this new healthcare provider into their overall system for addressing human resource needs for safe motherhood. In this regard, the MOPH will need to clearly articulate the roles and functions of midwives, auxiliary midwives and TBAs.

- 13. Improving training capacity and resources.** In addition to making the WHO evidence-based IMPAC reference documents and learning materials available in translation, a group of 10-12 medical and midwifery faculty/trainers qualified to teach basic and comprehensive EmOC should be developed through UNICEF's Regional Office for South Asia (ROSA) Women's Right to Life and Health (WRLH) and the Columbia University Averting Maternal Death and Disability (AMDD) projects to help disseminate "best practices" and provide on-site clinical training and supervision. The UNICEF ROSA will provide the opportunity for Afghanistan representatives (four—an ob/gyn doctor, an anesthetist, and 2 midwives) to join the WRLH/AMDD training in Bangladesh in July-August 2002. The MOPH and UNICEF should select appropriate participants as soon as possible.

The AMDD program provides selected medical and midwifery practitioners the opportunity to have their knowledge rapidly updated and skills standardized. This learning/practice program also is important in helping practitioners improve management practices (e.g., eclampsia) based on evidence-based case studies and use of problem-solving scenarios.

Once trained, these new faculty/master trainers, with UNICEF/ROSA support, can establish an appropriately upgraded and equipped national training site in Kabul. Following consolidation and mastery of their own skills, they could then work with and train staff at regional hospitals to improve and expand basic and comprehensive obstetrical care services at regional institutions. They could establish region-based training facilities, train local EmOC service providers in world standard clinical skills, train them in turn as clinical trainers, and facilitate linkages to community-level MCH/EmOC service sites.

- 14. Commodities and logistics.** Currently commodities are being supplied to SMI sites by NGOs, WHO, ICRC, UNICEF and other donors. For the most part, in NGO supported clinics and hospitals, supplies are available. In many instances, however, a sound system does not exist for forecasting stock needs, reordering, storing properly, and monitoring. Many hospitals and clinics we visited did not have oxytocics or magnesium sulfate available, nor did they have proper cold storage (outside of the EPI clinic) for oxytocics, blood, HIV test kits, etc.

Another major gap is the lack of insect repellent or insecticide impregnated bed nets and a system of distribution and health education focused on how to use them and how to re-impregnate them with insecticide. Very small-scale programs of bed net distribution are in place (e.g., one is operated by HNI) but these are inadequate to meet the need of what we found to be a serious malaria problem. The marketing/advertising elements of a successful bed net program need strengthening, and pricing affordable by the poor considered.

Many providers reported unsafe injection practices, e.g., reusing needles and improper needle disposal methods. We believe providers at all levels of the system could benefit from training in management of pharmaceuticals and supplies. Likewise, training and assistance in development of safe injection, universal precautions and other infection prevention methods is need to safeguard the public's health.

It may be possible to increase efficiencies in the system by sharing best practices and local expertise. For example, the Afghan nongovernmental organization Afghan Health and Development Services (AHDS) has designed a state-of-the-art pharmaceutical management system. This NGO could be supported to train other NGOs and hospital/clinic pharmacists and supply officers

Facility-level assessment of practices and support to improving the management of pharmaceuticals, disposable commodities and logistics management systems will be an important aspect of strengthening SMI service delivery sites.

## REGION-SPECIFIC REPORTS AND RECOMMENDATIONS

The following sections discuss the findings from the site visits to the Northern, Northeastern, Eastern, Southern and Western Regions. Because the regions are so different and findings from one area do not necessarily generalize to the others, we endeavored to make recommendations for the regions as specific as possible to the needs identified.

These reports describe assessment findings for sites observed in each of the regions visited, highlighting local factors that could affect efforts to improve access to Safe Motherhood and EmOC services. The assessment noted significant similarities and differences between these geographical regions that will be important to take into account when planning programs to reduce Afghan maternal mortality. Differences noted included wide variations in terrain (affecting transportation and physical access), resources and local economies, drought and conflict effects, numbers of IDPs, population density, and educational levels, among other factors.

The areas visited also shared many similarities. Some of these were common shortcomings in resources, management, infrastructure, practices, knowledge, and skills. Many of these may be addressed by strengthening national standards of practice, e.g., infection prevention in hospitals and clinics. Others, such as restored and improved educational institutions and capital resources for infrastructure improvements, will take more time and a revitalized peacetime economy.

Other similarities among regions, however, represent possible opportunities—strengths and best practices—upon which to build improved SMI and EmOC services. Although the main body of the proceeding report addresses many strengths and opportunities found by the assessment for the nation as a whole, certain key regional similarities are highlighted below. Specific details are noted more fully in each report.

### **Best practices common to all regions visited:**

- Across all regions visited effective partnerships have emerged between and among local and international NGOs and the MOPH. This helps to prepare the way for evolving relationships and partnerships in building on the SMI and delivering EmOC.
- At the community level, services have been maintained, although sometimes at very minimal levels, despite years of little or no support. Physicians, nurses, midwives, and other community health workers, largely working through local and international NGOs, have strived, often against extreme odds, to bring health services to families.
- The forced “decentralization” of recent years has led communities and partnering NGOs to make the most of their limited resources. As a consequence, many have developed local capacities for coordination and communication that, when coupled with the planned increased ability of the MOPH to support them, can enable services to be expanded in order to reach further and to more effectively serve the population.

### **Issues common to all regions visited that need improvement:**

- In nearly all cases, management and supervision systems within health services, especially regional, provincial and district hospitals, need updating and strengthening.
- Managers of healthcare facilities need refresher training in sound management, administration and supervision policies and practices. In addition they need consistent support and in some cases more personnel are needed.
- Across all regions visited the assessment found weak adherence in clinics and hospitals to recommended international infection prevention practices, including handling and disposal of sharps and biohazardous waste, and equipment operation, care and maintenance.

(See **Annex E**, which is a copy of the Health Facility Checklist used in this assessment.)

# STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE CENTRAL AND EASTERN REGIONS OF AFGHANISTAN

**SITES VISITED:** Kabul (Kabul Province)  
Jalalabad (Nangarhar Province)

**DATES:** 4-7 April 2002

## FINDINGS AND RECOMMENDATIONS

**Background.** Judith O’Heir, UNICEF midwife consultant to the Joint Donor Mission, prepared this sub-report. The observations and findings were obtained during the first week of the external SMI assessment. Accompanying her on these visits were Suraya Dalil, Mark Fritzler and Patricia Stephenson. (More detailed background information is contained in **Eastern Regional Report.**)

**Findings.** Key findings regarding the provision of MCH services, including basic and comprehensive EmOC, and proposed new programs for midwife and auxiliary midwife training are summarized below:

1. **UNICEF-supported EmOC training course in Kabul.** The training program was three-weeks long and ended in mid-March. The objective was to upgrade the knowledge and skills of trainees and at the same time train them to become master trainers. Nineteen doctors (18 female and 1 male) were trained in two batches. The trainees were from Kabul and other locations throughout Afghanistan and are now expected to conduct EmOC training at their respective locations.

The training program was developed and implemented by Dr. Feroza Begum, an obstetrician from Bangladesh. She was the sole trainer. The Malalai Hospital in Kabul, a 200 bed maternity facility, served as the training site. The hospital has almost 17,000 deliveries annually, 3% of which are by cesarean section. An office and a classroom in a building adjacent to the hospital were used. The classroom was used for lectures as well as demonstrations and practice with anatomic models. The reference manual used for the program was developed by Dr Begum and includes information from a wide range of MNH reference materials produced by WHO, JHPIEGO and others.

Conversations with Dr. Begum and a visit to Malalai Hospital enabled me to appreciate her knowledge and skills, as well as her enthusiasm for this training course; however, it was obvious that the hospital has shortcomings as a training center—examples include very poor infection prevention practices, outdated clinical practices and insensitive and generally poor quality care. Dr. Begum is aware of these shortcomings, and she also recognizes that the program should be longer. Other limitations include the weak clinical backgrounds of the trainees and the fact that some of them were not/are not involved in clinical practice—yet these people are now expected to train other healthcare providers.

Although the training program provided a good start to updating the knowledge and skills of some providers of EmOC, UNICEF has decided not to continue the program. This

decision is based on the availability of the upcoming UNICEF/AMDD supported regional training program (competency-based training on EmOC) that will include a team of Afghan health professionals.

- 2. Proposed auxiliary midwife training program.** HealthNet International (HNI) would like to get this new, shorter more practical training program off the ground as soon as possible. The curriculum is being developed in collaboration with the IMES at Jalalabad; however, it is on hold at the moment as HNI's current funding comes to an end in April. The plan is to implement the program in Ghani Khel, a peripheral area outside of Jalalabad, using the hospital there and an adjacent training facility (a building that has yet to be renovated and equipped among other things.) Twenty-five literate village women with grade 6 schooling have been selected as the initial batch of students, and a draft curriculum has been prepared. The curriculum is divided into three phases—I reviewed the five modules that comprise Phase 1 and feel that some expert technical input would help to make the program more practical by, for example, clarifying the overall approach to learning, the specific skills to be learned, and the methodologies to be used, particularly for learning skills. Moreover, the curriculum should include only what trainees absolutely need to know in order to practice the skills that they are going to learn. For example, it seems unnecessary to include lectures on all of the body systems (e.g., digestive, respiratory, nervous, or musculoskeletal systems) or on the basic needs of the human body. In other words, the program should include minimum theory and maximum hands-on skills learning.

Discussions with the HNI staff suggest that they would welcome technical input related to improving the curriculum, preparing teachers and training sites, and implementing a practical and good quality program. My own impression is that the proposed program presents an excellent opportunity to introduce an innovative approach that will hopefully help to make good quality midwifery services available to women closer to their homes.

- 3. Intermediate Medical Educations Schools (IMES).** The IMES in Kabul was visited during the World Bank Mission and although this did not involve a tour of the facility, it was obvious that some rehabilitation had taken place. The school runs a range of training program for allied health workers, including nurses and midwives. The curricula for all of these programs are about to be revised with the support of IMC. What is unclear, however, is who will provide technical input for the revision of the midwifery curriculum. This should be discussed when the SMI assessment team visits the school—it would make sense, for example, to have some overlap between the technical input for the auxiliary midwife training program currently under development (HNI, IMES) and the longer formal midwifery training being offered at the Kabul IMES. This will be important from the perspective of determining what aspects are common to both programs (e.g., the approach to learning, skills to be learned, methodologies, etc.).

