SAFE MOTHERHOOD INITIATIVE IN AFGHANISTAN

SUMMARY OF ASSESSMENT FINDINGS AND RECOMMENDATIONS

This report is a summation of an assessment made of UNICEF assisted programmes on safe motherhood in Afghanistan by Shairose Mawji. Ms. Mawji, an external consultant, conducted this assessment for UNICEF Afghanistan office in collaboration with UNICEF, MoPH, other UN agencies and NGO's between May-Aug 2000. The content of this report is reflective of the consultant's appraisal of the situation and may not be reflective of the other stakeholder's views. This report is submitted in conjunction with individual provincial reports that describes in detail the current status of the safe motherhood initiative and recommendations for better programming for each focal province.

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A. Executive summary

Afghanistan, where the maternal mortality ratio is estimated to be the second highest in the world at 1,700/100,000 live births, warrants the implementation of effective interventions to reduce the maternal mortality. UNICEF, in collaboration with other stakeholders, developed a strategic framework for Safe Motherhood in late 1997. This strategy was to be implemented initially in 'focal' provinces and it was envisioned that the experiences gained would later be used to replicate this programme to other parts of the country.

In an effort to assess the progress that has been made over the past 3 years, to consider the lessons learned and to develop effective ways to move forwards, UNICEF recruited an external consultant to review the safe motherhood programmes in Afghanistan. This report is a reflection of the findings of this assessment, the current situation of the safe motherhood programme in the 4 focal provinces that UNICEF has targeted- Logar, Laghman, Farah and Balkh and offers recommendations for operationalizing the safe motherhood programme.

Between May 1st and Aug 31st 2000, a review was made by this consultant in collaboration with UNICEF, MoPH and NGO's at the provincial level and regional level. This assessment entailed gathering qualitative and quantitative information by visiting most of the health facilities in various districts in the 4 focal provinces. Meetings with heads of NGO's and other UN agencies were held both at the initiation of the assessment as well as at the end in order to de-brief on the main assessment findings.

The general findings of this review have illustrated the complex situation that faces Afghanistan. In a country that has been at war for over 20 years, has a large geographical distribution and many inaccessible areas due to the physical terrain and climate, has no recognized government and the authorities that are in control are very weak in terms of their knowledge and managerial experience, where there has been a huge 'brain drain' - professionals leaving the country, putting into practice any programme has been a real challenge.

In light of this background situation, it must be noted that the implementation of the safe motherhood programme is still very much in its early stages. Although a strategic framework had been developed in 1997, many essential components of this strategy have yet to be realized. The tendency for UNICEF up till now in most of the focal provinces, had been to supply equipment, drugs and other materials to health facilities/hospitals as well as to work on aspects related to renovation and rehabilitation. However, in most of these areas, there is no monitoring or supervision systems set in place nor are the staff actually trained or oriented to provide emergency obstetric services. Various other essential facets of implementing the safe motherhood programme have yet to be actualised. The development of national training materials for health staff on provision of emergency obstetric care- EOC is one such example.

The recommendations that are inclusive of this report relate to implementing safe motherhood in a broad manner whereby intersectoral linkages between health, education, nutrition, gender and communication need to be addressed. Considering the context of Afghanistan and the current status of girls and women in this country, an assertive yet tactful and diplomatic approach must be taken in addressing these sectors.

In summary, UNICEF must take more of an active and leading role in the execution of the safe motherhood programme. It needs to coordinate and share information more openly with the other stakeholders, such as other UN agencies, MoPH and NGO's. UNICEF needs to spearhead this initiative, be more forthcoming and committed to this programme and develop the materials/tools that will enable the actualization of the safe motherhood programme in Afghanistan.

B. Introduction- Global view on Safe Motherhood

At least 1,600 women will die daily from complications of pregnancy and childbirth. That is approximately one woman every minute of the day or 585,000 women per year somewhere in the world will die due to the complications of pregnancy or childbirth.[1] In addition to the vast number of women who die, many more will suffer serious, painful, debilitating and often permanently disabling problems as a result of pregnancy or childbirth.[2] Several of these complications will lead to isolation and stigmatisation and in effect, will have serious consequences for the health and well being of the woman's family, community and nation.

In light of this background, the Safe Motherhood Initiative was launched in 1987. This International Conference on Safe Motherhood was held in Nairobi, Kenya and this was the first time that the international community clearly focused on women and participated in efforts likely to reduce the number of women suffering and dying as a result of pregnancy and childbirth.

The International Conference on Population and Development (1994), the Fourth World Conference on Women (1995), and the Safe Motherhood Technical Consultation (1997), reiterated the goal of reducing maternal mortality and also redefined maternal mortality as a social injustice that infringes on women's rights to quality maternal health services. This violation of women's human rights necessitated an integrated, intersectoral approach to maternal health.[3]

International consensus was reached that in order to reduce maternal mortality the immediate, underlying and basic causes of maternal mortality must be addressed. Some of these issues are related to promoting:

- The status of girls and women in society- increasing girl's access to education
- Access to basic health services and nutrition before, during and after childbirth (including family planning and appropriate vitamin and mineral supplementation)
- Attendance at birth by professional birth attendants (midwives, doctors)
- Training and deployment of staff with midwifery skills and
- Access to essential obstetric care when complications arise and policies that raise women's social and economic status and their access to property and other resources, as well as to the labour force [4]

Reducing maternal mortality therefore, requires a co-ordinated, long-term effort with commitment from national and local authorities, health professionals, the education system, the media, civil society groups, NGO's and the community. In some countries however, where conflict prevails and there is political instability, the level of implementation of maternal health programmes may be limited and challenging but still needs to be established.

