



# NATIONAL REPRODUCTIVE HEALTH STRATEGY

2012-2016

ISLAMIC REPUBLIC OF AFGHANISTAN  
MINISTRY OF PUBLIC HEALTH

PREPARED BY  
Reproductive Health Task Force





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**Printed on**

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Kabul, Afghanistan

## FOREWORD

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The Ministry of Public Health of the Islamic Republic of Afghanistan places reducing maternal and neonatal deaths and improving the quality of reproductive health among its top priorities. Afghan families deserve the highest possible standards of reproductive health. With this Strategy, the Ministry demonstrates its continued commitment to achieving its goal of making quality reproductive health services available to all families in Afghanistan.

Four components of the Strategy are considered to be of the highest priority: Maternal and Neonatal Health, Birth Spacing/Family Planning, breast and cervical cancer and Sexually Transmitted Infections. Several other areas are included with a view to developing a strategic plan and taking initial steps to implement it during the next five years with the understanding that full implementation is a long-range goal. These areas are Infertility and Obstetric Fistula. Numerous issues were also identified that affect more than one component of the Strategy and sometimes all components. These are treated separately in the document. They are Reproductive Health in Emergency Situations, Gender, Nutrition, Mental Health, Information Education Communication/Behaviour Change Communication (IEC/BCC), Quality Assurance, Reproductive Health Research and Reproductive Health and the Private Sector.

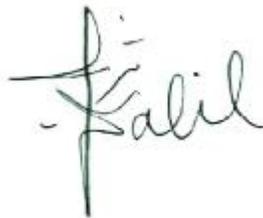
The role of the Reproductive Health Directorate is accurately defined in this National Strategy as one of *stewardship*. The principal activity of the Directorate, therefore, is not primarily one of providing services, but one of motivating, advocating, guiding, linking, standard setting, monitoring and collaborating with its partners. The Ministry considers this to be the most effective, efficient and least costly way for Afghanistan to achieve its reproductive health goals.

This revised policy and Strategy will guide the MoPH in developing an implementation plan and annual work plans to address the reproductive needs of the country. It will also guide the RH Directorate, the Ministry as a whole, related ministries, donors, implementing agencies, the private sector and other partners to identify means of financing and implementing its priority areas.

I would like to thank the Reproductive Health Directorate for the energy it put into the development of this revised Policy and Strategy. Working with the Directorate have also been many vital partners in reproductive health, without whose support and technical expertise this strategy would not have been able to take its final form.

I am confident that the MoPH and its many partners will coordinate their efforts in implementing this Policy and strategy; they will succeed in developing a strong reproductive health partnership from which all Afghan families will benefit.

Sincerely,



Suraya Dalil, ( MD , MPH )  
Minister of Public Health  
Kabul, Afghanistan

## ACKNOWLEDGEMENTS

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The Reproductive Health Strategy 2012–2016 was prepared by the Reproductive Health Task Force in close collaboration with the Reproductive Health Directorate of the Ministry of Public Health. The work was a collaborative effort, with 12 working groups deliberating on a regular basis over a period of more than three months to identify key elements of the Strategy. These working groups covered the areas of Maternal and Neonatal Health, Birth Spacing/Family Planning, Sexually Transmitted Infections, Infertility, Obstetric Fistula, Breast and Cervical Cancer, RH in Emergencies, Gender, Nutrition, Information Education Communication/Behaviour Change Communication, RH Research, and RH and the Private Sector. In addition, workshops were held in January, June and December 2010. The names of the principal contributors to the revised Strategy are listed in Annex 4.

The Reproductive Health Directorate and the Reproductive Health Task Force would like to extend their sincere thanks to H.E. Dr. Nadera Hayat Burhani, previous Deputy Minister for Health Care Services Provision, and Dr. Ahmad Jan Naiem, Policy and Planning Deputy minister, MoPH, for their continued support and guidance throughout the strategy development process.

The Reproductive Health Directorate is grateful for the input provided by participants in the National Consultative Meeting on the revision of the Reproductive Health Strategy held on 20 and 21 October 2010. Their recommendations have been incorporated into the present document. Finally, the Reproductive Health Directorate and the Reproductive Health Task Force express their appreciation for the support provided by the Consultative Group on Health and Nutrition, the Technical Advisory Group and the Executive Board.

Dr. Sadia Fayaq Ayubi  
Reproductive Health Directorate  
Ministry of Public Health

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## LIST OF ABBREVIATIONS/ACRONYMS

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AFSOG	Afghan Society of Obstetricians and Gynaecologists
AIDS	Acquired immune deficiency Syndrome
AMA	Afghan Midwifery Association
ANC	Antenatal care
BCC	Behaviour change communication
BPHS	Basic package of health services
BS	Birth spacing
CBHC	Community-based health care
CEmONC	Comprehensive emergency obstetric and newborn care
CGHN	Consultative Group for Health and Nutrition
CHN	Community health nurse
CHNEP	Community Health Nursing Education Programme
CHS	Community health supervisor
CHW	Community health worker
CME	Community midwifery education
CMW	Community midwife
DMPA	Depot-medroxyprogesterone acetate (injectable contraceptive)
EmONC	Emergency obstetric and newborn care
EPHS	Essential package of hospital services
FHAG	Family health action group
FP	Family planning
GCMU	Grant and Contract Management Unit
HEFD	Health Economics and Finance Directorate
HSCs	Health care services
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health Management Information System
HNS	Health and Nutrition Sector
IEC	Information, education and communication
IHS	Institute of Health Sciences
IPC	Interpersonal communication
IPCC	Interpersonal communication and counselling
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
LRP	Learning resource package
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MNH	Maternal and neonatal health
MoPH	Ministry of Public Health
NGO	Nongovernmental organization
PHCC	Provincial health coordination committee
PHO	Provincial health officer
PNC	Postnatal care
PPFP	Postpartum family planning
PPH	Postpartum haemorrhage
PPHCC	Provincial public health coordination committee
RH	Reproductive health
RHCS	Reproductive Health Commodity Security

RHD	Reproductive Health Directorate
RHO	Reproductive health officer
RHTF	Reproductive Health Task Force
SBA	Skilled birth attendant
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VIA	Visual inspection with acetic acid
WHO	World Health Organization

## BACKGROUND

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Afghanistan has made significant progress in rebuilding its health system, despite years of continuous conflict. The National Reproductive Health Strategy 2006–2009 contributed to improving the health of the people of Afghanistan, especially women and children, through the implementation of the basic package of health services (BPHS) and the essential package of hospital services (EPHS) as the standard, agreed-upon minimum package of health care services to be provided at each level of the health system.

Between 2003 and 2012, the number of graduated midwives in Afghanistan increased from 467 to 3,001, according to the Afghan Midwifery Education and Accreditation Board report. In addition, there has been a gradual increase in the number of births attended by skilled birth attendants (SBAs). In 2006 the Afghanistan household survey showed that 19% of births were attended by SBAs, while the National Risk and Vulnerability Assessment 2007/2008 showed that 24% of women delivered with a skilled birth attendant. More recently, the Ministry of Public Health (MoPH) Partnership Contracts for Health 2010 Household Survey showed that about one-third (34%) of deliveries were attended by an SBA.