Additional information also needs to be obtained about the teachers for the IMES midwifery program, the availability of learning resources and of the clinical facilities to be used. This information should also be obtained at the other IMES schools, which are located in the regional capitals, and will be visited during the SMI assessment.

My impression of the IMES in Jalalabad was much less favorable than for Kabul, For example, although efforts have been made to recruit female trainees for the dentistry, assistant doctor, physiotherapy and nursing programs, there was no evidence of the

learning resources needed to support these programs. Also, there has been no midwifery training for 20 years in Jalalabad and there were no apparent plans to reintroduce it. For the immediate future it might be better to pursue the development of the proposed training facility in Ghani Khel, as a satellite of the IMES in Jalalabad, rather than upgrading, updating, and equipping the present school, which would be a major undertaking and take much longer.

4. **Clinical facilities.** Infection prevention practices at the clinical facilities visited thus far are of a very low standard, although where support is provided by an NGO practices are marginally better. The midwives and doctors working at the facilities are well intentioned and interested in refresher training that would enable them to do a better job; however, at present there are obvious deficits in knowledge and skills relevant to managing pregnancy and childbirth complications—this was particularly true for the management of severe pre-eclampsia/eclampsia.

Maternity care at some of the facilities (e.g., Laghman Hospital) could be improved considerably simply by reorganizing the space around the labor room to enable the women who deliver there to spend 12 to 24 hours postpartum at the hospital, rather than being discharged within an hour or so of delivery.

## RECOMMENDATIONS

1. Based on the preliminary assessment of the recently completed EmOC training course (March 2002) in Kabul, it is recommended that UNICEF not continue training using this approach. Instead, it is recommended that UNICEF take advantage of the upcoming UNICEF/ROSA/AMDD supported regional training program (competency-based training on EmOC) tentatively scheduled for July or August 2002 in Bangladesh.
2. Because expanding and improving the quality of midwifery training in Afghanistan is a priority, it is recommended that UNICEF should provide an appropriate midwifery consultant to assist IMES/Kabul and HNI in developing and implementing their new midwife and auxiliary midwife training programs. Because both activities are already well into the planning phase, this recommendation should be acted on in a timely manner.
3. Because many of the serious complications, as well as maternal and newborn deaths occur within the first 24 hours postpartum, it is strongly recommended that health centres and hospitals providing delivery services make every effort to keep postpartum women and their babies under observation for at least this long.
4. The almost total lack of use of recommended international infection practices limits the quality of all basic and comprehensive EmOC services being provided. UNICEF should ensure that adequate support is provided for infection prevention training of health professionals and support staff. Also follow up and supervision should be included to ensure the recommended practices have been institutionalized.

# STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE EASTERN REGION OF AFGHANISTAN

**SITES VISITED:** Jalalabad district, Nangarhar Province;  
Mehtarlam district, Laghman Province

**DATES:** 4-7 April 2002

## FINDINGS AND RECOMMENDATIONS

**Background.** Suraya Dalil, Denisa-Elena Ionete, Patricia Stephenson, Mark Fritzler and Judith O’Heir visited Nangarhar Hospital, and the Intermediate Medical School in Jalalabad city, Nangarhar Province, and Mehtarlam Hospital in Laghman Province. We met with the staff of HealthNet International (HNI), Aide Medical International (AMI) and IbnSina, three NGOs providing safe motherhood services in the Eastern Region. We also met with the Director of the MOPH for the Eastern Region and his deputy, the MCH director and the local WHO representative.

The Eastern Region shares a border with Pakistan and comprises 41 districts and three provinces - Nangarhar, Kunar and Laghman. The population of the region is estimated to be 2.1 million (UNIDATA Population Estimates for 2001). Jalalabad, the largest town, has a population of approximately 184,000 people. The primary ethnic group is Pashtun. The region has experienced heavy fighting recently. Eastern Nangarhar Province is one of nine priority areas of the Afghanistan Interim Authority. The area has suffered drought but conditions appear to have improved in recent months. A large IDP camp is situated midway between Jalalabad and the border with Pakistan.

Several NGOs are active in the region including the Afghan Red Crescent Society, International Medical Corps (IMC), IbnSina, Health Net International (HNI), Aide Medical International (AMI). Of these, only the later three have active safe motherhood programs and services.

The UN Country Health Profile lists 10 hospitals in the region but only two of these offer maternity services. HNI supports the Nangarhar Hospital and AMI supports Mehtarlam Hospital. The database also lists 64 basic health centers. It remains unclear how many of these have female staff and offer safe motherhood services but it was our impression that only the hospitals offered EmOC. Some basic health centers served by NGOs do, however, offer nutrition and antenatal care. As in other regions, employees of health facilities have not received their government salaries but if supported by an NGO they receive an incentive.

**Findings.** Detailed human resource, facility and service assessment forms were completed for the two hospitals visited and for the Intermediate Medical School. (Copies of completed forms for each facility assessed are available at UNICEF ACO in Kabul).

Key findings regarding access to and quality of care, provision of EmOC services and midwifery training are summarized below.

1. **Access to and utilization of EmOC services.** Great distances must be traveled to facilities from villages. The primary means of transport from villages to basic health centers and hospital facilities is donkey cart. Providers state that all the women admitted to the labor and delivery ward have complications and many arrive in very serious condition. Those women in the north of Laghman Province and in the Tora Bora and Nuristan regions have no road access making these areas most underserved in the region.
2. **Staffing.** The bottleneck to expanding safe motherhood services in the region appears to be the lack of female staff. Several female obstetricians work in the two hospitals visited. Only 18 trained midwives work in the region and they are employed by the hospital in Jalalabad. On the other hand, NGOs have been able to expand coverage to communities through TBA programs. These programs have linked TBAs to basic EmOC facilities through training, supervision, routine, regular re-supply mechanisms, and routine monitoring of TBA activity and practice.
3. **Quality of care.** The Nangarhar University Teaching Hospital receives some support by HNI, although the primary support is for the new neonatal intensive care facility. The obstetric and general pediatric wards have not been improved and have not received technical assistance or other forms of support. The hospital does have a blood bank and the capacity for surgical delivery services. Testing kits are available for HIV and Hepatitis B, but it is not clear whether testing is routinely and universally conducted. Donors are reportedly volunteers, and particularly family members.

The hospital lacked some basic equipment and supplies (e.g., lighting for surgery, anesthesia equipment, a vacuum extractor, and some essential drugs, such as oxytocin and MgSO<sub>4</sub>). Infection prevention practices need improvement: linens and mattresses were in very poor condition, facilities for hand washing were needed in patient rooms, and injection equipment was reused in order to conserve supplies. In some instances, the management of complications was inappropriate and out of date, largely because the staff did not have the confidence and knowledge to respond appropriately. The experienced midwives and obstetricians on staff stated that they had not received any refresher training in over 18 years. They themselves recognized the need for new knowledge to help them be better practitioners.

The Mehtarlam Hospital (Laghman Province) receives active support from AMI and had functional management systems in place for drug procurement, stock management and forecasting. They operate a busy therapeutic feeding program and an outpatient antenatal care department offering full service (TT immunization, micronutrient supplementation, supplementary feeding, screening for complications, treatment of existing medical conditions, health education, and bednet distribution when supplies were available). Their facilities for water, sanitation and disinfection were marginally better than those of the Nangarhar Hospital. Surgical facilities and a blood bank were available. One of the chief concerns of the providers was overcrowding. This problem could be improved simply by reorganizing the available space. Overcrowding leads providers to discharge patients too soon after delivery (within 1-6 hours) which defeats the purpose of promoting births with a skilled attendant.

4. **Birth preparedness and community-based IEC.** TBAs were the main health informational link with communities. Women who were fortunate enough to receive

antenatal care (a small percentage of all pregnant women) also received some health information/ education by midwives and doctors as a routine part of their care.

HNI has successfully involved communities in decision-making by involving traditional community leadership bodies (shuras). Community shuras have been instrumental in selecting TBAs and women eligible for the proposed auxiliary midwifery training, in providing accommodation for health providers, and in selecting clinic sites and providing the land for them.

5. **Training.** The Intermediate Medical Education School in Jalalabad is in very poor condition and yet is now offering training to female students in dentistry, assistant doctor, physiotherapy, and nursing. We saw no evidence of learning resources—materials, learning aids, equipment—needed to support these programs. There has been no midwifery training for 20 years in Jalalabad, and there seemed to be no plans to re-introduce it.

HNI is attempting to address the shortage of trained female staff through the creation of an auxiliary midwifery training program. The plan is to implement the program using clinical training sites in Jalalabad (the Nangarhar Hospital) and Ghani Khel rural hospital. The adjacent training facility has yet to be renovated and equipped. Twenty-five literate village women with a 6<sup>th</sup> grade education have been selected for the program. A draft curriculum of five modules has been prepared. Expert technical input would help strengthen this curriculum and make it more practical for example, by clarifying the overall approach to learning, the specific skills to be learned, and the methodologies to be used, particularly for learning clinical skills. The HNI program cannot progress from this point without additional funding. Current funding will run out by the end of April.

6. **Family planning.** NGO programs offer family planning information and services. NGOs state there is high demand for these services for birth spacing. The majority of family planning acceptors prefer injectable contraceptives with oral contraceptives as second choice. No services as yet are available for men.
7. **Coordination, management and health information systems:** We were impressed by the availability of HIS data for the region and the mechanisms already in place for coordination at regional level. Routine monthly meetings are held with all UN agencies and NGOs. Long-term planning has not yet started, largely because the situation in this complex emergency is still fluid.

## RECOMMENDATIONS

1. As both hospitals (Nangarhar University and Mehtarlam) assessed provide emergency EmOC services on a 24-hour basis, their ability to respond quickly and appropriately to obstetrical emergencies should be strengthened. One way to assist and support providers would be to provide them refresher training and clinical updates. The quality of services provided could also be improved by strengthening existing support by NGOs. Such support should concentrate on improved infection prevention, water and sanitation, and clinical management issues (such as clinic flow to ameliorate overcrowding and to discourage early discharge from hospital).