[1] Maternal mortality. Safe motherhood fact sheet. Family Care International. New York, NY.
[2] The design and evaluation of maternal mortality programs. Centre for Population and Family Health, Columbia University.
[3] Women-friendly health services - Experiences in maternal care. Report of WHO/UNICEF/UNFPA, workshop, Mexico City, 1999.
[4] Programming for Safe Motherhood. Guidelines for maternal and neonatal survival. UNICEF. NY.

C. Background

Afghanistan, a war-torn country, has the second highest maternal mortality ratio in the world - estimated at 1,700/100,000 live births.[5] In light of this very high figure and in considering UNICEF's overall mandate, in 1997 UNICEF Afghanistan in coordination with other key stakeholders, including the MoPH (ministry of Public Health) identified a need to formulate a national strategy to reduce maternal mortality.

A comprehensive strategy and framework was developed after a consensus-building workshop was held in October 1997. Implementation was planned initially in five provinces- Logar, Laghman, Farah, Jwazjan and Oruzjan in a 2-phase approach- the second phase beginning 18 months after the first phase.

It is imperative to note that in reality, the political, social and economic situation inside Afghanistan have been unpredictable. There has been fighting between the Taliban and the Northern Opposition in many parts of the country. The authorities have issued various edicts some of which denied formal access to education for girls, have banned women from working except in health related activities, forbad male doctors for treating female patients for obstetric/gynaecological problems, restricted the movement of women in public places etc.

In spite of this fundamentalist patriarchal society, UNICEF Afghanistan in partnership with a number of organizations decided to promote the Safe Motherhood Initiative (SMI) in selected provinces (appendix 1- Map). The overall goal of the SMI project was to reduce the maternal mortality by focusing on:

- The long term development of systems in health
- Strengthening of maternal services with a focus on Emergency Obstetric Care
- Improving management, supervision and monitoring in maternal health
- Community involvement from the earliest stages of planning through implementation
- Interagency and intersectoral coordination

Three years on, in the year 2000, UNICEF Afghanistan decided to take stock of the Safe Motherhood programme and to consider how the strategic framework developed in 1997 could be realized to a fuller extent. The assessment was carried out primarily by a consultant but in collaboration and accompaniment by staff from UNICEF sub-office and ACO (Afghanistan country office) as well as MoPH representatives whenever possible.

This report will present the objectives of this assessment, methods used, general findings, key findings for each of the focus provinces followed by the general constraints experienced by most if not all of the focal provinces. General recommendations for UNICEF country office will then follow within which the suggestions for changes in the current managerial structure that may improve programme implementation will be outlined. Finally, a draft plan of action for reducing MMR for the period September 2000 - December 2000, followed by a draft plan of action for January 2001- December 2002 will be outlined.

1. Objectives of assessment

- Carry out an assessment of UNICEF- supported Safe Motherhood projects
- Draft plan of action for reduction of MMR covering the period of July 2000-Dec 2002
- Contribute to the implementation of the plan of action for Logar province
- Recommend changes in the managerial structure, staffing and other inputs for better programme implementation

[5] UNICEF Progress of Nations 1997

2. Methodology

Information was gathered and collated through:

- Review of available reports and documents;
- Interviews with key informants- representatives of UN agencies, international and local NGO's as well as MoPH officials (in Afghanistan, Peshawar and Islamabad);
- Completing a questionnaire - facility assessment form - via observation and interviewing (appendix 2) and
- Visits to most districts and health facilities in each focal province. Discussions with health care professionals, especially female staff, as well as health care users

D. General Findings

On the whole, the Safe Motherhood programme in Afghanistan is still very much in its infancy. Although, 5 provinces had initially been identified as focal provinces in 1997, in fact 4 provinces, Logar, Laghman, Farah and Balkh are now the SMI focal provinces for UNICEF. The SMI programme was to be incorporated in the overall plan for strengthening primary health care services (PHC) but in actual fact, this has not been realized due to various reasons, some of which will be outlined in the section entitled 'main constraints'. The achievements related to the implementation of the SMI programme have varied between each province and these aspects will be highlighted in the next section.

Though almost 3 years have passed since the consensus-building workshop on the strategy for Safe Motherhood in Afghanistan was held and there were some very clear recommendations for follow up action (appendix 3), it appears that most of these actions have not been implemented.

In reality, little advancement and progress has been made in Afghanistan over the past few years in improving conditions that can facilitate improvement for maternal health. It is important to note that in 1998, most of the international staff had been evacuated from Afghanistan. National staff continued to manage the programme on a skeletal basis. Many other reasons can be cited for this lack of progress, but two of the crucial ones that underpin these are:

1. The ongoing complex political situation in Afghanistan that has resulted in the instability of implementing most programmes and the continued fundamental patriarchal society that is exemplified in the lack of basic human rights for women. The lack of political will on the side of the authorities, the low level of decision making of women, the ongoing ban of formal education for girls, the restriction of movement for women, the lack of qualified female staff available to work in rural areas and the difficulties which lie in providing training for female health professionals all have contributed to the slow progress of the SMI program in this country.