According to the Reproductive Age Mortality Survey (RAMOS), in 2003 Afghanistan had one of the highest maternal mortality ratios in the world, estimated at 1,600/100,000 live births (Bartlett 2005). The Afghanistan Mortality Survey (AMS) 2010 estimated that the ratio had fallen to 327 per 100,000 live births. The differences appear to be consistent with the level of skilled assistance during delivery, skilled birth attendance, and delivery in a health facility, all of which have increased rapidly in Afghanistan in recent years. Based on 1999–2002 data collected from four sites, Bartlett et al. (2005) estimated the lifetime risk of maternal death at between one in six and one in nine. According to the 2010 AMS, approximately one in every 50 Afghan women dies of pregnancy-related causes.

Use of family planning also has increased remarkably in the last seven years in Afghanistan. According to the AMS 2010, the total fertility rate is 5.1 per 1,000 and more than one-fifth of married women use some method of family planning (22%), with the vast majority (20%) using a modern method.

The 2010 National EmONC Assessment showed that none of Afghanistan's health facilities has yet achieved the national goal of one skilled attendant for every 100 expected births. In district and regional hospitals, the ratio of midwives to 100 expected births was 0, and health facilities, regional hospitals, and specialized hospitals all had small ratios of 0.1 midwives per 100 expected births. The adjusted under-five mortality rate for Afghanistan is 97 deaths per 1,000 births and the infant mortality rate is 77 deaths per 1,000 births.

### ***Guiding Principles***

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

## Core Values

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

## Operational Principles

- **Quality of Care:** All interventions for reproductive health should be made available with the highest standard of quality and safety, and services should be delivered according to evidence-based best practices. Addressing providers' needs and community views, particularly those of women, on the quality of service provision is key to ensuring improved quality and increased access and utilization.
- **Continuum of Care:** All women have a right to the best possible care before and during pregnancy, childbirth and the postpartum period at all levels of the health system, as appropriate for each woman's or newborn's needs. These levels range from the household to the first service level, and to the higher-level service site. Primary care should be strongly connected to a referral system in order to effectively manage life-threatening complications. This continuum of care encompasses the life-cycle of the woman, from adolescence to the birth of her own child.
- **An Integrated Approach:** Comprehensive services are made available to all, especially to women and newborns, integrating maternal and newborn care, birth spacing and family planning, nutrition, immunization, child survival, prevention and treatment care of malaria, sexually transmitted and HIV infections, and other aspects of primary health care. Because of the close links between the different aspects of reproductive health, interventions in one area are likely to have a positive impact on the others. Existing services will be strengthened and used as entry points for new interventions, looking for maximum synergy.
- **Ownership, Partnership and Responsibilities:** Goals, objectives and strategies are commonly agreed upon and pursued by the government and their partners, and supported by the international community through coordinated actions and activities determined by national plans. The BPHS and EPHS are two key examples.
- **Good Governance, Peace and Security:** These elements are vital components of a sustained effort to improve the health of all people, including the health and survival of mothers and their newborns, and are especially relevant to the country.
- **Sustainability through Technical and Financial Capacity Building:** Financial and technical self-reliance is a target for the government and partners working collectively, with ongoing development of infrastructure.

- **Policies and Strategies Based on Evidence and Best Practices:** The choice of policies, strategies and practices is informed by research findings, surveillance, monitoring and evaluation, need assessments, economic analysis, and the sharing of lessons learned and other available evidence-based norms and standards.

### ***Achievements and Successes***

Health needs in Afghanistan continue to be enormous as the country seeks stability, attempts to develop its infrastructure, accelerates the education of its people and raises their standard of living all at the same time. Nevertheless, after less than a decade of effort, significant improvements have been made in the health status of the population and the strengthening of its health system. For example:

- The BPHS was introduced in 2003; by 2009, 75% of the population was covered by the package's services, as cited by the Health and Nutrition Sector Strategy (HNSS) 2007/08–2012/13.
- Use of a modern birth spacing/family planning method among married women increased from 10% (MICS 2003) to 20% between 2003 and 2010 (AMS 2010).
- Receipt of antenatal care by pregnant women increased by 60% and assistance at delivery by skilled birth attendants increased by more than one-third, according to the AMS 2010.
- Infant mortality declined in the last three years, exceeding the midpoint target set for the achievement of the Millennium Development Goals (MDGs).

### ***Problems and Constraints***

Despite these and other advances, Afghanistan is still far from its goal of making quality reproductive health care available to all the people of the country and thereby improving their health and nutritional status. Use of health services for antenatal, delivery, postpartum and newborn care and for family planning is still far below the average of other countries in Asia.

The Reproductive Health Directorate (RHD) identifies a number of challenges and constraints that must be addressed if continued progress is to be made, including:

- The shortage of qualified female health workers in rural areas;
- Low community awareness of RH services due to the dispersed population, geographical barriers, and a lack of transportation infrastructure;
- Insecurity, which makes program implementation difficult due to challenges with the recruitment and retention of staff, expansion of service coverage, and RH monitoring supervision by the provincial and central RH officer;
- Lack of mechanisms for effective regulation of for-profit, private-sector clinics and governmental health services that mainly focus on RH;
- Lack of a reporting system for RH mortality and morbidity;
- Lack of a national birth, marriage and death registration system;
- Lack of a national system for tracking budget expenditures (public and external) on health, including resources specific to reproductive and maternal and newborn/child health; and
- Low levels of quality and utilization of RH services.

## Government Policy Statements

### Policy, Vision, Mission and Goal Statements of the National Reproductive Health Strategy

#### Policy

The Ministry of Public Health (MoPH) is committed to/should work effectively and efficiently to reduce high levels of maternal and neonatal morbidity and mortality by serving as steward of Reproductive Health services: motivating, mobilizing, setting standards, monitoring progress, coordinating and collaborating with partners in RH services.

#### Vision

Healthier families in Afghanistan where all individuals would have access to comprehensive reproductive health information and quality services throughout their lifecycle

#### Mission

To improve the reproductive health status of families in Afghanistan by ensuring the provision of quality reproductive health care services and the promotion of reproductive health in an equitable and sustainable manner.

#### Goal

The goal of the reproductive health strategy is to improve the reproductive health status of families in Afghanistan through the provision of integrated reproductive health services in partnership with communities, development partners and the private sector.

The following other government policy and strategy statements related to reproductive health (RH) are in place:

#### **Afghanistan National Development Strategy, 2008–2013**

The National Development Strategy emphasizes:

- Leadership at all levels in policy formulation and translating policies into concrete actions to ensure that actions are geared toward attaining the specified goals;
- Conducting monitoring and evaluation of the implementation of health care services in order to ensure quality, equity and efficiency of the health system;
- Coordinating the contributions of all national and international agencies involved in the health and nutrition sector, upholding standards and mapping services to avoid duplication and gaps;
- Decentralization of appropriate responsibility and managerial autonomy to the provincial level;
- Increasing the active participation of communities in the management of their local health care services through developing strong, active participatory links with *shura* (community committees) and training and supporting community health workers; and
- Developing legislation and regulations to facilitate growth and assure quality in the private sector provision or civil service provision of health care services.

#### **Health and Nutrition Sector Strategy, 1387-1391 (2007/08–2012/13)**

The Health and Nutrition Sector (HNS) is committed to ensuring that development partners deliver the different components of reproductive health as an integrated package. In maternal health, the HNS is committed to increasing the access for mothers and women of childbearing age to quality

reproductive health care services, including antenatal care (ANC), intra-partum care, routine and emergency obstetric care, postpartum care, counselling and modern family planning services, through skilled birth attendants working with community and other health care workers (HCWs).

### **Targets to Be Achieved:**

The national reproductive health indicators baseline and targets have been revised and set based on RAMOS 2002, MICS 2003, AHS 2006, NRVA 2008, AMS 2010, HMIS and M&E reports with close coordination of relevant MoPH department and development partners.