2. HNI should be supported to continue curriculum development and plans for auxiliary midwifery planning. We do not recommend that this training go to scale before it has been adequately tested and piloted in one region. Curriculum development could benefit from technical assistance (MOPH, UNICEF, other collaborators with training and curriculum development skills) in developing state-of-the-art clinical training oriented toward skills development. The curriculum should include only what students absolutely need to know in order to practice effectively. For example, it seems unnecessary to include lectures on all of the body systems or on the basic needs of the human body. In other words, the program should include minimum theory and maximum learning in hands-on skills. HNI should be assisted in hiring a training coordinator to help manage this training program.
  
3. Policy dialogue should begin with the MOPH so that they recognize auxiliary midwives as a legitimate cadre of health providers. The MOPH will need to address certification issues for auxiliary midwives and be an active partner in curriculum development. The MOPH will also need to incorporate plans for developing this cadre of skilled birth attendants into their overall plans for addressing human resource needs for safe motherhood. In this regard, the MOPH will need to clearly articulate the roles and functions of midwives, auxiliary midwives and TBAs.

# STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE NORTHEAST REGION OF AFGHANISTAN

**SITES VISITED:** Faizabad, Baharak and Jurm districts, Badakhshan Province

**DATES:** 11-15 April 2002

## FINDINGS AND RECOMMENDATIONS

**Background.** Patricia Stephenson and Mark Fritzler visited the one hospital serving Badakhshan Province, two basic health centers supported by NGOs, and the Intermediate Medical School in Faizabad. We also met with the Director of the MOPH for Badakhshan, Dr. Momin; the Head of Faizabad Hospital, Dr. Hajera; the persons in charge of MCH and HIS for Badakhshan, Drs. Najeeba and Najla. We also met with staff of the two health NGOs active in Eastern Region (Medecins Sans Frontieres and the Swedish Committee for Afghanistan) and with the local WHO representative. Dr. Majeed, the UNICEF OIC and Dr. Nafissa, the UNICEF Assistant Nutrition Officer, accompanied us on our site visits.

The Northeast region comprises Badakhshan, Takhar, Baghlan and Kunduz Provinces with a total population of 3.4 million. Badakhshan Province is in the remote NE portion of the region and borders Tajikistan, Pakistan and China, with an estimated population of about 804,778 (UNIDATA Population Estimates for 2001). Faizabad District is the most populous with approximately 223,000 and 50,000 in Faizabad city. The province contains 13 districts (currently being revised to form 26). The primary ethnolinguistic group is Tajik.

This province has some of the most inaccessible and difficult terrain in all of Afghanistan, consisting of high mountains and deep valleys in the heart of the Hindu Kush. There are few roads and deep snows can isolate many outlying districts, reportedly for as much as six months of the year. Distances between Faizabad, the provincial capital, and some remote districts are often measured in the number of days or weeks it takes to walk.

During the past decade, the region has been cut off from the rest of the country, as this was the one of the few areas of Afghanistan not controlled by the Taliban. The region has experienced continuous fighting over two decades and is heavily mined in Takhar Province west of Badakhshan around the area called the Frontline, which marked the line of control between Taliban and non-Taliban. In spite of its poverty, literacy rates in the province are high. Because the Taliban never controlled Badakhshan, schools were never closed and although the society is generally quite conservative, girls commonly attended. The three-year drought severely affected agricultural production, since most farming in the region is rain-fed. The population experiences chronic protein-energy malnutrition and iron, iodine and vitamin A micronutrient deficiencies. Malaria, leishmaniasis and tuberculosis are endemic.

It is not entirely clear how many health facilities and personnel exist in the provinces, as estimates vary according to source. For example, the UN Country Health Profile lists 12 basic health centers in Badakhshan, but we were able to identify 23 that still function at some level. Many of these are built and run by NGOs or are MOPH facilities supported by NGOs. The region receives little funding from the government. Staff employed by the MOPH have not been paid in months—they are paid an incentive if employed in a clinic supported by an

NGO, or paid a salary if employed directly by an NGO. The MOPH has relied on UNICEF, WHO, and NGOs to support its programs.

Because of the geographical size of the region and the mountainous terrain, only 30-40% of the population has physical access to health services. That is, health services are available and within several hours travel time weather conditions permitting. In practice, women's access to health services is greatly restricted by the limited number of female staff available, cultural norms requiring women to be accompanied when they venture from their homes, security issues, a strong preference or tradition for giving birth at home, and severe transportation limitations. The most widely available means of transport is donkey.

**Findings.** Detailed human resource, facility and service assessment forms were completed for: Faizabad Provincial Hospital (supported by MSF, DFID and UNOPS); Baharak district basic health center (supported by MSF); and Jurm district basic health center (supported by SCA). Additionally, an assessment form for the Intermediate Medical Education School was completed. Copies of completed forms for each facility assessed are available at UNICEF ACO in Kabul.

Key findings regarding access to and quality of care, provision of EmOC services and midwifery training are summarized below.

1. **Access to EmOC services.** Badakhshan is served by one hospital with 10 maternity beds located in Faizabad. A new 20 bed maternity facility under construction with support by DFID and UNOPS will replace the current maternity section. The hospital receives support from MSF (incentives for staff, drugs and commodities) and UNICEF (basic equipment). The hospital offers 24-hour comprehensive EmOC services.

Badakhshan is also served by 36 basic health centers—23 of which are still functional. Of these, MSF supports two basic health centers and the provincial hospital. SCA supports 10 basic health centers. However, only two of the 36 basic health centers (those supported by MSF) do normal deliveries and could potentially serve as basic EmOC facilities. Only four of the 36 offer antenatal care services. Some private practice exists in the area including community midwives and traditional birth attendants (dayas). The UN Country Health Profile lists three additional facilities in the Northeast Region (for a total of seven) providing MCH services. The main limiting factor to expansion of NGO capacity to deliver MCH services is the lack of qualified female staff, the mechanisms to secure for them and their families adequate, safe accommodation near to clinics, and the means to pay their salaries. Greater support to NGOs to upgrade facilities could potentially see maternal and newborn health services extended to all their functional clinics in the province.

2. **Utilization of services.** Very few deliveries in Badakhshan occur in facilities with a skilled attendant. No statistics were available on the proportion of women in the Province who deliver with a skilled attendant or a TBA, or who receive any antenatal care. Utilization of MCH services varied widely, explained primarily by (1) availability of female staff, and (2) quality of services rendered including the availability of supplementary feeding programs for mothers and children. Supplementary feeding programs may be functioning as an entry point to antenatal care and other reproductive health services.

The MSF clinic we visited has an active maternity service with 2-3 normal deliveries and 40-50 antenatal visits per day (the antenatal care service operates three days a week). The facility is clean, female staff are available, and they appear to be well trained and oriented to providing service to patients. They offer a nutrition program two days per week.

The clinic in Jurm (supported by SCA) had one female physician to provide antenatal and MCH care. The number of women seeking antenatal care at this clinic was fairly low. The facility itself had limited equipment and supplies and no electricity or running water. The lack of female staff was a serious constraint on MCH and safe motherhood services.

The Faizabad Hospital serves as the only referral facility in Badakhshan and managed 600 deliveries in 2001 (there were five maternal deaths in the hospital for the period). According to the Chief Obstetrician nearly all of their patients come (or are referred) because they are experiencing complications. It is the only facility in Badakhshan providing blood or cesarean section. The hospital has one instrument pack for cesarean delivery. Blood is available only from several paid, “professional” donors. Relatives are reluctant to donate blood. Blood transfusion and collection kits are available. Refrigeration does not exist for blood storage or for storage of HIV test kits and oxytocics.

The new maternity facility being built may increase capacity to serve more patients. Still the overall maternity bed capacity in the province is limited. Should interventions be designed to increase demand for services, it is doubtful that the bed capacity exists to serve them.

3. **Staffing.** The hospital has on staff 26 doctors and 45 nurses. Fifty percent of the professional staff are female. Midwives exist but have only on-the-job training—no formal training in midwifery skills. Few midwives or female physicians exist outside of Faizabad, although they are in high demand. Expatriate doctor-nurse teams work in MSF clinics. Due to the shortage of staff they have little time for skills transfer, spending much of their day in direct service provision to meet the demand.

TBAs are accepted by professional staff and seen as an import link to the community. The TBAs known to the system have received training and support from NGOs and WHO. MSF has the most active program with regular contact and supervision of the TBAs who serve their clinic. SCA has also provided training (no recent refresher training), TBA kits and has regular contact with supervisory TBAs. WHO has trained 208 TBAs since 1993, but these women receive no additional support, refresher training or supervision.

Badakhshan is now experiencing a “brain drain”. Educated professionals who fled to Badakhshan during the Taliban regime now try to relocate to Kabul or other cities to secure higher paying jobs and better living conditions for their families. This poses considerable stress on NGOs trying to keep facilities open and providing services to communities.

4. **Quality of care.** The quality of the services available to women varies from one facility to another. The Baharak BHC (MSF) observed a high standard of infection prevention with hand washing facilities in every room and universal precautions in place. Hand washing facilities were basic but effective, comprising a small tin tank with a faucet, a bucket to catch the flow of water, hand soap and a nailbrush. All equipment was

available locally and did not require shipping or structural renovations to the clinic facilities. The Faizabad Hospital and the Jurm BHC had limited facilities for hand washing. All facilities had functional equipment for sterilization of instruments. Injection safety is a major issue in some facilities. Safe disposal and incineration of sharps and other biohazard materials was available at Baharak and the hospital. Supplemental electricity generation was available at the Baharak BHC.

All facilities had stocks of drugs and supplies provided by NGOs. Management systems for re-supply, storage, distribution and cost-recovery varied widely. Refrigeration for oxytocics is generally not available, which limits the shelf life of stocks. Use of oxytocics following delivery for active management of the third stage of labor is not routine practice. Malaria drugs, drugs for the treatment of helminthes, micronutrients (especially iron and folate), contraceptives, antibiotics for the treatment of sepsis, tetanus toxoid, and IV solutions and sets are available in the clinics and in the Faizabad hospital.