2. The underperformance and shortfall on the side of UNICEF Afghanistan to view the Safe Motherhood Initiative as a programme, to develop the appropriate materials required for this initiative and to give it the time and effort that it rightly warrants. Part of this reason may be due to the strong focus within the Survival section/ Health section to concentrate on issues related to EPI (expanded program of immunization).

   Another explanation for this lack of movement in the SMI program may be related to the lack of adequate human resources within the women's health section. Currently, one Afghan female staff member in ACO is directly responsible for this program.

This staff member's movements are very much restricted within Afghanistan as she must travel with a mehram and cannot meet with senior authorities or attend formal meetings within Afghanistan. There is also a lot of other responsibilities that she must undertake within ACO that take away from her focus on 'women's health' and the SMI programme.

On an optimistic note, some progress has been made towards creating awareness amongst the authorities, the NGO's, health professionals and the community to a certain level as to what the Safe Motherhood programme entails. There have been national consultants recruited to initiate the Safe Motherhood programme in 3 of the 4 focal provinces and these have had varying degrees of success. Key findings from the 4 focal provinces will now be described.

1. Logar Province- Key findings

The establishment of the Safe Motherhood programme in this province dates back to the beginning of 1998. The SMI component was one aspect of the MOU (memorandum of understanding) drafted on the PHC implementation in Logar province. MoPH was meant to play the lead role in ensuring that coordination took place and that PHC activities were actually implemented. Various NGO's were present- AMI, SCA and ARCS/IFRC- all of which are still functioning in Logar province at this time.

In considering the overall strategy of the SMI programme and the establishment of facilities that can provide emergency obstetric care (EOC), it was expected that at least 3-4 health facilities be upgraded to providing EOC at the basic level and one facility be upgraded to provide comprehensive EOC.

In reality, at this point in time, there is one facility- Baraki Rajan hospital, supported by the NGO -AMI that is providing comprehensive EOC services. One clinic- in the capital of the province, Puli-Alam, supported in a financial manner directly by UNICEF (MoPH had refused for NGO involvement), is providing services at the basic EOC level. Nevertheless, Puli-Alam generally faces a shortage of drugs and therefore cannot always manage the emergencies as it is meant to and Baraki Rajan hospital although can perform direct blood transfusion, does not have a blood bank and therefore blood may not be available in emergency situations.

In other districts of this province, there are female staffs in some of the other clinics however they are not well qualified/trained to provide EOC services. In the more remote and isolated districts, there are no female medical staff present whatsoever and therefore no EOC services provided.

In reality, much work still needs to be done for the Safe Motherhood programme to be a reality in this province. The specific achievements as related to Logar province will be listed below whilst the constraints, which are similar for all the 4 provinces will be grouped together and listed at the end of this section. A brief outline of the support given by the consultant in the implementation of the SMI program in Logar province will conclude this section.

Achievements to date/ current situation:

Achievements to date	Current situation
1. Puli-Alam – rehabilitation of 2 buildings; provision of basic equipment to support these two buildings	1. 1 building- functioning as OPD with basic laboratory and training room; 2nd building is the MCH clinic within which Basic EOC care is provided; recruitment of female medical staff and provision of incentive by UNICEF to the staff whose activities are related to providing PHC services. No water source at the clinic.
2. Establishment of MCH & OPD services in Kharwar district using a local building (mud)	2. One midwife present who can provide some assistance if complications arise in pregnancy or labour, but needs upgrading of skills to provide the range of basic EOC services; also will require drugs/equipment and better facilities/infrastructure to manage cases
3. Baraki Rajan hospital functional as a comprehensive EOC	3. Supported by AMI, female staff present continuing to function as comprehensive

	EOC
4. Establishment of Provincial Health Management Team (PHMT) with attendance from NGO's, monthly coordination meetings held at Puli-Alam	4. Though meetings are held, no real decision making power amongst members. Forum for sharing information/ reports etc
5. HIS in place to a certain level	5. Monthly reports submitted to Puli-Alam on a regular basis by most districts (some hard to reach areas- Kharwar and Azro)
6. Referral system in place for seeking further medical services	6. Issues of cost/transport need to be addressed as even though a referral place may be designated, it needs to be accessible and affordable
7. Monitoring and supervision of clinics by PHMT	7. Vehicle provided by UNICEF to assist in the supervision and monitoring of the clinics
8. Training of 33 TBA's by MoPH; 35 TBA's trained by other NGO's –SCA	8. No clear linkages between the TBA and the clinic- no reporting, no provision of renewable supplies, no ongoing refresher courses
9. Training of 11 female staff from Logar at Malalai hospital for 3 months as basic CHW	9. Only 2 of the female staff have been recruited at the clinics; others are waiting for opportunities of work

Implementation of SMI programme in Logar Province:

Unlike any of the other focal provinces that UNICEF has chosen for implementing the SMI programme, Logar province has two health facilities - Puli-Alam and Kharwar clinic that UNICEF is directly supporting in terms of incentives. Both of these facilities are managed directly by MoPH. The Minister of Health in a meeting earlier this year with UNICEF representative refused to allow an NGO to manage the health facility in Puli-Alam, the provincial capital. UNICEF agreed to provide incentives to the staff at this clinic and additionally also began to directly support Kharwar clinic - which is in a remote and isolated part of Logar province.