List of Reproductive Health Program Indicators in Health and Nutrition Sector Strategy

No.	Indicators	Definitions	Baseline	Targets
<b>Process Indicators</b>				
1	<b>Number of health facilities providing basic EOC<sup>1</sup></b>	Number of facilities with functioning basic essential obstetric care per 500,000 population	830 <sup>1</sup>	1,000
2	<b>Number of health facilities providing comprehensive EOC<sup>1</sup></b>	Number of facilities with functioning comprehensive essential obstetric care per 500,000 population	81 <sup>1</sup>	110
<b>Output Indicators</b>				
3	<b>Percentage of health facilities with a skilled birth attendant<sup>1</sup></b>	Percentage of health facilities with at least one skilled birth attendant	68 <sup>1</sup>	80%
4	<b>Percentage of health facilities with at least three modern FP methods<sup>1</sup></b>	Availability of at least three modern FP methods in the health facilities	81% <sup>1</sup>	100%
5	<b>Couple Year Protection<sup>1</sup></b>	Protections provided by family planning services during a one-year period	23.2 <sup>1</sup>	40%
6	<b>Percentage of deliveries at health facilities<sup>1</sup></b>	Percentage of deliveries occurring in the health facilities in a specific time	32.4% <sup>2</sup>	45%
<b>Outcome Indicators</b>				
7	<b>Coverage of deliveries attended by SBA<sup>2</sup></b>	Proportion of births attended by skilled health personnel	34% <sup>2</sup>	50%
8	<b>Access to RH</b>	Total of population within one hour's walking	57.4% <sup>3</sup>	75%

<sup>1</sup> Health Management Information System (HMIS)

<sup>2</sup> Afghanistan Mortality Survey (AMS)

No.	Indicators	Definitions	Baseline	Targets
	services <sup>4</sup>	distance from a BPHS health facility		

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<sup>3</sup> National Risk and Vulnerability Assessment (NRVA), 2007–2008

No.	Indicators	Definitions	Baseline	Targets
9	Percentage of caesarean sections out of all births <sup>3</sup>	Caesarean section deliveries as percentage of all deliveries	5% <sup>2</sup>	10%
10	Percentage of women receiving four ANC visits <sup>3</sup>	Proportion of women attended, four times during their pregnancy, by skilled health personnel for reasons relating to pregnancy	16.1% <sup>2</sup>	30%
11	Percentage of pregnant women receiving TT2+ <sup>1,3,4</sup>	Coverage of tetanus toxoid (two doses) among pregnant women	50.2% <sup>2</sup>	80%
12	Modern contraceptive prevalence rate <sup>3</sup>	Proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time	20% <sup>2</sup>	40%
<b>Impact Indicators</b>				
13	Maternal Mortality Ratio <sup>2</sup>	Number of maternal deaths per 100,000 live births	327 <sup>2</sup>	295
14	Total Fertility Rate <sup>3</sup>	Number of births a woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to age 49	5 <sup>3</sup>	4.5

## Strategic Goals

### National Reproductive Health Strategy Goal

The goal of the reproductive health strategy is to improve the reproductive health status of families in Afghanistan through the provision of integrated reproductive health services in partnership with communities, development partners and the private sector.

### Health and Nutrition Sector Goal

The goal of the HNS is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and underserved areas of the country (from HNS Strategy).

### HNS Goal for the Reproductive Health Programme

The Health and Nutrition Sector Strategy mandates the Reproductive Health Directorate to establish and define a framework for the implementation of the national RH and Maternal and Child Health (MCH) programme and to set forth clear guidance for programme implementation, in order to improve health and reduce mortality and morbidity and to achieve universal access to RH by 2016.

<sup>4</sup> Expansion Programme on Immunization (EPI)

### ***Strategic Objectives (Based on RH Segment of HNS Goals)***

- Increasing the coverage and quality of services to prevent and treat RH problems;
- Improving access to and utilization of quality emergency and routine RH and newborn care services at community, outpatient and hospital levels;
- Strengthening organizational development and management at central and provincial levels to ensure the effective and cost-efficient delivery of quality RH services;
- Further developing the capacity of health personnel to manage and better deliver quality RH services; and
- Facilitating evidence-based decision-making through coordination of relevant and useful research.

# STRATEGIC COMPONENTS

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## ***Component 1: Maternal and Neonatal Health***

In its primary role as steward of reproductive health services, the RHD will improve the quality and coverage of maternal and neonatal health (MNH) care, primarily through advocacy, collaboration with other MoPH units and other stakeholders, and overseeing implementation of partners' projects. Principal strategic approaches include:

### **Strategic Approach 1.1: Increase women's access to and utilization of antenatal care, skilled care, emergency obstetric and neonatal care (EmONC) and postpartum care**

#### **1.1.1. Strengthen community-based health care delivery using community health workers**

Many Afghan women never leave their community, from the pre-conception period through the postpartum period. Because of this, beginning in 2011, the MoPH and implementing partners will place a major emphasis on strengthening community-based MNH services using community health workers (CHWs) in conjunction with family health action groups (FHAGs). Specifically:

- CHW job descriptions will be revised based on RH service requirements.
- Quality will be included as an integral part of CHW activities, in consultation with the Improving Quality in Health Care (IQHC) and Community-Based Health Care (CBHC) units.
- In-service and refresher training of reproductive health issues will be integrated, strengthened, and coordinated with CBHC in the following areas:
  - Promoting healthy behaviours
  - Providing preventive care
  - Identifying problems and danger signs
  - Facilitating and encouraging timely referrals
  - Encouraging appropriate early care-seeking
  - Referring to health facilities for other MNH services
  - Strengthening linkages between CHWs and other community-based health participants such as community health supervisors (CHSs), health shuras, and community midwives (CMWs)

As a result of the expansion of their role, CHWs, working with FHAGs, CHSs, health shuras, and CMWs, will be able to map pregnancies; provide health messages; provide vitamin A, iron folate, and anti-malarials; prepare and make available home delivery kits; ensure cleanliness and enhance mother education for proper birth planning; educate mothers on clean delivery principles; make postpartum visits to mothers and newborns according to schedule; promote early and exclusive breastfeeding; and refer patients to the health facility as needed. While CHWs are not SBAs and do not conduct deliveries, they can be present at deliveries to ensure cleanliness, keep the baby warm, promote early and exclusive breast feeding, and so on.

**1.1.2. Strengthen community-based health care delivery with community midwives**

In addition to expanding the role of CHWs, the RHD will deploy CMWs to improve RH care at the community level. The RHD will advocate among its partners and implementing nongovernmental organizations (NGOs) to deploy CMWs nationwide. CMWs will provide facility-based MNH services in their communities in addition to conducting home visits. CMW community services include ANC, delivery care, postnatal care (PNC) for mother and baby, nutrition education, breastfeeding promotion, vaccinations, support and monitoring of community health shuras, and psychosocial support. Much of this work will be done through home visits. Linkages will be strengthened between CMWs and other community-based practitioners (e.g., CHWs, CHSs, health shuras and FHAGs). This will include an increase in frequency of outreach field/home visits, participation in community-based meetings, and ensuring the quality of data collected by CHWs, with a special focus on RH services. In addition, quality will be included as an integral part of CMWs' job description. Training and building the SBA cadre, along with equitable distribution and deployment of trained SBAs, will enhance access to and utilization of skilled care at birth.