Staff appeared to be motivated to provide a high standard of service to women. As mentioned previously, all facilities suffer from “brain drain” of qualified staff relocating to larger cities. Staff work hard when provided an adequate working environment, incentives and nonfinancial incentives such as training and supportive supervision. Staff could also benefit from reference materials and protocols for clean, safe delivery and infection prevention, handling of waste, and management of obstetrical and newborn complications.

5. **Birth preparedness and community-based IEC.** Everyone we spoke with identified the need for a better-informed population. Very basic health knowledge is lacking including information on warning signs of complications, information on clean, safe delivery practices, basic hygiene and family planning. The providers with whom we spoke considered the UNICEF and WHO-supported house-to-house health education program provided by the Badakhshan Voluntary Women’s Association a model program addressing these issues. The Association trained 26 teachers and three nurses to conduct the person-to-person education. An evaluation revealed an increase in the use of EPI services and a decrease in the number of admissions for neonatal sepsis. Such activities could benefit from health education materials that would reinforce messages conveyed verbally. Community-based IEC programs could also be a vehicle for distribution of clean, safe delivery kits, ORS, vitamin A, condoms and other materials.
6. **Training.** There is an Intermediate Medical Education School in Faizabad. It was established in 1994, closed in 1997, and reopened in 2001. Students seeking entrance must first take an exam, the results of which are sent to Kabul for evaluation. Students may indicate a preference for medical or nursing training but the entrance exam is the same for both. Above a certain cut-off, the student may be placed in the medical school—below the cut-off the student is placed in nursing training. Classes are gender-segregated. But as classroom space is limited, in a given year, only males or females may be admitted. A class of 70 female medical students was admitted last year. There is no dormitory to safely house female students from the outlying districts, a factor that will hamper attempts to deploy female personnel to outlying districts. The IMES currently lacks funding and is temporarily closed. The school has enjoyed support, however, in terms of educational material and equipment supplies (microscopes, books, laboratory equipment) from the governments of Turkey and Norway, and from UNICEF and WHO.

7. **Family planning.** Family planning services appear to be in high demand and acceptable to people so long as they are offered for the purpose of birth spacing. Services are offered by MCH clinics and the Faizabad hospital—no CBDs exist. Services are not organized around addressing the high level of unmet need as a key public health, primary prevention strategy. Methods are available free of charge (stock is supplied by UNFPA and NGOs). Women prefer injectable contraceptives. Three methods are available in Badakhshan, DepoProvera, oral contraceptives, and condoms. Women’s groups try to include family planning information and referral in their health education activities. Nothing is available for men and providers state that men are reluctant to talk about contraception, but it may be that male providers are uncomfortable with the subject, thinking this to be a women’s issue.
8. **Coordination, management, and health information systems.** Routine monthly coordination meetings are held by UNOCHA with all UN agencies and NGOs in attendance. There are subcommittees for health, education, agriculture and food security that may be useful as vehicles to assist UNICEF in carrying out its programs. Because the situation in this complex emergency is still fluid, planning occurs on a month-to-month basis. Strategic planning for the transition and for reconstruction is yet occurring, but will rapidly increase in importance should the security situation improve.

Because of NGO support to clinics and direct provision of services, a great deal of data are available internally to NGOs that could be extremely useful determining and monitoring actual coverage of services and changes in use. Badakhshan, like other places we have visited, is data rich but information poor. Activity reports, e.g., from TBAs and clinics, are collected and sent to management teams that, in turn, compile the data in summary reports to agency headquarters. Such data are not yet available to coordinating bodies for planning and monitoring purposes nor are they fed back to the providers who generate the data so that they can use the data to improve services and monitor performance.

## RECOMMENDATIONS

1. We recommend that UNICEF, in conjunction with other collaborating partners, supply the new MCH unit at the Faizabad Hospital with the basic equipment needed to provide antenatal, maternal and newborn health, safe delivery, and EmOC services. Some of the needs include equipment for basic sanitation, a generator, lighting, delivery room equipment, refrigeration, and basic surgical equipment. In collaboration with MSF, develop a plan to increase supplies of RH drugs to meet the increased demand for services. Improvements to facility management should address, among other things, patient flow mechanisms so that women are not discharged too soon following delivery, which defeats the purpose of having a skilled attendant at birth. Patients should be able to stay for 12-24 hours for observation of the mother and child.
2. UNICEF, in cooperation with the Voluntary Women’s Association, WHO, and other partners may consider how to expand upon the IEC work and experience in Faizabad. Appropriate health education materials for people who cannot read and write should also be available, some of which might be adopted from the Maternal and Neonatal Health birth preparedness materials developed for Nepal. Key issues for IEC include clean, safe delivery, the warning signs, promotion of skilled attendance, exclusive breastfeeding for at least 6 months and complementary feeding, knowledge and practices of essential

family nutrition, newborn care, and family planning. As other women's associations exist in Afghanistan, it might be possible to tap this civil society resource to replicate the work in Faizabad and to try other approaches at the community level, to get health information to women and families.

3. SCA supports a number of clinics in very difficult and remote locations in this region and has had a presence and been providing services for longer than almost any other organization. Given how thinly spread medical and health services can be in this rugged environment, SCA-supported facilities provide crucial health resources to thousands of people who would otherwise receive none. Because of geographical obstacles and other difficulties that arise in supporting these clinics and BHCs, we recommend that UNICEF and SCA work together to review program implementation and to devise a collaborative strategy to specifically strengthen these clinics to provide safe motherhood and basic EmOC services to key BHCs. For example, a strategy that couples a targeted UNICEF support package with an SCA-led program of community-based health education, clinic upgrades, and clinic staff assistance could relatively quickly extend maternal and newborn healthcare and EmOC to women who have never had these lifesaving opportunities. Transportation will be a problem in this region for years to come—perhaps always. This strategy will help ameliorate the obstacle of poor transportation by bringing maternal and newborn care and EmOC services closer to women at risk.

## STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE NORTHERN REGION

**SITES VISITED:** Mazar-e- Sharif , Code Barq and Balkh District (Balkh Province)  
Andkhoy and Sheberghan (Jawzjan Province)

**DATES:** 11-16 April 2002

### FINDINGS AND RECOMMENDATIONS

**Background:** During a five-day period Suraya Dalil (Assistant Project Officer, Health, ACO) and Noel McIntosh (UNICEF SMI consultant) visited one regional (Mazar) and four district hospitals, two NGO-MCH clinics and the Intermediate Medical and Education School (IMES) located in Mazar. We also met with Dr. Mirwais Rabi (Regional Health Director, MOPH). Accompanying us on all our travels was Dr. Ghulam Rafiqi (Project Officer, Survival, Mazar). Because both Drs. Dalil and Rafiqi know the region well, having spent many years living and working there, we were able to accomplish a great deal in a short period of time.

The Northern Region forms the northern border of Afghanistan from Uzbekistan in the East to Turkmenistan in the West and comprises 56 districts and five provinces—Balkh, Samangan, Jawzjan, Saripul and Faryah. The population of the region is estimated to be 3.2 million (UNIDATA Population Estimates for 2001). Mazar, the regional capital, is the largest city and has a population of approximately 167,000 people. The primary ethnic groups living in the region are Tajik and Uzbek.

During the past 23 years the region has suffered greatly from the war, having many displaced persons, and most recently a prolonged drought affected many districts. In addition, many parts of the region are isolated because it has few serviceable roads, low population density and rugged terrain.

From a reproductive health perspective, the region has received little funding or attention from the government in several years. The UN Country Health Profile lists 16 hospitals, but only two of these are known to provide more than basic EmOC. The database also lists 46 basic health centers. It is unclear, however, just how many of these have female health staff and offer even antenatal and nutrition care, but clearly few of them provide EmOC. Employees of many health facilities have not received their salaries, but if the facility receives NGO support, they generally receive an incentive. Moreover, opportunities for refresher training (all cadres of health professionals) have been nearly nonexistent (i.e., most health professionals have never received any updates since graduation or receiving their certificate). Furthermore, with the dramatic downsizing of the MOPH during the Taliban era, combined with the separation of healthcare services by sex, maternal and newborn health has not fared well.

**Findings:** Detailed human resource, facility and service assessment forms were completed for:

- Three hospitals: Mazar Regional Hospital, MOPH; Code Barq hospital, Ministry of Mines; and Andkhoy District Hospital, MOPH. (Because we only briefly visited the Sherberghan District hospital, no assessment forms were completed for this hospital.)
- Two NGO-supported clinics: one funded by the Swedish Committee of Afghanistan (SCA) in Balkh District and the other a MCH clinic supported by Save the Children/USA (SCF USA) in Andkhoy.

In addition an assessment form for the Intermediate Medical Education School (IMES) in Mazar was completed.

For all healthcare facilities, UNICEF/Mazar is providing varying degrees of technical assistance, some supplies (mainly drugs) and limited equipment (e.g., BP cuffs, stethoscopes, thermometers, etc.) and EmOC instruments. Copies of completed forms for each facility assessed are available in the UNICEF ACO in Kabul.

Key findings regarding access to and quality of care, provision of EmOC services and midwifery training are summarized below:

1. **Quality of care, motivation and performance of staff** were not related to the age or general condition of the facility. For example, the oldest facility (Code Barg hospital, managed by the Ministry of Mines), which was built more than 30 years ago, was clean, well run and the services provided in an acceptable manner. The staff appeared to be well trained and the hospital well managed. Clearly, having regular pay and the opportunity for limited outside practice (fee for service) were important.

By contrast, at the recently renovated (August 2001) Maternal and Child Unit at the Mazar Regional Hospital (MOPH), the facility was poorly maintained (the only moderately clean area was the doctors “on call” room); children roamed the halls including the labor and delivery rooms; almost all equipment was broken (autoclaves, refrigerators, BP cuffs, etc); needles and syringes were being reused, no recommended infection prevention practices (e.g., handwashing, safe handling and disposal of syringes etc) were observed; safe waste disposal was lacking (food, used gauze and dressings, needles and syringes, catheters and empty medicine vials littered the delivery room, recovery area and patient rooms); and there was no waste removal system (all waste items—biohazardous and nonhazardous—were discarded in a huge pile at the back of the hospital. Interestingly, since tap water and electricity were available at Mazar but not at sites in other communities, one would have expected higher quality conditions at the regional hospital.