In an effort to reach an understanding that this support on the issue of incentive is not limitless and that MoPH must take more responsibility in the management capacity, a memorandum of understanding (MOU) has been drafted. This MOU draft was developed in consultation with UNICEF sub-office personnel and has been one of the consultants' contributions to the operationalization of the SMI programme. It is expected that UNICEF sub-office staff will share the MOU with key MoPH personnel for their comments, input and commitment and as well UNICEF representative will be requested for his remarks and feedback on this draft. Once the key parties are satisfied with the content and layout of the MOU, a meeting with the MoPH will be held and signing of the MOU will take place.

Other main contributions from the consultant to the implementation of the SMI programme for Logar province have been:

- Revision of the project plan of action (PPA) for the remaining months in 2000;
- Outline of a 'calendar of events' that delineate what key points need to be addressed between July 2000 and the end of the year and by whom and
- Recommendations for specific improvements to clinics in Logar province- renovation/ rehabilitation aspects, establishing water sources etc.

2. Laghman Province- Key findings

The Safe Motherhood programme was initiated in Laghman province in early 1998. This programme was also supposed to be part of UNICEF's approach to strengthening PHC services and in accordance with this strategy, an MOU was prepared in an effort to make the responsibilities of each partner clear. In reality however, most of the activities within the MOU have not been implemented and the various reasons for this will be listed in the section entitled constraints.

In considering the population of this district and the overall strategy of the SMI programme of establishing facilities that can provide EOC services, it was expected that at least one hospital be able to provide comprehensive EOC services and 4 clinics provide basic EOC services. In actual fact, there is currently one hospital (run by AMI) in Mehterlam city that provides comprehensive EOC services, and one clinic- Islamabad clinic (run by SCA) that provides Basic EOC services.

Although it can be noted that a lot of effort had been made to begin the implementation of the SMI in this province, for instance, establishment of four delivery rooms in Basic Health centres and provision of equipment for EOC services; orientation of all service providers and policy makers to the concept of SMI; establishment of village health committees; development of SMI messages etc, there seems to have been not the systems in place to support these interventions on a long-term basis. For example, even though 4 delivery rooms where established, the female staff in these clinics did not have the training to provide EOC services.

Therefore, the piecemeal approach that has often been indicative of implementation of other programmes seems to also be reflective of the implementation of the SMI programme by UNICEF as well.

One issue that is a large impediment to the provision of EOC services in all provinces is the lack of willingness of female medical staff to move from the urban areas to work in the rural areas- especially as some of these districts are very remote and isolated. This issue is faced country wide and only when the conditions of work and salary are very attractive, are female staff willing to move their families to these outlying areas.

One NGO, Health Net International, has developed an innovative method of providing health services in Nangarhar province, neighbouring province to Laghman. This method groups several adjacent districts together and forms a 'cluster'. A rural hospital provides the comprehensive services for the 'cluster' area, with each district having either a basic health centre and/or sub-health centre. Strong links are in place between the district level and the community via TBA's and village health volunteers and the district level in turn has links with 'cluster' level, which in return has links with the regional level. Female medical staffs have been recruited for many of these clinics by guaranteeing a job for their mehram, provision of housing and reasonably good salary.

There has been a lot of effort by HNI on strengthening the management component on their programme as evidence by the number of staff that they have in place for monitoring and supervising their programmes. This is one example that may be replicated in other regions and the concepts within this model may be applicable even to smaller scale to Laghman province.

The following is a summary of achievements and current situation for Laghman province.

Achievements to date/ current situation:

Achievements to date	Current situation
1. Upgrading of Mehterlam hospital to comprehensive EOC- by establishment of blood bank	1. Mehterlam hospital functioning in provision of various services including c-section operation but no blood in blood bank- have to find donor at time of transfusion, no stock in blood bank
2. Current training of 4 asst nurses and 2 asst midwives by Expatriate midwife of AMI at Mehterlam Hospital- (theoretical and practical)	2. Ongoing training of staff but no formal curriculum used for training which makes it difficult to replicate the course content
3. Establishment of one Basic EOC at Islamabad clinic, Alishing district by SCA	3. Adequate female staff at clinic, knowledgeable and able to perform skills required for Basic EOC; clinic is located away from the community on top of a hill (only land donated by community for the clinic)
4. MOU prepared on SMI/PHC in Laghman and signed by some of the stakeholders	4. In truth, MOU is not being put into practice or achieved and the roles and responsibilities are not realistically allocated or distributed
5. HIS system in place	5. Monthly reports submitted to Mehterlam Hospital by most clinics (usually at monthly coordination meetings)
6. Orientation of Mullahs on SMI/ involvement in social mobilization for blood donation	6. No blood stored in blood bank- needs ongoing motivation which is not being provided or campaigned for and no blood bags available at present (pt has to purchase from bazaar)
7. MCH/SMI coordination meeting held with Regional MCH staff	7. Meetings are irregular and often not attended by all parties concerned
8. Provincial Health Management Team- meetings held monthly, involvement of NGO's and MoPH	8. PHMT- No decision making power. Usually referred to regional level and then issues are often forgotten about at next meeting and therefore change does not happen.