**1.1.3. Increase number of skilled birth attendants**

- Advocacy with partners, mainly the MoPH and Ministry of Higher Education (MoHE), will be maintained to train and deploy more skilled birth attendants, with a focus on female doctors, nurses and midwives.
- Support to midwifery education will be sustained until the required number of midwives is reached. By 2016, it is estimated that an additional 3,650 CMWs will have been trained, if sufficient funding can be mobilized. The RHD will collaborate with the Nursing and Midwifery Directorate of the MoPH to advocate for sustained donor support for midwifery school funding.

As a member of the National Midwifery and Nursing Education Accreditation Board (NMNEAB), the RHD will work to align the number of community midwifery education (CME) schools per province and the number of students per CME school with national standards. Due attention will be paid to keeping student enrolment at each school within the limits of the case loads of the clinical teaching facilities.

**1.1.4. Improve distribution and deployment of SBAs**

Unpublished data suggest that there is an obvious imbalance in the distribution of skilled birth attendants throughout the country. According to the programme evaluation of the pre-service midwifery education programme, the deployment/employment rate for both hospital-based and community-based midwifery programmes is 85% (Institute of Health Sciences, 81%; CME, 91%). To address this issue, the RHD, in coordination with Ministry of Public Health/Human Resource Directorate, the Institute of Health Sciences, the MoHE, and Kabul Medical University, will work on the development of a personnel policy for SBA cadre management, career pathways, recruitment, training, and deployment according to geographical and national needs, as well as appropriate remuneration to attract and motivate doctors, midwives and nurses to work in rural and underserved areas.

**1.1.5. Promote the creation of family health action groups**

In addition to providing a liaison between the community and health services, FHAGs have been shown to contribute positively to the community aspects of MNH. The existing FHAGs are already providing a valuable contribution in the areas of information, education and communication/behaviour change communication (IEC/BCC), advocacy and interpersonal

communication (IPC). Their scope will be further expanded to enable them to participate in postnatal visiting and reporting in conjunction with CHWs, under the supervision of the CMW.

**1.1.6. Increase involvement of religious leaders (Khotba)**

Religious leaders have enormous influence on their people. Many religious leaders already have a significant impact on MNH in their communities through the messages they preach and through interpersonal contact. To extend their influence, a curriculum has been developed to train them to support RH services in their communities. The RHD will now collaborate with the Grant and Contract Management Unit (GCMU) of the MoPH to fund NGOs to train religious leaders across the country. A strategic plan to this effect will be developed through the collaboration between the RHD, the GCMU and the Islam and Science Department of the MoPH.

**1.1.7. Expand IEC/BCC activities in MNH (see 6.5 below)**

**1.1.8. Promote the implementation of a community health nursing education programme**

To address the country's need for community health nurses, a community health nursing education programme (CHNEP) has been introduced in the health systems of the MoPH. The community health nurse (CHN) works at various levels of the health system assisting in the achieving the country's health indicators. In RH, they can provide IEC/BCC, ANC, PNC, family planning (FP) and management of sexually transmitted infections (STIs). The RHD will collaborate with Nursing Education to promote CHN implementation.

**Strategic Approach 1.2: Improve the quality of MNH services, including EmONC**

**1.2.1. Strengthen provision of basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC) services within existing health facilities**

Huge improvements in the provision of health services have been made; yet most health facilities, especially the more peripheral ones, require special attention to improve the provision of EmONC services. In this regard, the RHD will address the following needs:

- Coordinate the review of facilities providing basic services with implementing partners. Those facilities lacking essential equipment will be prioritized for upgrading. In many cases the physical infrastructure will require renovation, and donor support will be sought for this. Where staff is inadequate, RH will advocate with responsible agencies for staff recruitment.
- Use findings from EmONC needs assessment to identify knowledge and skill gaps among MNH staff. Coordination with implementing partners will be needed to provide supportive supervision and fill gaps by means of the coordination of in-service education programmes for practicing doctors, house job students in clinical rotations, new graduates, and nurses/midwives.
- Advocate for a sustainable incentive system that will ensure that skilled health care providers are available for EmONC 24 hours a day at all facilities. The incentive system will include performance-based incentives, particularly in rural areas, and may not necessarily include financial incentives.
- Advocate with implementing partners to strengthen and increase the number of facilities that are functioning on a 24-hour basis and limit the number of facilities that are not capable of functioning 24 hours a day. Facilities that cannot ensure 24-hour coverage may still remain open if they are providing quality services in other areas.
- Ensure availability and administration of magnesium sulphate (MgSO<sub>4</sub>) at all facility levels. Since treatment of eclampsia and pre-eclampsia is essential to reducing

maternal mortality, MgSO<sub>4</sub> must always be available in BPHS and EPHS facilities. To ensure that supplies of MgSO<sub>4</sub> and other essential drugs are maintained, the RHD will coordinate with the Health Economics and Finance Directorate (HEFD) for BPHS and EPHS and with the Curative Medicine Department for health centres and hospitals. Administration and use of calcium supplementation during antenatal visits should be considered for prevention of pre-eclampsia and eclampsia.

- Advocate for funding for implementing partners to train facility staff and community members in setting up and maintaining “walking blood banks.” Because lack of blood banks in health facilities restricts the provision of CEmONC, walking blood banks can be used in their place. Donors will be identified within the facility's catchment area. The donors' blood type will be determined, and they will be screened for hepatitis and HIV. Their contact details will be registered, and a contact mechanism will be established to call them in for a donation when the need arises. Management of the walking blood banks will be in the hands of the community where the CEmONC facility is located.
- Ensure that all skilled providers at basic and comprehensive EmONC facilities are adequately trained in providing these services through the coordination of in-service programmes with implementing partners Reproductive Health and the Human Resource Directorates.
- Coordinate with implementing partners for the development or revision of diagnostic and management protocols for EmONC as needed to ensure a ready reference source for EmONC problems.
- Support ob/gyn doctors who are working in community health centres plus district and provincial hospitals to perform caesarean sections.
- Offer ANC services, including iron, folic acid, and calcium supplementation; treatment of worm infestation; detection of danger signs and complications during pregnancy (e.g., anaemia, hypertensive disorders, malpresentation); height, weight and blood pressure measurement; urine and blood examinations; administration of tetanus toxoid; and provision of information on maternal nutrition, birth planning and delivery preparedness.

The RHD will also explore the possibility of pilot-testing or introducing other priority actions to improve the provision of services within BPHS and EPHS facilities. Some of the items that may be explored in collaboration with partners include:

- Training health workers in interpersonal communication and counselling (IPCC) skills, focusing on client-centred MNH services;
- Advocating for the deployment of medical graduates and ob/gyn residents and the recruitment of a quota of female students in the university;
- Coordination among the RHD and Human Resource Directorate for development of an HR development plan to fill RH gaps;
- Providing services for mild to moderate anaemia, pregnancy complications, bleeding, infection, complicated abortion, urinary tract infections, postabortion care and family planning;
- Providing support for women with special needs (e.g., adolescents, women living with violence and women with STIs);

- Improving supportive clinical supervision based on approved standards and checklists;
- Strengthening in-service training;
- Practicing service delivery according to standard technical treatment guidelines, including ANC, PNC, newborn care and delivery care;
- Establishing a Maternal & Newborn Death Review Committee at each facility level to help track delivery cases that are not followed and performed well;
- Training health providers in principles of medical ethics;
- Assessing patient/client flow through facilities to ensure efficient, prompt service while maintaining patient privacy;
- Developing job aids for providers to help decision-making in problem areas such as treatment of eclampsia;
- Developing a simple system for maintaining the cold chain for oxytocics;
- Establishing a system of maternal death notification at health facilities (maternal death review committees; near-miss and adverse event reporting systems) as well as at the community level, with maternal death reviews instituted in facilities;
- Collaborating with the appropriate sectors to advocate for the establishment of a system of continuous professional development and regular clinical practice recertification every three to four years for ob/gyns and midwives, based on recertifying examinations;
- Strengthening the referral system between communities and facilities as well as among facilities;
- Making field visits and outreach activities an obligatory part of peripheral health centres that provide ANC and PNC services;
- Advocating for the assignment of medical graduates to rural areas for a fixed period of time after training to provide MNH services;
- Advocating for training and deployment of family physicians to deliver MNH services for a fixed period of time after their training;
- Advocating for a policy on sending graduates of ob/gyn residency programmes to rural areas to practice for a fixed period of time;
- Advocating through the MoHE to recruit a quota of female medical university students based on province requirement; and
- Accelerating the implementation of a Human Resource Development Plan related to the Safe Motherhood Initiative to fill HR gaps (gynaecologists and midwives) in collaboration with the Human Resource Directorate.