2. **Access to and use of EmOC services.** To varying degrees, basic EmOC services were being provided at all facilities. The most complete EmOC services were provided at the Andkhoy MCH clinic (funded by SCF USA and UNICEF); the least at the Maternal and Child Unit at the Mazar Regional Hospital. The Andkhoy clinic had a well-trained team of CHWs and assistants providing antenatal, postpartum, infant and childcare. The records were complete and up to date; staff were highly motivated and outreach activities are linked to nearly 250 TBAs located in the surrounding catchment area. The MCH unit

had a simple, clean delivery area and was adequately equipped. A female physician performed the deliveries (16 deliveries and 19 D&Cs for incomplete abortion in January and 19 deliveries and 29 D&Cs in March). The capability to perform Cesarean sections had only recently resumed with appointment of a surgeon at the Andkhoy District hospital located in the same compound as the MCH Unit. While neither the MCH unit nor the district hospital had running water or regular electricity, they managed quite well with water from a drum with a tap and flashlights for surgery when the power was off.

For the Northern region, it is estimated that less than 10% of women deliver in a hospital or EmOC facility. Based our assessment of the only referral hospital in the entire region (Maternity and Child Unit at the Mazar Regional Hospital) and 2 other district hospitals, use of obstetrical services in the Northern region by pregnant women is indeed very limited. For example, the catchment area for the Andkhoy District hospital is about 130,000. Assuming a CBR of 30 /1000 (low estimate) this would yield about 3,900 deliveries (low estimate) per year in this area. The MCH unit's outreach efforts are linked to about 3,000 deliveries per year. Currently the MCH unit does no more than 20-25 deliveries per month (about 300 per year) and almost all of them are from city of Andkhoy—not from the surrounding catchment area. Moreover, according to the birth registry at the MCH clinic, as expected, they are uncomplicated deliveries (only 9 Cesarean sections were performed in the OR at this district hospital the entire previous year). Thus, the question becomes what happens to the estimated 15% of women (about 600) who would be expected to have major complications of labor and delivery (obstructed labor, hemorrhage, infection or eclampsia)? Given the condition of the road (50% nonexistent and a 2-3 hour drive at best) to the closest other district hospital in Sheberghan, it is doubtful they are taken there to be managed.

Several factors account for the low use, especially for complications, of even the available obstetrical facilities we surveyed. Two of the most important, in addition to limited access, are cost and the poor quality of care, especially in Mazar. For example, surrounding this hospital are 28 pharmacies and countless physicians offices, yet the only medicines available at no cost to pregnant women are iron and folate tablets. The patient must pay for everything else.

Also the poor quality of services and the unsanitary condition of the Maternal and Child Unit would discourage most pregnant women and their families from using the MCH unit or hospital. Interestingly, in the past year a medical team (1 or 2 surgeons, some nurses and an anesthesiologist) from India has taken up residence in the hospital compound. They are using 2 of the 3 operating theatres (OT). They use one for storage and the other they have completely re-equipped, including bringing in their own electric autoclave, anesthesia machine and suction equipment. They have done this because the hospital's several autoclaves and anesthesia machines are broken and are stored in the now unused third operating theatre. The door to the re-equipped OT is locked and sealed with gauze stuffed around the edges of the door to keep the dust out. The Indian team has the key, and we were unable to see it. Reportedly, the hospital surgical staff are only permitted to assist the Indian team, otherwise, they do not use the OT. The Indian team, however, performed 11 of the Cesarean sections performed at the Mazar hospital during a recent month, all in their refurbished OT.

3. **Blood transfusion services.** At all three hospitals visited blood transfusion services were limited to fresh blood transfusions from relatives. Even at the Mazar Regional Hospital, banked blood is not available. Testing is limited to blood type and RH (when test materials are available). Screening for serology, HIV or hepatitis B (HBV) are not performed. At the Mazar Regional Hospital, kits for rapid HIV and HBV are stored in the only functioning refrigerator (two others were broken). When queried regarding why these tests are not performed, the technician stated that the doctors were unwilling to wait for them to be performed.
4. **Availability and use of oxytocics.** At no facility were oxytocin or injectable methylergometrine available, which are routinely given as part of WHO's recommended active management of the third stage of labor. No hospital or clinic had magnesium sulfate for treatment of severe pre/eclampsia. For example, at the Andkhoy District hospital, a woman with severe pre-eclampsia (hypertension, proteinuria and edema) in the third trimester was being treated unsuccessfully (BP>150/100) with bed rest, diazepam, antihypertensives and expectant delivery. At all sites, knowledge about the benefits of oxytocin to decrease postpartum hemorrhage, or magnesium sulfate for management of eclampsia, was limited both for physicians and midwives.
5. **Family planning services.** FP services were provided at all MCH sites. Demand is increasing, especially for birth spacing. All sites have limited supplies of condoms, oral contraceptive pills and DMPA, and they are provided at no cost to clients (stock supplied by UNFPA and NGOs). Counseling is limited and no active promotion, except by word of mouth or by some to the TBAs, is conducted.
6. **Health professional staffing patterns** were adequate to excessive, especially for male physicians, at all sites. For example, at the Mazar Regional Hospital there were 38 physicians (19 on staff, including 2 female physicians, and 19 male "volunteer" physicians) for a 70-bed hospital. By contrast the Code Barg hospital (50 beds) had only 13 physicians—1 female Ob/Gyn, 8 surgeons, 3 internal medicine and 1 ENT) and no volunteers. If expansion of MCH and EmOC services is to occur, human resource development will need to focus on recruiting and training female physicians and midwives.
7. **Midwifery training.** The old nursing school building, recently renamed Intermediate Medical Education School (IMES), is located in the Mazar Regional Hospital compound. Currently, about 1000 students are enrolled in nursing, midwifery, dental, lab technology and pharmacy programs. The existing building is in poor condition, dark and poorly lit and totally inadequate (e.g., most classes are conducted under make-shift tents outside the building.) This situation will worsen, the IMES plans to increase the number of midwifery students from 40 or so per year to nearly 100, according to the head of the IMES. In addition, until last year all students came from Mazar, or very close by, as there are no accommodations for students at the school. Moreover, the graduates do not want to work outside of the city. Starting this year, however, the MOPH has requested that the mix should be 80% urban (local) and 20% rural (distant), but no provision has been made to house these rural students.

With exception of pharmacy, which is a 2-year program, all the others are three years in duration. Entrance requirements for midwifery are lower than for the other disciplines (9 years' schooling versus 12). The head of the midwifery program estimated that the students could only read about 4-6 pages of "easy" material per day and about 2 or 3 pages of "hard" material, such as anatomy. Since there are no texts for students (or teachers) for any course, it is difficult to ascertain the accuracy of this. Clearly reading capability, even in the local language, is limited for midwifery students. The only learning materials they were able to show us were a very old, dusty human anatomy model and a wooden pelvis with a fetal head with the bony landmarks (suture lines, etc.), which they produced from a locked, old Russian truck container located adjacent to the IMES building.

The method of instruction is lecture and review: First the instructor dictates his/her notes, and the student writes them down; the next day s/he reviews her/his dictated notes with the students; and then the process is repeated until the course is completed.

The IMES midwifery head, who is a very bright, articulate and enthusiastic midwife, stated that because of space limitations, it is not possible to practice with even the existing models. Thus, the only clinical practice the students possibly can get is observing deliveries in the Maternal and Child Unit. Since there are only about 50 deliveries per month in the unit, it is unlikely the students get much clinical experience. It will be even less when the class grows to 100.

## **RECOMMENDATIONS**

1. Because home deliveries, especially in the remote areas, will continue to be where most women have their babies, improving the skills of (the proposed) newly trained auxiliary midwives has been identified as a major need. In the short-term, while the steps needed to develop, implement and evaluate an improved curriculum are occurring, some simple things would improve the existing program in the IMES at Mazar. For example, at present most midwifery students in the IMES do not even have paper to take notes on. Just supplying paper, pencils and simple supplies to the IMES would be helpful.
2. Because of the need for home-based delivery care, an auxiliary midwife training program, similar to that proposed by HealthNet International (HNI) for Jalalabad, should be considered. Due to the long distances, poor roads and limited transportation, selecting older, literate women (early 25-30s) from remote villages and providing them with essential information and very practical clinical skill training over a shorter time frame would work in Mazar. Moreover, this strategy would likely have more immediate impact than investing the large sums it would take to upgrade the existing IMES.
3. If midwives graduating from the proposed new MOPH 2-year program or the proposed auxiliary midwifery program, which will be shorter and even more hands-on skill oriented, are to be better prepared to conduct home deliveries, they need up-to-date information provided in a simple, largely audiovisual and interactive format. To do this will require considerable resources (physical, human and financial) to develop a practical, competency-based curriculum that provides only essential, up-to-date knowledge in easily incorporated packages and maximizes clinical practice opportunities so that graduates have the basic skills to conduct normal deliveries (e.g., use of partographs and active management of the third stage of labor) and manage basic medical problems. For

example, to improve the quality of the midwifery training in Mazar, more than one practice site, besides the regional hospital MCH unit, will be needed to ensure there are sufficient deliveries for students to learn and practice the required skills.

Before this can happen, teachers with new knowledge, evidence-based practices and standardized skills need to be trained; service delivery/training sites need to have their services improved, especially infection prevention; and the IMES will have to have considerable administrative and management support initially to make this happen.

4. In the Northern Region, the potential to bring in a small team of practitioners from other countries to provide on-the-job training of staff at the Mazar Regional Hospital should be considered. If properly orchestrated, such a team, like the Indian medical team now living and working at the Mazar hospital, could be used to quickly provide much needed new knowledge and practices to existing staff. Alternatively, an appropriately qualified and experienced NGO should take over operation of the recently renovated MCH unit and operate it independently of the main hospital until the MOPH or other donors can upgrade the main hospital, provide long-term administrative and management support, and pay the staff on a regular basis.

## STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE SOUTHWESTERN REGION

**SITES VISITED:** Kandahar and Maiwand, Kandahar Province  
Grishk and Lashkar Gah, Helmand Province

**DATES:** 17-21 April 2002

### FINDINGS AND RECOMMENDATIONS

**Background.** During a five-day period, Patricia Stephenson and Noel McIntosh (UNICEF SMI consultants) visited two provincial hospitals (Kandahar and Lashkar Gah) and 1 district hospital in Grishk District; four MCH clinics supported primarily by NGOs (AHDS, ICRC, Mercy Corps and IbnSina); and the nursing school in Kandahar. We also met with Dr. Tihar, Grishk District Public Health Officer. Accompanying us on all our travels was Mr. Nasrat (IT Officer, UNICEF/Kandahar). Because Nasrat knows the region well, having spent many years living and working there, we were able to accomplish a great deal in a short period of time.

Geographically the Southwestern Region forms the southern border of Afghanistan (from Pakistan on the East to Iran on the West). The region comprises 62 districts and five provinces—Kandahar, Helmand, Oruzgan, Zabul and Nimruz), three of which are very large. The population of the region is estimated to be 2.9 million (UNIDATA, Population Estimates for 2001). Kandahar, the regional capital, is the largest city and has a population of approximately 450,000 people. The primary ethnic groups are Pashtun and Baluchi.

The Southwestern Region has suffered greatly from more or less continual war over more than 20 years and most recently a prolonged drought. Both have resulted in many people being displaced from their homes (IDPs) and contributed to the extremely poor health conditions throughout the region. Severe food shortages for both children and adults still exist, especially in Helmand and Nimruz Provinces, despite the lucrative poppy (heroin) industry (largely in Helmand Province). This region is very isolated because it has few serviceable roads, low population density (largely desert) and limited resources, especially water.

From a reproductive health perspective, the region has received little or no funding and attention from the government in recent years. Moreover, as is the case for other regions, opportunities for refresher training (all cadres of health professionals) have been nearly nonexistent (i.e., most health professionals have never received any updates since graduation or receiving their certificate). This combined with the separation of healthcare services by sex, which was imposed during the Taliban era, has further limited access to and the quality of maternal and newborn healthcare.

**Findings.** Despite the geographical size of the Southwestern Region, there are relatively few healthcare facilities in the region. The UN Country Health Profile lists 12 hospitals in the region, but only the Mir Wais Regional Hospital in Kandahar has the potential capacity (medical staff, blood bank, central supply, operating theatre, instruments and anesthesia equipment) to provide comprehensive EmOC. This poses special problems for pregnant

women living in this region. For example, Kandahar is considerably closer to Pakistan border than to Iran—both in terms of distance and time. In addition, a fair road and only a 4-5 hour drive connect Quetta, Pakistan, a large commercial city with full-specialty hospital services. Thus, women living in the eastern portion of the region have reasonable access to comprehensive EmOC. However, for pregnant women with obstetrical problems who live in the northern (Urozgan Province) or far western portion of the region (Helmand and especially the Nimruz Provinces) travel to Kandahar is nearly impossible to reach by car or truck.

For all healthcare facilities visited, UNICEF/Kandahar is providing varying degrees of technical assistance, some supplies (mainly drugs) and limited equipment (e.g., BP cuffs, stethoscopes, thermometers, etc.) and basic EmOC instruments and/or delivery kits.

Key findings regarding provision of MCH, including basic and comprehensive EmOC, as well as the potential for midwifery training are summarized below:

1. **Provision of MCH and basic EmOC services.** According to UNICEF/Kandahar, there are 4 NGOs providing MCH services (some with basic EmOC) in the region. They are:
  - **Afghan Health and Development Services (AHDS):** Since 1990 AHDS has been developing sustainable primary healthcare facilities in Afghanistan. Currently, they operate 38 primary healthcare facilities (10 MCH units) in two provinces (Kandahar and Urozgan). In addition, they have a functioning clinical training program for mid-level providers (TBA, midwives, CHWs, etc) operating out of their main administrative office in Kandahar. This office also houses their central storeroom and a training center.

The central storeroom is located in a well-ventilated, temperature controlled (about 21 Celsius) dry cellar. The storeroom is clean, well organized, fully stocked and meticulously maintained. The logistics manager has developed a computerized logistics and supply system. The training center is clean, adequately ventilated and illuminated, has the basic equipment (chalk board, overhead projector, and screen), and has seating for about 12-15 students around a conference table. Dormitory accommodations are available on site for both women and men. AHDS staff provides short-course RH training as well as logistics and supply and management training, not only for their own staff, but also for staff from other NGOs in the region as well. In addition, the MCH clinic in Kandahar has a small clinical training unit with dormitory space for of 4-6 midwives, TBA or female CHWs and their children. This unit is specifically used for basic EmOC training.

We visited two AHDS MCH units, one located in Kandahar City, the other in Maiwand, a 1-hour drive west of Kandahar, just off the main road to Grishk. Both were clean, well staffed and organized, busy and had midwives, TBAs and a female physician. Basic EmOC services are provided during the daytime at present but soon will be available on a 24/7 basis. As was the case in the Northern region, each MCH clinic is linked to a network of TBAs. In the AHDS system, however, TBA services are regularly monitored and 1-3 day short courses are conducted at frequent intervals for knowledge updates and skill training, as well as for new TBA provider training,. Again, as in other regions, the number of deliveries per month was low (less than 20-25) at each facility while antenatal services were heavily utilized (50-60 per day). Disposal of biohazardous waste is by burning and then burying the ash. (A copy of the

AHDS annual reproductive health report for 2001, which details their extensive MCH service, training, supervision as well as logistics and supply capability, is available at UNICEF ACO in Kabul.

- **IbnSina.** This NGO has four MCH clinics in the region, three in Helmand province and one in Grishk at the district hospital. MCH services are largely limited to providing antenatal and postpartum care (three sites) because they have a difficult time keeping female physicians on staff. According to the Regional Director, Dr. M. Daud Zahir, this is because salaries of both the MOPH and NGOs are low.)

The IbnSina MCH clinic we visited is located in separate buildings immediately behind the Grishk District hospital. At the time we arrived (around 10 AM) the clinic was in full operation. While the buildings are very old and not well kept, the antenatal area, though small and very crowded, was relatively clean (50-60 pregnant women are seen each day in the clinic). In the room where TT was being given, the table where the injections were being given was covered with more than 50-100 used autodestruct syringes, and no safe disposal container was available. (The lack of proper syringe and needle disposal was a common problem at most sites we visited.) The delivery room was small, clean and well stocked, but did not look like it had been used. The female physician was new but very enthusiastic about her work.

- We were unable to visit the MCH clinics operated by IAHC and Mercy Corp International in Lashkar Gah. By the time we reached the city and toured the general hospital, which was built by the US government in the 1950s as part of the Helmand Valley Authority (HVA) hydroelectric project, both clinics were closed for the day.

2. **Comprehensive EmOC services.** The team assessed three hospitals – the Mir Wais Regional MOPH Hospital in Kandahar, the Grishk District hospital, and the HVA hospital in Lashkar Gah.

- **Mir Wais Regional Hospital.** As mentioned above, this is the only hospital in the region providing comprehensive EmOC services. Twenty years ago, this was a full-specialty referral hospital and served as the major teaching center for the medical and nursing schools. In recent years, however, funding from the MOPH has been minimal, and the hospital now only provides general surgery services. Currently, even to the keep hospital functioning at this level requires the continuing support (equipment, instruments and staff) and technical assistance of several donors and NGOs. For example, ICRC operates the entire general surgery unit (operating theatre, blood bank, and recovery area).

Although physically the hospital is in poor condition, the surgery unit is clean, adequately staffed and appears to be well managed. Full anesthesia services (general and regional block) are available on a 24/7 basis and female physicians are on call to cover obstetrical emergencies, including Cesarean sections. During our visit, an abdominal laparotomy (acute appendicitis) was being performed under general anesthesia. The operating team and support staff performed well. Recommended infection prevention practices were used, including handling of sharps, surgical technique and maintenance of an aseptic operating field. Unfortunately, only surgery

for obstetrical problems or complications is available as the hospital does not have a labor, delivery or postpartum recovery area, nor is antenatal care provided.

The blood bank, which is located in a separate area of the GS unit, is well kept and very clean. The technician was competent and able to fully describe all procedures. On the day we visited the hospital, more than 50 units of whole blood of all types were available and were listed by blood type on white board in the unit. All blood is fully screened (type and Rh) as well as tested for serology, HIV (rapid test) and HBV and is stored in a refrigerator. A directory of potential donors is regularly updated, especially for uncommon types (AB negative) and those who are O negative. In addition, relatives of all surgical patients are strongly urged to donate blood. As a result, the hospital generally has sufficient blood to meet routine demands.

Waste handling and disposal practices are reasonable in the general surgical unit. Although housekeeping staff do not wear gloves, the biohazardous waste from the general surgical unit was burned and buried. We did not check how waste is handled and disposed in other parts of the hospital, however.

A quick tour of the female ward, which is not managed by ICRC, revealed that there were numerous problems (e.g., water for handwashing and other tasks was not available, and clean and dirty cases were mixed together).

- **Grishk District Hospital.** This small (10 bed) hospital is located northwest of Kandahar (about a 2 hour drive on the main road to Herat). The District Public Health Officer met us and walked us through the hospital. The building resembles a warehouse in design and construction, with a wide central corridor, which was jammed with children and adults, running the entire length. On either side are offices, the male and female wards, OT, recovery area and medical OPD. It is an old, dirty, poorly maintained building.

The OT is small and is lit by a single, large light bulb that hangs from the ceiling. The OT is fairly clean and equipped with an operating table, ambu bag and suction apparatus (foot powered). The hospital has a surgeon and an anesthetist, who states he can do general (open drop ether with pentothal induction) and spinals (he showed me several disposable, sterile spinal needle sets). Cesarean sections are not performed (patients are referred to Kandahar), and most cases in the logbook were minor (hemorrhoids, suturing of trauma cases, and splinting) with an occasional appendectomy. No postoperative records are kept, and no record of complications were available.

Running water (small tank with spigot) is located in the preoperative area. In addition, there is a sink and drying rack for instruments. A well-used kerosene-powered autoclave is used for sterilizing instruments and other items. Biohazardous and nonhazardous waste is burned or dumped behind the hospital and adjacent MCH clinic.