3. Farah Province- Key findings

The safe motherhood initiative is a programme initiated by UNICEF in Farah province in late 1998 and the programme was officially launched in March 1999 in the presence of representatives from MoPH, WHO, UNICEF, CHA, MDM and MERLIN. All stakeholders signed an MOU on the implementation of SMI in this province and at that time, several NGO's were actively working in the province. An OBS/GYN ward was strengthened in Farah hospital and a provincial health management team (PHMT) was formed with membership from all stakeholders to coordinate, review and plan for health activities.

Presently however, no concrete aspect of the SMI programme is evident in this province. Farah hospital is not providing adequate health services- as a basic hospital let alone in the provision of comprehensive EOC services. Although one might be required to admit that surgical procedures- c-sections are performed at this hospital, the conditions under which these are performed and the quality of care received afterwards are substandard. Therefore, there are still neither a comprehensive EOC nor any Basic EOC services in this province

At the time of conducting this assessment, there was no external support of either the hospital or most of the clinics from any NGO. MDM and MERLIN had withdrawn their support from this province in late 1999. CHA, an Afghan NGO was supporting health clinics in 2 districts in the province. MoPh was managing the hospital with their limited resources and knowledge, whilst the majority of the clinics were being run on semi-private basis- health professionals used the clinic structure to provide health services and payments made for consultation and drugs were used as payment for services rendered.

Achievements to date/current situation:

Achievements to date	Current situation
1. PHC/SMI project officially launched on March 1st 1999 in the presence of representatives from all stakeholders	1. No evidence of SMI programme in the Province in terms of establishment of EOC services
2. Establishment of Provincial Health Management Team (PHMT)	2. PHMT not functioning/no meetings held Poor concept of management and lack of responsibility by MoPH for health services
3. 8 midwives trained by MDM- 3 year midwifery course - completed in 1999	3. Plan was that midwives will relocate to rural areas and work at basic health centres but with the exception of 2 midwives, the rest are in Farah hospital
4. 12 females trained by UNOPS as basic health workers - completed in 1999	4. Plan to have female health workers in district areas, but since no NGO/MoPH financial incentive to move to districts, most health workers remain in Farah city
5. All the districts have good physical structures for clinics- infrastructure is in place and also there is provision for water supply at each clinic- hand pump in the clinic compound	5. Infrastructure remains in place, though maintenance/upkeep of it is now lacking. Some of the wells are dry due to drought situation.
6. Bakwa clinic newly built with support from UNOPS	6. No female staff present- no MCH services provided in this district
7. Renovations to Herat Maternity Hospital as the regional referral centre	7. Herat Maternity Hospital continues to provide referral services for the region;

Accomplishments since assessment conducted:

As a result of this assessment, one of the main recommendations was to invite CHA, the Afghan NGO to expand their programmes and to incorporate managing Farah hospital as well as other clinics at the district level for implementation of the safe motherhood programme. After many meetings by staff at ACO level and the consultant as well as UNICEF sub-office staff with CHA, CHA agreed to this idea and have presented UNICEF with a proposal for funding. Both ACO staff as well as the consultant have spent much time on the discussions regarding this proposal and have tried to hasten the process so that the program may begin later this year.

4. Balkh Province- Key findings

The political instability in the north of the country from 1997 to 1999 resulted in the lack of implementation of the SMI programme. In early 2000, UNICEF resumed full operation in the north. At this time, based on a review of circumstances, the sub-office decided to change the focal province from Jwazjan to Balkh. This information was shared amongst the stakeholders and with UNICEF Islamabad office.

Up to this point in time, the focus of the SMI programme has been directed to planning for rehabilitative works on Mazar hospital. A visit by the UNICEF regional director paved the path for this rehabilitation and support for the hospital. Lists of the achievements to date are listed in the table below.

It is important to note that MoPh is managing the hospital in Mazar-I-Sharif, the regional and provincial capital. Although comprehensive EOC services are being offered at this point in time, the quality of care and the circumstances within which these services are being provided leaves a lot to be desired. There is an abundance of female staff- especially female doctors at this facility and most of them are present from 830am till 11am after which there is a skeletal staffing. Most of the staff have their private clinics that they attend to in the afternoons.