### **1.2.2. Improve supportive clinical supervision**

Standardized quality assurance (QA) tools, standards and checklists already exist for many areas of RH supervision. These tools will be reviewed and further adapted to accommodate new developments in RH focus areas. This review will pave the road for smooth implementation of updated standards and tools at health facilities and at the community level. In coordination with the IQHC Unit, the RHD will adopt evidence-based methodologies

to improve the quality of health services by building the capacity of provincial RH staff and health care providers at all facility levels and providing on-site clinical supervision.

### **1.2.3. Strengthen in-service training**

A list of national trainers and the RH component(s) for which they are qualified will be prepared. When a sufficient number of qualified trainers have been developed for each RH component, all training will be carried out by qualified trainers, regardless of whether the MoPH or an NGO partner sponsors the training. This approach will help institutionalize training as a profession and improve the quality of training. Certification of trainers will be for one year, during which the newly qualified trainer will be evaluated as part of post-training follow-up activities. If the trainer is training adequately, certification will be extended. For more detail, see the RH in-service training strategies.

An accreditation system for national and regional training centres for competency-based training in fields such as EmONC, family planning, basic newborn care and advanced newborn care will be developed, and each site and trainer will be accredited each year. This mechanism is designed to maintain the quality of the training site and will help to identify each training site's needs. As a means of ensuring quality basic and comprehensive obstetric and neonatal care, these training centres will train newly graduated doctors who are to be employed in provincial health services in EmONC, FP, and basic and advanced newborn care, until these skills are included in the undergraduate medical curriculum.

Furthermore, resources will be mobilized for building the capacity of RH staff in management and RH leadership.

### **1.2.4. Improve the delivery of newborn care services**

The RHD will steward several initiatives to strengthen the quality and scope of newborn care services. These include:

- In collaboration with implementing partners, ensuring that health care service providers in the community and in facilities from health posts to district hospitals are trained and become competent in basic newborn care, including neonatal resuscitation;
- Collaborating with medical schools and those departments responsible for secondary and tertiary health care delivery to introduce competency-based training in advanced newborn care;
- Collaborating with IEC/BCC to launch an early and exclusive breastfeeding campaign;
- Promoting the concept of kangaroo care for prevention of hypothermia in neonates;
- Advocating with partners for the inclusion of Laerdal neonatal training kits in both EmONC and newborn care training for the management of newborn asphyxia; and
- Working and coordinating with national and international implementing partners, the Child and Adolescent Health Directorate and donors to ensure that required resources for essential newborn care are available at all sites at all times.

### **Strategic Approach 1.3: Improve monitoring and evaluation of MNH services and use of data**

Monitoring data is inconsistently collected at the provincial and district levels, frequently insufficiently analyzed, and often not fed back to the units that provided the data or to the RHD. In addition, multiple agencies collect data but do not consistently pool their data. A system of coordination will strengthen the RHD's capacity to track key indicators in MNH reporting. It will also strengthen feedback mechanisms in order to ensure that relevant information is given to provincial reproductive health officers (RHOs) and implementing NGOs to improve MNH service provision.

Maternal death reviews are useful in identifying ways to reduce maternal mortality. The RHD will work with its partners, particularly NGO implementers, to institutionalize maternal death review committees as widely as possible.

In addition, to make the monitoring and evaluation (M&E) process more useful for decision-making, the RHD will support the Afghanistan Maternal Mortality Survey and the interpretation and dissemination of its results. Based on the results of the survey, maternal health policy and strategy may be revised.

### **Strategic Approach 1.4: Other Initiatives**

#### **1.4.1. Pilot-test and evaluate new approaches to MNH services**

New approaches to MNH are developed regularly. Innovative projects need to be pilot-tested with a research protocol and evaluated. Those demonstrated to be successful will be integrated into national policy and strategy. With coordination provided by MoPH-related departments and partners, the RHD will develop a mechanism to systematically review the results of pilot projects and incorporate successful projects into the general provision of MNH services. Pilot projects to be considered or scaled up during the 2012-2016 period include:

- Primary prevention of eclampsia and pre-eclampsia through calcium supplementation, and secondary prevention through urea protein testing;
- Strengthening MNH services at the community level by improving the referral system between communities and health facilities, using FHAGs and CHWs (see 1.1.1 and 1.1.5 above);
- Scaling up the use of misoprostol for the prevention of postpartum haemorrhage (PPH) to include the entire country;
- Sharing the results of the pilot test of maternity waiting homes with stakeholders and advocating for the incorporation of this concept into the governmental health system, expanding to an increasing number of provinces;
- Implementing the Helping Babies Breathe initiative to decrease neonatal deaths from asphyxia;
- Reviewing the pilot test of Family Health Houses and scaling up as appropriate; and
- Studying the feasibility of implementing midwife-led maternal delivery centres.

#### **1.4.2. Advocacy for implementation of the new schedule of postnatal follow-up visits**

Based on new evidence, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have revised their recommendations for the timing of postnatal follow-up visits. They now recommend visits at days 0, 3, 7 and 28. Since this new schedule has been demonstrated to decrease maternal and neonatal morbidity, the RHD will

collaborate at the policy and planning level to adopt this new schedule and coordinate the implementation at the service delivery level.

**Monitoring indicators:**

- Maternal mortality ratio (annual number of maternal deaths per 100,000 live births)
- Percentage of births attended by skilled health personnel (excluding trained or untrained traditional birth attendants)
- Antenatal care coverage (percentage of women who attended ANC provided by a skilled attendant at least four times during pregnancy)
- Crude birth rate (births per 1,000 population)
- Neonatal mortality rate (deaths up to 28 days per 1,000 live births)
- Perinatal mortality rate (perinatal deaths per 1,000 total births)
- Low birth weight prevalence (percentage of live newborns weighing less than 2,500 grams)
- Percentage of institutional deliveries
- Caesarean section deliveries as a percentage of all deliveries
- Prevalence of anaemia in pregnant women (percentage of screened women with haemoglobin levels below 110 g/L)
- Percentage of pregnant women receiving two doses of tetanus toxoid
- Obstetric and gynaecological admissions owing to abortion (percentage of admissions owing to abortion among all ob/gyn admissions)
- Percentage of women knowing at least three risk factors for/danger signs of pregnancy-related complications
- Percentage of government expenditures directed toward RH (out of total government health expenditures)
- Number of facilities with functional comprehensive essential obstetric care per 500,000 population
- Number of facilities with functional basic essential obstetric care per 500,000 population
- Number of skilled birth attendants per 1,000 population (excluding trained or untrained traditional birth attendants)
- Percentage of midwives who received competency-based reproductive health in-service training in a given year
- Mandatory notification of maternal deaths (i.e., exists as a national policy or does not exist as national policy)

**Component 2: Birth Spacing/Family Planning (BS/FP)**

Increasing coverage of BS/FP throughout the population, especially in rural areas and among poor and nomadic populations, remains one of the RHD's highest priorities, as is encouraging young women to delay their first pregnancy. As stewards of family planning in Afghanistan, the RHD will act primarily to coordinate, advocate and mobilize donor resources in collaboration with its partners.