- **HVA Hospital in Lashkar Gah.** As mentioned above this hospital was built in the 1950's by the USA government. While the structure is well built, severe neglect over the past 20 odd years has taken a heavy toll. It has no running water and the sewage system is blocked. The only exception to the general shambles was the hospital

administrator's office, which is clean and well furnished. The wards and corridors are filthy. Patients and their immediate families live together in the wards where they also do their cooking. As a consequence, the walls and ceilings are covered with soot and cobwebs. By about 12:30 PM when we arrived, both the OT and blood bank were locked and the staff with the keys were gone for the day. It is doubtful that either is in noticeably better condition than other parts of the hospital.

Because the hospital has no pharmacy, patients must buy all their own medicine, syringes and other items. Also, if a patient needs a transfusion, first the blood collection kit must be purchased from the pharmacy, and then brought to the blood bank where the technician collects the blood and screens it (blood type only). While relatives are asked to donate blood, paid donors (\$50-100 dollars per unit) are the usual source. As a consequence, patients who desperately need transfusions and cannot pay, do not get them.

For past 20 years or so, this hospital has received no assistance from the government or any other source. Somehow the physicians in the community, including several female physicians, have kept the hospital open, waiting for the time when the political and economic situation would be better and assistance to restore the hospital to its former status would be forthcoming.

3. **Midwifery training.** There is no IMES in this region. There is a nursing school located within the Mir Wais Regional Hospital compound. At present, midwifery training is not provided at the nursing school. The nursing school was closed the day we visited the hospital. We were able to look at the facility but were not able to talk with any faculty. The facility is located on the second floor of a building donated to the hospital by the Guardian Foundation. It is in reasonable condition and the floor in the central corridor was clean. Since 11 September, the facility has been divided into two halves to accommodate both women and men students. Living accommodations, however, are not available for students within the hospital compound.

## RECOMMENDATIONS

1. Provision of MCH and basic EmOC services should be expanded as expeditiously as possible. Of the four NGOs currently supporting MCH centers, AHDS clearly is doing a very good job and has the management and technical capacity to expand services both within the two provinces they are working (Kandahar and Urozgan) and to other provinces as well. They also have the administrative and financial capacity to responsibly handle more resources (current budget, nearly \$1 million dollars per year). Finally, they are viewed by the other NGOs as highly collaborative and responsible for most of the training of local providers, even for other NGOs. Thus, over the next few years, they should be looked on a key NGO to expand and improve MCH and EmOC services in the region.
2. As described above, AHDS has two training units in Kandahar, as well as living accommodations for both women and men. Currently, AHDS is providing some new and refresher training to physicians and other mid-level providers. Because community-level midwifery training is a priority for the region, a program similar to that being set up in the Eastern Region by HNI could be established. Therefore, consideration should be given to having AHDS develop the program, in collaboration with HNI or another appropriate

partner, and manage it until such time that the nursing school (or IMES, if it is renamed) is capable of running it.

3. The excellent management and logistics systems developed by AHDS should be replicated in other regions. For example, using the AHDS training center, management and logistics staff from other regions could be brought to Kandahar for short-course training.
4. The general surgical (GS) unit at the Mir Wais Regional Hospital in Kandahar does not have a labor, delivery or postpartum recovery area, nor does the hospital provide antenatal services. It is recommended that MCH/EmOC services be established as expeditiously as possible. Currently, two floors of a wing of the hospital, which is adjacent to the GS unit, are being renovated as a new OPD. If quick action is taken, it may be possible to have an NGO, such as AHDS, assist in developing a MCH/EmOC unit in this area while it is still under renovation. (At the very least, this situation should be followed up on by UNICEF/Kandahar to confirm this possibility.)
5. Because of the vast size and poor roads, a priority for the region should be establishing comprehensive EmOC services in the far western area (probably in Helmand Province). One possibility would be to build a new obstetrical/surgical unit at the HVA hospital in Lashkar Gah. While this is potentially doable, it is recommended to have the project overseen by a local NGO(s), such as MCI for the construction, logistics and management aspects, and AHDS to coordinate developing a quality program. Recent experience in dealing with the hospital indicates that just providing assistance (e.g., drugs, equipment or instruments) may not yield the desired result unless carefully monitored. For example, recently donations of drugs reportedly were found for sale in local pharmacies. (The possibility of doing this is being followed up on with DFID, as they are providing funding to Mercy Corp International to provide MCH and other services in Helmand Province.)

## STATUS OF THE SAFE MOTHERHOOD INITIATIVE IN PARTS OF THE WESTERN REGION

**SITES VISITED:** Herat City, Maslakh IDP Camp, Shindand District (Herat Province)

**DATES:** 18-21 April 2002

### FINDINGS AND RECOMMENDATIONS

**Background.** Dr. Suraya Dalil, Mark Fritzler (UNICEF SMI consultant) and Dr. Jawad Mofleh (Health Officer, UNICEF, Herat) visited Herat City and Shindand District in Herat Province in the Western Region to examine the status of SMI services. The team visited:

- Maternity Ward, Herat Regional Hospital, supported by UNICEF and IMC.
- Maslakh IDP Camp (five clinics): one each operated by Medecins du Monde (MDM) and Medecins sans Frontieres (MSF); two clinics supported by UNICEF with Afghan NGO implementing partners Coordination for Humanitarian Assistance (CHA) and Hewad Reconstruction Services (HRS); and one clinic supported by the NGOs IbnSina and IMC.
- Shindand Comprehensive Health Center (CHA and UNICEF), Shindand District
- Herat Intermediate Medical Education School (IMES) to assess the nursing and midwife programs.

The team met with Dr. Mohammed Omar Samim, Regional Director of Health, MOPH, Dr. Ghulam Ahmad Hanifi, Director of the Herat IMES, Dr. Mohd. Farid Waqfi, CHA Medical Coordinator, and Dr. Tsogzolmaa Dorjgochoo (Dorji), IMC's EmOC trainer.

Herat Province is one of four provinces in the Western Region, which borders Iran and Turkmenistan. The province is divided into 15 districts. The provincial population is approximately 1.1 million (UNIDATA Population Estimates for 2001). Herat District is in a generally well-watered, intensively farmed, wide river valley, with a population of approximately 227,000. Herat city is the largest urban center and often considers itself the "second city" of Afghanistan.

Herat District also hosts a large number of Internally Displaced Persons (IDP) in several camps, the largest of which is Maslakh, currently with over 100,000 persons. Most of these IDPs were migrants escaping the effects of the recent three-year drought that severely affected most of the region, particularly in the northern and eastern parts of the region (largely Badghis and Ghor provinces). The wet winter and spring of 2002 appears to have relieved the drought and local/regional authorities have announced they intend to close the IDP camps and move the occupants back to their home villages within 2-3 months. In addition, repatriation of hundreds of thousands of refugees who fled to Iran during the last 20 years of fighting has begun, adding to the flow of returnees to the region.

A large number of these IDPs and refugees have learned to expect health services and when they return to their village communities they will likely wish to continue having them. This

will put a heavy strain on the ability of the MOPH and other organizations to provide these services, especially since they are largely absent from those areas.

**Findings.** The team completed detailed human resource, facility, and service assessment forms for all health facilities visited and a brief assessment form for the IMES. Copies of these forms are available in the UNICEF ACO Health Office, Kabul.

1. **Access to EmOC services.** In the Western Region, two facilities offer comprehensive EmOC services—the 40-bed maternity ward of the Regional Hospital in Herat and the UNICEF-supported CHA hospital in Farah Province. The Herat Maternity Ward offers 24/7 comprehensive EmOC services and is a physically separate facility in the same compound with the Regional Hospital. It has two delivery rooms, its own pharmacy, operating theatre and training room (soon to be outfitted by IMC with a reference library). The hospital also has a blood bank. The team was unable to visit the Farah facility but CHA reportedly also offers 24/7 comprehensive EmOC services at their facility in Farah City.

According to the MOPH Regional Health Director, Herat Province has 26 Basic Health Centers (BHC). CHA operates 19 BHCs, mostly in Herat Province (which includes Shindand District) and Farah Province. CHA reports they offer antenatal services and 24/7 basic EmOC in all. The CHA Comprehensive Health Center in Shindand offers full PHC OPD, plus TB, malaria, and supplemental nutrition services, and has a delivery room and five beds. They offer basic EmOC services and their records show they have approximately 4-5 deliveries/month. Complications are referred to Herat Hospital.

At Maslakh IDP Camp, IbnSina clinic offers 24/7 Basic EmOC services. Ibn Sina Clinic records show that two deliveries were performed in the clinic in March 2002. MDM maintains a 24-hour ambulance service with a driver and a nurse on night duty for emergencies. Emergencies and pregnancy complications are referred to the Herat Hospital and/or Maternity Ward.

Herat and Farah provinces have relatively good road access, although villagers living more than a few kilometers from the roads must use donkey or travel by foot. Reportedly the other two provinces of region, Badghis and Ghor, have few functioning healthcare facilities outside the provincial centers. Road access in Badghis and Ghor is very poor outside the provincial centers. Residents must travel great distances on foot or by donkey to reach health facilities.

2. **Use of services.** As is typical of the country, very few births occur in facilities with a skilled birth attendant. No statistics were available on the proportion of women who deliver with a skilled attendant, a TBA, or who receive any antenatal care. There were a few deliveries in the IDP clinics and the Shindand facility. Shindand records show, for example, an average of 4-5 deliveries per month. The IbnSina clinic in the Maslakh ID camp reported two deliveries in the past month. The Herat Regional Hospital reported nearly 320 deliveries per month but most were admitted due to complications and most were from the city only. At the time of the visit, the Dr. Dalil noted that two of the patients had been brought in from the Maslakh IDP camp.

Antenatal services are well attended in the IDP clinics and at Shindand. CHA has an extensive network of TBAs (approximately 250) and Village Health Volunteers (VHV)

they train and supervise and who are taught to provide antenatal information to village women.