Achievements to date/current situation:

Achievements to date	Current situation
1. Discussions held with MoPH/WHO- change of focus province & clarification of issues on SMI programme- roles and responsibilities	1. UNICEF is to take the lead role in implementing SMI in this province (work with MoPH- support them in terms of technical advice, supplies, equipment, materials but not incentive)
2. Obtained funding for Mazar hospital rehabilitation plans- special funding after regional director's visit; plans prepared by engineer for rehabilitation works and construction of OPD and training facility	2. Though plans had been prepared by engineer, recommendation by consultant is not to place the operation theatre within the ward- this alters most of the plans already prepared and requires another engineer to make a field visit and plan
3. Equipment list sent to country office in ISL to procure items for Mazar hospital	3. List needs to be reviewed together with staff in country office and Mazar sub-office staff

Accomplishments since assessment conducted:

One of the contributions that the consultant has made with regards to Balkh province is related to the renovation/rehabilitation of Mazar hospital. The consultant recommended that the proposed operation theatre within Mazar hospital not be situated within the current women and children's ward as planned due to the lack of space and overcrowding in this ward. It was recommended that an operating room should have adequate facilities in a sterile environment and should be well planned.

An alternative suggestion was that the operation theatre be situated in the new proposed building that was to be an OPD and training room. New plans would be required and the consultant assisted UNICEF ACO staff in making arrangements for this aspect- discussion

with civil engineers in Afghanistan and in Islamabad. It is envisioned these works will also start before the end of the year- at least on the renovation of building.
The following section will now briefly describe some of the major constraints that have been noted to hinder the progress of the Safe Motherhood programme in Afghanistan.

E. Main Constraints- for all focal provinces

1. Weak overall management of MoPH - in terms of planning, supervision, monitoring & evaluating programmes. Responsibilities designated or defined in MOU for all agencies (MoPh, UN and NGO's) but no one to take responsibility/accountable for these actions;
2. Few number of qualified female staff within the country and of those existing staff- many not willing to work in rural areas unless the remuneration is very high. In addition, staff who are working in the rural areas are not well trained to deliver quality services required of them due to lack of training/upgrading of skills;
3. Various levels of restrictions exist for women, both consumers and service providers. I.e. access for females to reach the health facility- requires permission of her family to access health services and she needs an escort-mehram to travel there; service providers- female doctors are also segregated and do not have the opportunities to learn and share information in an open manner with their male colleagues- cannot attend meetings with men, do not share in aspects the decision-making. Female supervisors and managers also face great difficulty in monitoring programmes, as their movement is very restricted and must involve being accompanied by their mehram;
4. Lack of female vaccinators in the clinics (treating EPI as a vertical program and not an integrated approach so that when female staff are present but hold another position, i.e. nurse/midwife, they do not give vaccines) inefficient usage of female staff;
5. No standardized training material on EOC- no curriculum exists for training on case management of EOC or on upgrading knowledge or skills of staff providing EOC;
6. No advocacy or communication package available for creating awareness on key SMI messages i.e. danger signs etc;
7. Lack of resources in many clinics- drugs, supplies, materials etc;
8. Poor linkages between facilities at district level and provincial level- in terms of referral system as well as links with personal in community- TBA's and health workers;
9. Lack of NGO presence in some areas- Due to the inability of MoPH at this point in time to effectively manage and support health clinics and hospitals independently, NGO presence is vital to the provision of health care;
10. Poor planning of clinic locations in several districts – difficult to access by community, especially women if experiencing a complication in pregnancy (community often designates land that is far from village as this land is not being cultivated);
11. Lack of national HIS (health information system) that incorporates the recording of data required for measuring the process indicators for monitoring progress in SMI programme
12. Poor road conditions – some hard to reach areas, inaccessible in the winter season;
13. Lack of political will on the side of authorities to implement the safe motherhood programme- no resources from the authorities towards this initiative. Verbal commitment given but no actions to substantiate the commitment and
14. Lack of fervour on the side of UNICEF Afghanistan office and sub-office to focus on the implementation of safe motherhood and to see this programme as a package- not just the provision of supplies, equipment, drugs and rehabilitation of buildings but on the technical aspect, provision of training materials for upgrading the skills of staff to provide EOC services etc.

The above list of constraints exemplifies some of the difficulties and challenges that NGO's and UN agencies face in the day-to-day work in Afghanistan. Nevertheless, some of these issues can be addressed and the next section will list some of the recommendations specifically for UNICEF country office for operationalizing the safe motherhood programme.

F. Recommendations

The following lists of detailed recommendations are for UNICEF country office as an effort to strengthen the overall safe motherhood programme; specific recommendations for each province are given in individual provincial reports.

1. Develop national training materials on case management of emergency obstetric care- competency based approach specific for the level of EOC services provided.

   For example, staff providing basic EOC services need to be capable and skilled to perform assisted deliveries, i.e. manual vacuums extraction. This skill needs to be taught not just on a theoretical level, but more importantly on a practical level so that the staff member is confident and competent to perform the procedure when she is on her own.

   The development of this training material may involve the following steps:
   - Collecting materials that have already been developed with regards to case management of EOC (from WHO, NGO's etc)
   - Reviewing and sorting through the above materials to see the relevancy for application to the situation in Afghanistan
   - Inviting a group of individuals representing MoPH, NGO's and other UN agencies to come together, brainstorm on the content of this training material and then come up with a skeleton version of the training material (the terms of reference for this team as well as the learning objectives also need to be developed)
   - Developing the guidelines for case management - an algorithm approach
   - Translating the materials to local language
   - Field testing the material
   - Identifying specialists that may be required for training of certain skills- i.e. manual vacuum extraction
   - Conducting a training for trainers
   - Conducting the training within the different regions by the trainers

2. Develop effective communication strategies in order to disseminate key messages on SMI related issues that will result in a behavior change- allow/support women to access medical care when they need it.