## **Strategic Approach 2.1: Strengthen the capacity to provide a full range of FP methods**

### **2.1.1. Strengthen BS/FP training**

Training of health workers from all cadres and at all levels of the health system remains a key priority for strengthening family planning services. This requires a comprehensive approach to training. Specifically, during the 2012–2016 period the RHD will undertake to:

- Coordinate the revision of the national BS/FP learning resource package (LRP) to align it with international standards (Global Handbook, the Medical Eligibility Criteria book) and the expanded contraceptive mix indicated in this strategy;
- Advocate for the post-training follow-up system to be used as the national standard with implementing partners and MoPH;
- Set up an RHD national training program database;
- Expand and strengthen the BS/FP clinical learning system (coordinate with implementing partners to ensure that existing national trainers are certified and receive regular knowledge updates based on the current contraceptive method mix and revised LRP);
- Collaborate with BS/FP key stakeholders for the inclusion of BS/FP in the pre-service curricula of physicians, CHNs and other nurses (working with the directorates that develop and revise pre-service curricula of these providers to introduce or expand training in FP into those curricula); and
- Coordinate with implementing partners the provision of BS/FP counselling training for all RH providers.

## **Strategic Approach 2.2: Improve provision of BS/FP services at all levels**

### **2.2.1. Expansion of BS/FP services at health facility level**

In Afghanistan relatively few BS/FP methods are in common use. The RHD will continue to expand utilization of these methods, but will also work to increase the range of effective FP methods for which there is demand or for which demand can be generated. As partners demonstrate the demand for and effectiveness of additional contraceptives, these will be included in the system. The RHD will collaborate with the Afghan Society of Obstetricians and Gynaecologists (AFSOG) and the Afghan Midwives Association (AMA) as well as its traditional partners in this regard.

Methods will be categorized into “modern” and “traditional”.

The modern method also categorized into universal and selective. Categories, and where necessary, methods will be included in the essential drug list. Specific

approaches to be introduced include the following:

- Postabortion contraception as part of postabortion care. Partners will be identified to develop an LRP and train postabortion care (PAC) workers in postabortion contraception.
- Expanding provision of postpartum intrauterine devices (IUDs). The 2010 midwifery curriculum update includes training in postpartum insertion of IUDs. For already graduated midwives, in-service training will be provided at the national and regional FP training centres. Trainers will be updated in knowledge and skills in this area and an appropriate model for this training will be sought. The RHD will collaborate with its partners in this regard and will issue guidelines and authorization to enable trained midwives to insert IUDs during interval and postpartum care.
- Initiation of any other BS/FP evidence-based services

- Strengthening integration of postpartum and postabortion family planning with ANC and PNC as part of CMW and CHW RH counselling
- In collaboration with implementing partners, facilitating a pilot study on the use of contraceptive implants, and introducing contraceptive implants as a new contraceptive method if the results of the study are positive
- Including emergency contraceptive pills (ECPs), already approved by the RH Directorate, in the BPHS through collaboration with the BPHS Department. The Directorate also will continue negotiations to have ECPs included in the essential drug list.

### 2.2.2. Strengthen reproductive health BS/FP commodity security

The system of reproductive health commodity security (RHCS) has not been used universally by all partners in BS/FP service delivery; and where it is used, it is used inconsistently.

Strategic approaches to remedy this situation include:

- Advocating to donors for the allocation of more resources for RH commodities and for the inclusion of a budget line for commodities within national budgets;
- Developing a detailed and comprehensive national RHCS action plan in collaboration with the FP partners (which will ensure that the RHD plays a coordinating role and links the actions of all of the partners to the strategy);
- Strengthening coordination among government and other stakeholders through the establishment of a coordinating body made up of representatives of all the BS/FP stakeholders; and
- Coordinating the establishment of a working logistics management system for RH commodities logistics, distribution and warehousing.

## Strategic Approach 2.3: Expand Approaches for Community-Based BS/FP

### 2.3.1. Strengthen linkages between health facilities and the community

FHAGs, CHWs and CHSs already have a role in linking communities to health facilities in the area of BS/FP as much as in MNH. Increasing the number of provinces with FHAGs as well as the number of FHAGs will strengthen the connections between communities and health facilities. Formal linkages between communities, represented by FHAGs, and health services also will be sought.

### 2.3.2. Improve counselling of family health action group on postpartum family planning

### 2.3.3. Expand community-based postpartum family planning using CHWs

Providing family planning services during the first year postpartum to prevent unintended pregnancies and promote longer birth intervals is an essential intervention to improve maternal and child health. By agreement of the MoPH, the Postpartum Family Planning (PPFP) Project has been implemented successfully in 13 provinces and expanded in 34 provinces. The system of supportive supervision monitoring and reporting will be strengthened through the joint coordination of the M&E and CBHC departments to ensure its sustainability. The following elements will be included:

- Strengthen the referral system for PPFP and follow-up of the referees
- Improve the use of existing IEC materials during counselling sessions
- Strengthen the reporting system

**2.3.4. Community-based distribution of BS/FP methods**

Besides the distribution of condoms and contraceptive pills at the community level, injectable contraceptives (i.e., DMPA) can also be delivered in communities, with CHWs providing the first dose. This approach has already proven effective in a pilot program and has been expanded at the national level, with the following results:

- Improved follow-up of CHWs
- Improved supervision, monitoring and on-the-job training
- Improved regular supply system by BPHS-implementing NGOs

**2.3.5. Strengthen referral and follow-up of the clients**

The referral mechanism and feedback approach will be strengthened through close coordination and collaboration with related partners.

**2.3.6. Ensure quality of community health worker activities at the community level**

Because greater emphasis is to be placed on the community level, and particularly on the services of the CHW at that level, the RHD, in coordination with the CBHC department and NGO implementers, will work to follow up and assess the quality of CHW activities at the community level using a QA tool. Where deficiencies in quality are detected, the RHD will work with the implementer NGOs to improve them using in-service education programmes and strengthening supportive supervision.

**Strategic Approach 2.4: Increase information, education and communication (IEC) and behaviour change communication (BCC) for wider use of BS/FP**

**2.4.1. Revise existing IEC/BCC BS/FP materials and develop new ones as needed**

During the 2012–2016 period, all of the IEC/BCC materials for BS/FP will be reviewed. Existing birth spacing and family planning IEC materials should be standardized with regard to the IEC/BCC approved strategy. Materials that are outdated, incorrect or inadequate will be revised in coordination with the health promotion department. New materials that are needed will be developed. The RHD will work with the media to ensure that all TV and radio spots and messages concerning RH meet the approval of the Directorate to avoid transmitting incorrect or misleading messages.

**2.4.2. Develop standard IEC material distribution system in coordination with health promotion department**

**2.4.3. Reach community youth and married couples with BS/FP information and services in collaboration with the Child and Adolescent Health Directorate**

**2.4.4. Increase involvement of community and religious leaders in FP and enlist their collaboration**

Linkages will be strengthened with the Ministry of Religious Affairs at the national level. In this context, a unique strategy will be developed for community and religious leaders in family planning. The Directorate will work with partners toward uniformity of approach. In addition, a national guideline and LRP will be developed for enlisting and informing these groups in the FP effort.