3. **Staffing.** Staffing in the seven observed facilities was generally good, with at least a minimum of female staff. The Maternity Ward of the Herat Hospital has a large staff of female nurses, midwives and male doctors. The IDP clinics are all adequately staffed with doctors, nurses, and midwives and the Shindand clinic has an adequate number of female staff. CHA reports their other BHCs are still low in female staff and all of their VHVs are male—a legacy of the Taliban days—but they are working actively on recruiting and training more female staff and things are improving. CHA has organized Village Health Committees for clusters of villages and these take an active role in overseeing TBA and VHV activity. For field-based TBA and VHV training and supervision, CHA has 9 married couple training teams that go to the village areas and live in locally-provided accommodations for long periods. In most other BHCs, especially in Badghis and Ghor provinces, there are reportedly no female staff, either doctors or midwives.

In all facilities observed, patients were accompanied by significant numbers of family members, including other children, who waited around the health facilities. In some of the facilities, the team observed that staff, such as midwives, had their own small children (under 6 years old) accompanying them in the clinic and being looked after by the cleaning staff or other clinic assistants.

4. **Quality of care.** The quality of the services available to women varies from one facility to another. At all the clinics observed, for example, standards of infection prevention varied widely, but were generally in need of improvement. Some had hand washing facilities in every room and universal precautions in place, but all need better adherence to recommended infection prevention practices. Hand washing facilities were basic but effective and consisted of a small, locally made sheet metal tank with tap, a plastic bucket to catch the water and hand soap. Much of the specialty equipment—sterilizers, instruments, refrigerators, cold boxes, etc.—was provided by donors, but a significant amount of equipment was locally produced (e.g., water tanks, beds, lights). All facilities had functional equipment for sterilization of instruments.

Sharps and medical waste safety is a major issue in some facilities. Safe disposal and incineration of needles and other biohazard materials was available at some clinics and the hospital, but none adhered as closely to recommended practices as they should. Items such as safe sharps containers and properly maintained incinerators need to be upgraded.

Electricity supply is a major problem for all clinics. The Herat Hospital has city power only at night with generator power only for emergencies. The other observed facilities had no electricity.

All facilities had stocks of drugs and supplies provided by the implementing NGOs or UNICEF. Management systems for re-supply, storage, distribution and cost-recovery varied widely. Refrigeration for oxytocics is generally not available which limits the shelf life of stocks. Use of oxytocics following delivery for active management of the third stage of labor is not routine practice. Malaria drugs, drugs for the treatment of helminthes, micronutrients (especially iron and folate), contraceptives, antibiotics for the treatment of sepsis, tetanus toxoid, and IV solutions and sets are available in the clinics.

The Herat Hospital maintains a blood bank and tests for type, Rh, and HBV. They have HIV test kits, but do not use them routinely for at least two reported reasons. Doctors are reluctant to test for HIV because in emergencies, they do not want to take the time to wait for a result. The team also heard, however, that doctors or lab technicians are reluctant because they feel the process of handling blood samples and slides poses risks to them.

CHA reports that malaria is a significant problem and they perform health education, blood testing and provide treatment (chloroquine). TB is also a significant problem, especially among IDPs. The Shindand clinic conducts TB testing. Proper TB treatment for IDPs poses a serious problem, as it is very unlikely that, if they are diagnosed with TB, they will be able to complete the usual 6-month DOTS treatment regimen before they leave the camps and return to their home villages.

The Herat Hospital Maternity Ward has its own pharmacy but receives its supplies from the general hospital pharmacy. This presents a difficulty, as the hospital is very slow in responding to Maternity Ward requests for drug or equipment supplies. In addition, reportedly the EmOC kits supplied by UNICEF go to the general hospital pharmacy where the staff disassemble the kits and distribute the contents to their own pharmacy shelves. When the Maternity Ward doctors need EmOC medicines, they have to fill out requisitions and submit to the hospital pharmacy, which is very time consuming and frustrating.

The Maternity Ward maintains an Emergency Cabinet, stocked with enough emergency supplies to treat only 2-3 patients. Supplies include very basic injectables, catheters, dressings and drugs. The Ward should be encouraged in this practice and assisted to include a more comprehensive stock of emergency supplies in the emergency cabinet for EmOC. Magnesium sulphate is available in the market but not in the hospital. Doctors prescribe it, bringing it in from the outside.

All facilities gave iron and folate during antenatal care, although time initiation varied. Training should emphasize that it should be given to patients early in the pregnancy—even before pregnancy.

5. **Birth preparedness and community health education.** Everyone interviewed identified a need for greater community-based understanding of primary health and maternal and newborn health. The IDP clinics and the CHA Shindand clinic conduct regular health education in the clinics for both men and women. MDM, MSF, and CHA had the most detailed and extensive health education activities at their clinics. MSF (Maslakh IDP Camp) and CHA (Shindand) conducted their health education activities in conjunction with supplementary nutrition counseling. CHA trains their TBAs and VHVs intensively in basic health education, provides regular supervision and supplies and periodically reviews and refreshes their knowledge. CHA reports they have been very successful in changing those TBA traditional practices that were harmful, such as cutting and tying the umbilical cord with dirty scissors and string or placing the husband's shoe under it.

In short, health education is being done in the IDP camp clinics and in CHA-operated (and UNICEF-supported) facilities but a great deal remains to be done in the general population. Generally good health education is available for IDPs—if they attend the clinics—but they will find little or no continuation when they return to their home communities.

The team observed that CHA has prepared a number of excellent health education learning materials—posters and flipcharts—particularly for family planning. These could be a very useful resource for the MOPH if adopted, replicated and disseminated more widely.

6. **Training.** The Intermediate Medical Education School (IMES) in Herat is in very good condition, having been renovated completely by the Danish Afghanistan Committee (DAC). The IMES is located in the same compound as the Herat Hospital and Maternity Ward. The school also has a renovated dormitory for male students, many of whom come from rural districts. There is no accommodation for women students, although Dr. Hanifi, the IMES Director, reported that they are seeking approval from the MOPH (and presumably donor support) to renovate some existing buildings to provide a women's hostel. Because there is no women's hostel, all female students are from Herat city.

The school has about 200 students in four disciplines—nursing (120 male and 8 female), sanitarian (8, all female), assistant doctor (50, all male), midwifery (30, all female), with a total of 18 male and 6 female instructors. The IMES is clean and well-equipped with furniture and whiteboards. The nursing and midwifery courses have learning materials and basic instruments, models and charts. It was encouraging to see that the learning materials and equipment were available and regularly used in a separate room dedicated for learning purposes, and not packed and hidden away.

During the visit, IMC was concluding a three-week training in EmOC for ob/gyn doctors, mostly from the Maternity Ward. Midwives were not included. The team obtained a copy of the detailed training curriculum and recommends that it be reviewed to bring some of the components in line with current WHO standards. CHA conducts regular in-service training and refresher training for the clinicians in their health facilities.

CHA trains TBAs and VHVs effectively through a repeated pattern of two weeks of group training followed by two weeks of practice in the field in their home territories. This pattern continues for six months. In addition, the TBAs and VHVs are closely supervised, both by CHA and by the Village Health Committees in their home communities. CHA also has 9 husband-and-wife training couples who live in the communities for long periods of time conducting training and providing ongoing support to TBAs and VHVs. CHA has also developed detailed guidelines and checklists to guide TBAs and VHVs in the field. These materials would be a good resource for the MOPH and other implementing partners in establishing standard guidelines for field health workers.

MDM has trained 18 TBAs in the IDP camps and supplies them with delivery kits. It is a usual practice by most other healthcare providers, however, to train TBAs how to use safe delivery kits, but to give the delivery kits to the expectant mothers.

7. **Family planning.** Family planning education and services are offered at all observed facilities. CHA and MDM report significant demand for FP services and products. DepoProvera is the most preferred method.
8. **Coordination, management, and health information systems.** Record keeping at the Herat Hospital Maternity Ward needs much improvement. For example, the patient

record form does not provide adequate detailed information on the diagnosis, treatment, and outcome of the visit. Records at the other clinics observed tended to be more detailed, but could also be improved with greater detail and a system for reporting to central data banks and subsequent analysis. Coordination meetings with all IDP health implementation organizations are routine, which may change once IDPs and refugee returnees are gone and relief activities cease.

## RECOMMENDATIONS

1. With the in-house training room and the nearby excellent IMES facilities, the Maternity Ward of the Herat Regional Hospital should be considered as potential site for the UNICEF/AMDD competency-based EmOC training program. In preparation for this it will be important to identify a strong implementing partner (we suggest either CHA or IMC) to improve the overall management of the facility and to assist in upgrading the HIS system, introduce new and more detailed record forms and train staff in proper maintenance and use of basic equipment and instruments. (One team member noted that an infant incubator was used as storage for people's sandals.)
2. Having an emergency cabinet, such as the one at the Maternity Ward at the Herat Hospital, is a good practice and should be encouraged. It does, however, need additional supplies for more than 2-3 patients.
3. The Maternity Ward pharmacy should be separated from the hospital pharmacy and independently stocked and operated. Also, UNICEF should stock it with more of the UNICEF-provided EmOC supplies in order to provide them to patients free-of-charge.
4. Concerning IDPs, it is very important to continue providing MCH and basic EmOC services in the camp as long as the camp is active. UNICEF could consider creating a maternity-only facility, with beds and family space, to consolidate delivery services in a more women and family friendly environment. Local comments led the team to believe that this would encourage IDP women to use maternity services, as the available sites offer little privacy and are not attractive to women.
5. If IDPs are moved out of the camps and returned to their village areas in the eastern and northern provinces of the Western Region, there will be a serious shortage of health services accessible to patients when they re-settle in their original communities. As noted, health services are available mostly in the provincial centers of Badghis and Ghor provinces. Therefore, it is recommend that an NGO (CHA or IMC) be appointed now as an implementing partner, regardless of the IDP camp closure plans and timing, in order to begin establishing BHCs, including MCH services, in key district areas of Badghis and Ghor Provinces. As an anticipatory strategy, this could be a very effective and dramatic intervention that would add greatly to helping IDPs and refugee returnees to make a home in their former communities.
6. Continue support to CHA clinic at Shindand and other CHA BHC locations.
7. Review and reproduce CHA's health education and family planning education materials and consider for wider dissemination and use by the MOPH and other NGOs. In particular, look into using or adapting CHA's TBA/VHV guidelines and checklists for wider use in village-level health education activities.