   One of the first steps may be to identify the group that may be targeted for these messages. Although messages must be aimed at both men and women, in Afghanistan the messages should be tailored for each group separately. The approval and active participation of the local leaders is crucial to the success of bringing about a change in the society. It is also imperative that messages be field tested by persons who have been working with the population so as to validate their content. The use of metaphor and analogy is very effective in the Afghan context as is the utilization of quotations from the Quran.[6]

   Some of the actual messages that need to be developed, in a well thought out manner, are those that sensitize women and men to the danger signs in pregnancy. Both the pregnant women as well as her family members need to know and be able to recognize how quickly they must act if they are to escape the serious repercussions that some of these complications can lead to. Therefore, the content of the messages as well as the method

[6] Social communications and Afghans: continuity and change. Pamela Hunte, Consultant anthropologist, 1992.

of delivery, communication strategy, are both crucial aspects to consider and must be addressed in developing this strategy.

3. Increase awareness amongst authorities, health professionals and the community of the relationship between the nutrition of girls and women, various micronutrient deficiencies and maternal and neonatal health and survival.[7]

   An action plan might include UNICEF supporting the distribution of vitamin A, multi-vitamin and mineral supplementation in conjunction with iron/folate supplements for pregnant women in Afghanistan, while at the same time supporting the training of health staff or community mobilizers in promoting affordable, locally available calcium-rich and vitamin A rich foods.

   UNICEF needs to consider the following areas and develop guidelines/policies and possible further assessment on:

   - *Anemia*- prevalence, cause- due to parasite or nutritional, percentage of women reached with supplementation, compliance of women in taking supplements etc;
   - *Iodine deficiency*- what is the percentage of salt iodized at the consumer level? May be difficult to assess this issue, therefore promote the iodization of salt as lack of iodine is known to increase the risk of stillbirths and spontaneous abortions and in severe cases, may contribute to maternal mortality;
   - *Vitamin A*- if the upcoming survey on vitamin A deficiency in Afghanistan illustrates vitamin A deficiency, then supplementation with Vitamin A should be advocated for and
   - *Breastfeeding*- promotion of exclusive breastfeeding right from birth to 6 months needs to be promoted in a culturally sensitive manner, targeting both men and women. There is a longstanding tradition of not giving colostrum to the newborn that will need to be tackled in a perceptive manner.

4. Develop a strategy for the elimination of maternal and neonatal tetanus (MNT).

   Afghanistan is one of the countries where the routine immunization coverage is below 50% and more than 50% of the districts are considered 'high risk or in a state of civil unrest'.[8] This fact, along with the low percentage of births attended by skilled birth attendants, poor access to routine health services, remote geographical areas, and lack of vaccinator at the clinic on a daily basis (a lot of missed opportunities for vaccinating women with TTV - tetanus toxoid vaccine due to the current scheduling of vaccinators in most of Afghanistan- 2 days in the clinic, 4 days mobile clinic in the community), appears to justify the need to prepare plans to eliminate MNT and implement the 'high-risk approach' discussed in the document entitled 'maternal and neonatal tetanus elimination by 2005'.

5. Review the current HIS (health information system) developed for Afghanistan and currently being piloted in Logar and Laghman province to assess if information related to process indicators is being collected.

   The team that is proposed for developing the training material for each level of EOC may agree on a set of process indicators appropriate to measure in Afghanistan and then

[7] Programming for Safe Motherhood. Guidelines for maternal and neonatal survival. UNICEF. 1999
[8] Maternal and neonatal tetanus elimination by 2005. Strategy paper: A high-risk approach.

review the current HIS system in light of this and make recommendations accordingly to UNICEF.

6. With regards to the management structure currently at the ACO level, two main aspects that may positively affect the SMI programme implementation are:
   - An improvement in the flow of information/communication within various levels of the country office.

     This must be a two-way process and should encourage information sharing. One example might be a more open and collaborative interaction between the Survival section and Supplies section regarding the status of items requested/ordered by sub-office staff. This aspect needs to be followed up by the project officer or the assistant project officer and if there are delays in the procurement or sending of these items to the field, then the reasons must be communicated from the supplies section to the survival section and subsequently to the staff at the sub-office level. It appears that frustration and even delay may be avoided among staff if the communication channels could be enhanced and a more supportive environment could be fostered.

   - Strengthening the human resources capacity within the Women's health program.

     At the sub-office level, this aspect is being strengthened by the recent presence of United Nation Volunteers at three of the four sub-offices that has an SMI focal province. Since the UNV's are linked to the Survival section, one of their main responsibilities will be to support the implementation of the SMI programme. Their roles and responsibilities in relation to the SMI programme needs to be clear and unambiguous so that their input can be maximized.

     At the country office, there also needs to be more support within the Women's health program. It is imperative that encouragement, guidance and backing for staff at the field level be available. Maintaining the close collaboration that has been developed with some of the key NGO's working in Afghanistan is also of essence. ACO needs to provide both technical and managerial supervision within Afghanistan while at the same time maintaining dialogue with authorities, MoPH, NGO's and other UN agencies.