**2.4.5. Increase participation of elder women/mothers-in-law**

Elder women in the family exert a strong influence on a couple's decision-making and specifically on the man's. The involvement of these opinion makers can help to promote

family planning in the community. As part of its efforts to increase community participation in FP activities, FHAGs, CHWs and CMWs will be trained to mobilize the elder women of their community.

#### **2.4.6. Improve IPC skills of health workers in all provinces**

Deficient IPC skills resulting in inadequate counselling and lack of respect for client privacy continue to be a barrier to the delivery of FP services at all levels. Training in IPC will be revised and strengthened in collaboration with the RHD's partners, and an increasing number of health workers who deliver FP services in all provinces will be trained.

### **Strategic Approach 2.5: Strengthen monitoring and evaluation of BS/FP activities**

#### **2.5.1. Improve monitoring of BS/ FP service utilization, quality of services and follow-up**

As in the case of MNH, data for monitoring is inconsistently collected at the provincial and district levels, and often it is not analyzed or used appropriately. In collaboration with partners, RHD will strengthen collection and analysis of monitoring data on service utilization and quality.

#### **2.5.2. Establish system whereby M&E data is fed back to users and utilized in decision making**

Working with partners, the RHD will strengthen its capacity to track key indicators in BS/ FP reporting as well as the interpretation and dissemination of results. Feedback mechanisms will be reinforced to ensure that relevant information is given to BS/FP service units and providers in a timely way for use in decision-making.

##### **Monitoring indicators:**

- Percentage of primary health care facilities providing at least three modern family planning methods
- Contraceptive prevalence rate (percentage of women or their partners using a contraceptive method at a particular point in time)
- Unmet need for family planning (proportion of married women 15–49 years who do not want any more children during the next two years but are not using any method of contraception)
- Adolescent birth rate (number of live births per 1,000 population of women 15–19 years)
- Percentage of health service delivery points providing youth-friendly services
- Percentage of health providers trained in youth-friendly service provision

### **Strategic Approach 2.6: Strengthen BS/FP services through the private sector**

#### **2.6.1. Private sector should follow MoPH standard protocols and IEC/BCC materials in BS/FP**

#### **2.6.2. Private sector should report regularly to MoPH at the provincial and central levels**

##### **Monitoring indicators:**

- Percentage of primary health care facilities providing at least three modern birth spacing/family planning methods
- Contraceptive prevalence rate (percentage of women or their partners using a contraceptive method at a particular point in time)

- Unmet need for BP/FP (proportion of married women 15–49 years who do not want any more children during the next two years but are not using any method of contraception)
- Percentage of women referred to health facilities by CHWs
- Adolescent birth rate (number of live births per 1,000 population of women 15–19 years)

### ***Component 3: Sexually Transmitted Infections and HIV/AIDS***

The extent and nature of sexually transmitted infections (STIs) in Afghanistan is largely unknown, because no prevalence studies have been conducted yet. National-level prevention, diagnosis, management and follow-up of STIs have not been the responsibility of any division of the MoPH until now. Because of the close link between RH and STIs, the RHD will initiate an STI intervention strategy. Since STIs and HIV/AIDS are also closely linked, RHD will coordinate with the activities of the HIV/AIDS Control Programme and its partners, the Curative Medicine, Child and Adolescent Health and BPHS Directorates, and the GCMU. Elements of the new STI strategy are listed below.

#### **Strategic Approach 3.1: Improve the quality of STI clinical services**

- 3.1.1. Integrate STI management and HIV screening and primary prevention into BPHS and EPHS services**
- 3.1.2. Monitor progress in STIs using the Health Management Information System (HMIS)**
- 3.1.3. Identify resources for further STI/HIV/AIDS prevalence research**

#### **Strategic Approach 3.2: Build health workers' capacity in STI management**

- 3.2.1 Collaborate with implementing partners to allocate resources for the training of health workers in STI prevention, identification and treatment**
  - Coordinate with implementing partners for the development of an LRP for STIs.
  - Coordinate with implementing partners the implementation of an STI training program for health workers in STI management including the syndromic approach.
  - Include STI management in RH workers job descriptions.

#### **Strategic Approach 3.3: Increase public awareness of STIs**

- 3.3.1. Collaborate with the IEC and HIV/AIDS departments on the development of IEC/BCC materials for STI prevention, including those that promote condom use**
- Monitoring indicators:**

- Percentage of young men and women age 15–24 years (at-risk group) who have correct comprehensive knowledge of STI/HIV prevention
- Percentage of new cases identified through the HMIS

### ***Component 4: Strategic Approaches to Breast and Cervical Cancer***

Only very limited services are available in Afghanistan for the diagnosis and treatment of breast and cervical cancer. No radiotherapy or chemotherapy centres exist in the country. Similarly, expertise in surgical treatment of breast and cervical cancers is only minimally available. The total mortality rate

due to cancer in all ages of women is 8.4%, and 16% of the cancer is in women ages 15–49 (Afghanistan Mortality Survey, 2010). Unfortunately, no specific data exist on breast and cervical cancer; therefore, it should be considered an RHD activity.

To begin to decrease cancer morbidity and mortality, a preliminary strategy will be developed to increase awareness among the general public, especially women, about breast and cervical cancers and to improve primary health care providers' knowledge and skills for screening for new cases at early stages. Improving referral services for suspected cases and strengthening diagnostic and management services are longer-term goals, which could be addressed through private-public partnerships and/or by encouraging the private sector to work with the RHD's traditional partners and the AFSOG and AMA.

## **4.1: Breast Cancer**

### **4.1.1. Build health workers' capacity to detect the early signs of breast cancer**

- In collaboration with implementing partners, improve health care workers' knowledge and skills in breast examination through the provision of an in-service training program.
- In collaboration with the IEC Directorate, develop IEC/BCC resources to increase awareness of breast cancer early detection.
- Raise women's awareness of the importance of early detection and treatment of breast cancer.
- Raise women's awareness of when and how to do breast self-examination.

## **4.2: Cervical Cancer**

A promising approach that can be implemented quickly and inexpensively to identify cervical cancer is the technique of visual inspection with acetic acid (VIA). VIA is a simple, low-cost procedure that consists of swabbing the cervix with vinegar, waiting for one minute, and viewing the cervix with a light source in order to visually detect precancerous lesions. When a cervical lesion has been identified, it can be treated during the same visit using a freezing technique to destroy the lesions (cryotherapy). The following strategic approaches to cervical cancer are to be considered:

### **4.2.1. Build health workers' capacity to identify cervical cancer in early stages**

- In collaboration with the Directorate of Curative Medicine, develop an LRP to provide nurses and midwives the knowledge and skills they need to use the VIA technique for detecting and treating cervical cancer.
- In collaboration with the Midwifery and Nursing Directorates, ensure that the VIA technique is incorporated into the pre-service midwifery curriculum and into nursing curricula.

### **4.2.2. In collaboration with the IEC Directorate, develop IEC/BCC resources to increase awareness of cervical cancer early detection and treatment**

- Raise women's awareness of the importance of early detection and treatment of cervical cancer.
- Raise women's awareness of VIA as a method for cervical cancer early detection.