7. Prepare a comprehensive list of equipment, supplies, materials as well as specific drugs required to equip a health facility in the provision of comprehensive, basic or first aid EOC.

8. Develop a strategy on cost recovery in conjunction with other stakeholders- MoPH, other UN agencies and NGO's. Consider the current practices within Afghanistan and outline a strategy that can be implemented (a phased approach) that may be acceptable to the MoPH and to the communities in Afghanistan.

9. Advocate for the training of women in the health profession- specifically for midwifery schools and medical school for women. Underlying this specific issue is the advocacy for access to education for all girls that UNICEF Afghanistan is currently addressing.

10. Promote policies and programmes that encourage families and communities to support delayed marriage and childbirth.[9]

In Afghanistan, girls are often married at a young age. Due to the physiological and social factors, adolescent women are more vulnerable than older women to pregnancy-related complications. Therefore, in a sensitive and culturally acceptable manner, this message needs to be transmitted to the leaders in the community, to the health professionals and to both the men and women in the community. With time and effort, maybe a change will be noted in the Afghan community.

11. Co-ordinate and share information related to the safe motherhood programme with other UN agencies, MoPH and NGO's.

    By attending the monthly coordination meetings at ACBAAR, this is one forum for sharing information on the progress of the SMI programme and to get continued support from other agencies and UN bodies.

[9] Delay marriage and first birth. Safe motherhood fact sheet. Family care international. New York, NY. 1998

G. Proposed Plan of Action - UNICEF Afghanistan Country Office

Timeline of activities for September- December 2000 (proposed)

Major Activities	Months- 2000			
	Sept	Oct	Nov	Dec
Develop national training materials on the case management of emergency obstetric care (EOC)- competency based approach specific for the level of EOC services provided	****	****	****	****
❑ Collect materials already developed with regards to case management of EOC (from WHO, NGO's etc)	****			
❑ Specify ideal functions and skills to be performed by health staff at EOC levels- First aid, basic, comprehensive	****			
❑ List the terms of reference for the team members who will gather for the development of the EOC training materials (include preparing a comprehensive list of supplies, materials and equipment for each level of EOC)	****			
❑ Make initial contact with these team members (list of names submitted by consultant to UNICEF ACO staff) to confirm their interest and availability	****			
❑ Plan date and venue for this one week meeting - proposed date- 3rd week of October	****	*		
❑ Review the available training materials gathered on EOC to sort through; see what information might be relevant for the Afghanistan context (build on information that is available)		**		
❑ Plan the methods that will be used to conduct the training meeting and finalize logistics of the meeting (venue, transport etc)		**		
❑ Hold training meeting at specified venue		*		
❑ Collate the information from the training meeting; rewrite/design in a manner that will be applicable for master trainers and for trainees (guidelines for clinical practice should also be developed and be in line with medications available on the essential drug list in Afghanistan)		*	***	
❑ Initial draft of the training package should be sent to members of the training team for comments/suggestions			*	
❑ Training package should be finalized and sent for translation into local language				***
❑ Translated version sent for back translation and validation of content				*
❑ Training material- translated version should be available for use (links will be made as to how the training package will be used- master trainers will have been identified and the process of training will be clear by this stage so that training may begin in the year 2001)				*
Review the current HIS (health information system) developed for Afghanistan (currently being piloted). Assess if data is being collected that will allow calculation of process indicators for maternal health.				
❑ Collect the HIS forms currently being used in Afghanistan	****			
❑ Examine all the process indicators for monitoring progress in maternal health care and determine the appropriate ones for use in Afghanistan context (discuss with team members at training session- if time permits)		*		

Timeline of activities for January 2001-December 2002 (proposed)
Brief outline of activities

Major Activities	Quarters Year 2001				Year 2002			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Develop effective communication strategies for disseminating information related to SMI	****	****	****	****				
❑ Conduct qualitative research to ascertain acceptable methods of communication	****							
❑ Develop key SMI messages for dissemination		****	****					
Increase awareness regarding the relationship between the nutrition of girls and women, Plan for supporting supplementation with multi-vitamins, Ferrous sulphate, Vit A where indicated	****	****	****	****	****	****	****	****
❑ Hold sensitization workshops regarding the importance of nutrition on neonatal and maternal survival		**		**		**		**
❑ Conduct qualitative research on the current use and acceptance of iron/folic acid tablets		****						
❑ Conduct qualitative research on breastfeeding practices		****						
❑ Promote exclusive breast-feeding for 6 months			****	****	****	****	****	****
Develop a strategy for the elimination of maternal and neonatal tetanus (MNT).	****	****						
❑ Link with EPI/child health programme in planning a strategy for elimination of MNT	****	****						
❑ Implementation of strategy			****	****	****	****	****	****
Participate to develop a strategy on cost recovery in conjunction with other stakeholders. Implementation of strategy			****	****	****	****	****	****
❑ Examine the current strategy used by NGO's in Afghanistan		****						
❑ Support the adaptation and implementation - cost recovery			****	****	****	****	****	****
Conduct training session - competency based for health workers at different levels of EOC	****	****	****	****	****	****	****	****

H. Appendix