### 4.3: General Approach to Breast and Cervical Cancer

#### 4.3.1. In collaboration with implementing partners, plan a long-term, sustainable approach to the early detection and treatment of breast and cervical cancers, incorporating:

- Undertaking a prevalence survey for breast and cervical cancers;
- Advocating to the MoPH for the establishment of a cancer registry;
- Collaborating with the Directorate of Curative Service and the private sector to improve diagnostic services;
- Advocating to the Directorate of Curative Services for the development of a training program on chemotherapy and radiotherapy and modern techniques of breast and cervical cancer surgery;
- Advocating to the Directorate of Curative Services for the inclusion of breast and cervical cancer early detection and treatment services in the RH services package; and
- Advocating to the MoPH to establish a radiotherapy treatment centre in Afghanistan.

#### Monitoring indicators:

- Existence of a policy on cervical cancer screening (yes/no)
- Existence of a policy on breast cancer screening (yes/no)
- Percentage of women of reproductive age (15–49 years) screened for cervical cancer during the past five years

## Component 5: Strategic Approaches Related to Other Issues

### 5.1: Obstetric Fistula

A rudimentary obstetric fistula programme has been established in which a limited number of physicians have been trained in repair, and funds have been made available to women for transport and medical expenses to make fistula repair accessible to all, regardless of economic status. This programme will be strengthened and expanded in collaboration with one or more RHD partners. The initial step will be to establish a national obstetric fistula committee made up of representatives of the MoPH, other ministries such as Ministry of Women's Affairs, professional organizations, health professionals experienced in fistula prevention and treatment, and women's and community-based organizations. To guide future policy development, a needs assessment will be conducted to add to findings from the 2010 prevalence study. Studies will attempt to identify gaps in the available information about obstetric fistula, define specific local determinants, and map current preventive and curative service provision. The committee will strengthen the fistula programme using strategic approaches such as the following:

#### 5.1.1. Increase awareness of fistula prevention, side effects and treatment among communities and health care providers

- In collaboration with implementing partners, develop an LRP on fistula prevention, identification and treatment.
- Include data collection on fistulas in the HMIS.

#### 5.1.2. Improve access to fistula treatment

- In collaboration with implementing partners, develop clinical guidelines for the identification and referral of fistula patients.
- In collaboration with implementing partners, develop a training program for doctors on fistula repair.
- Establish reintegration system after treatment at the social level through national obstetric fistula committee.

**Monitoring Indicators:**

- Number of fistula cases identified
- Number of fistula cases treated

## 5.2: Infertility

While basic counselling and treatment for infertility is possible, advanced and highly technical interventions are not feasible at this time. As a first step in developing an infertility programme, simple interventions for management of primary infertility and identification of opportunities for the prevention of secondary infertility can be initiated. The following steps will be taken with multiple partners (including professional societies) to begin to address the problem and lay the groundwork for a more complete programme in the future:

- In collaboration with an NGO partner, undertake a prevalence survey to understand the extent of the problem in Afghanistan;
- Collaborate with the appropriate sectors in the MoPH to develop national clinical guidelines for the diagnosis and management of infertility, and introduce these guidelines at the BPHS and EPHS levels; and
- In collaboration with partners, identify appropriate, acceptable and accessible intervention strategies to reduce the incidence of primary and secondary infertility.

**Monitoring indicator:**

- Prevalence of infertility (percentage of women 15–49 years of age, at risk of pregnancy, who report trying for a pregnancy for two years or more)

## ***Component 6: Cross-Cutting Issues***

### **6.1: RH in Emergency Situations**

During the 2012–2016 period, the RHD will play an advocacy role to ensure the adequate delivery of RH services in emergency conditions. The objective will be to create a plan to guide the implementation of RH programming in humanitarian settings. This will be used to guide RHOs, RH programme managers and health service providers to ensure RH services during emergencies. The strategic approach of the plan will attempt to meet the following conditions:

- Strengthen coordination and collaboration with the Emergency Preparedness and Response Office health cluster, the Afghanistan National Disaster Management Authority and BPHS implementers to ensure timely RH preparedness and response in emergencies by having RH represented on emergency committees at the national and provincial levels.

- Advocate with implementing partners and the Emergency Preparedness and Response Office for the development and distribution of RH emergency kits.
- Increase health providers' capacity for preparedness and response activities in RH services in emergencies.
- Make sure the minimum RH services can be reached by affected RH target groups in emergencies.

## 6.2: Gender Issues

The Gender Department plays a key role in addressing gender equality and equity in the national health policies and guidelines. The main aim of this unit is to focus specifically on priority areas of RH, especially mothers and newborns, and women's and children's rights. Success in achieving these goals will be evaluated, as well as how adequately they have contributed to overall RH rights and to the attainment of MDGs.

The RHD's strategic approaches to supporting the Gender Department include the following:

### 6.2.1. Support an increase in awareness of gender issues and reproductive health rights among health workers

- Officially endorse and support the integration of the gender training program developed by the MoPH into existing RH training programs.
- Support the strengthening of the health services delivery system in relation to gender issues.
- Officially endorse the development of a referral system for cases of gender-based violence in collaboration with the legal enforcement and justice system.
- Officially endorse the improved data collection in disaggregating data by sex, gender-based violence, and early marriage.

### 6.2.2. Enhance women's decision-making role in relation to health-seeking practices

- Advocate for the continued recruitment and deployment of female CHWs, whose presence permits increased access to health services by rural women.
- Advocate for the empowerment of women in decision-making regarding their RH needs.
- Advocate for inclusion of RH topics in school curricula in coordination with Ministry of Education.
- Advocate for the provision of maternity leave and child care for women in the workforce.
- Support the code against sexual harassment in all public and private organizations providing health services.

## 6.3: Nutrition

Prevention and treatment of malnutrition, support of healthy nutritional practices and micronutrient supplementation are the primary responsibility of the Nutrition Department, which has developed a detailed strategy covering many aspects of RH. The RHD will support the Nutrition Department in the following ways:

### 6.3.1. Support and promote breastfeeding

The three primary breastfeeding goals are to put babies to breast immediately after birth (to avoid wasting colostrum), breastfeed exclusively for the first six months (no additional foods or liquids during this time) and continue breastfeeding until two years of age. RHD will support the Nutrition Department by:

- Providing women with one-on-one support at critical points before delivery, immediately after delivery and in the postnatal period;
- Establishing a standard of ensuring seven contacts from the antenatal period until the baby is two months old; and
- Ensuring that providers who attend deliveries in facilities or in the community are trained in breastfeeding support.

#### **6.3.2. Support the promotion of micronutrient supplementation**

- In collaboration with implementing partners, support the availability of required micronutrient supplements to women during and following pregnancy
- Develop and disseminate nutrition education messages regarding micronutrient intake and utilization during and following pregnancy

#### **6.3.3. Support the Nutrition Department in its advocacy role**

- Advocate for laws based on the International Code of Marketing of Breast Milk Substitutes (adopted by the World Health Assembly in 1981) to prevent the commercial promotion of breast milk substitutes, bottles and teats. Legislation must be enforced and monitored.
- Advocate for maternity legislation allowing working women to breastfeed. Legislation should be aimed at compliance with the International Labour Organization's recommendation for 14 weeks of maternity leave, with income replacement of salary and special concessions for breastfeeding.
- Advocate for the establishment of breastfeeding rooms in institutions to ensure that employed mothers can breastfeed their children. The RHD will set an example by providing breastfeeding rooms in the buildings under its control.

### **6.4: Maternal Mental and Reproductive Health**

A national survey conducted in Afghanistan in the first year after the U.S.-led invasion found high levels of symptoms of depression (59.1% of men and 73.4% of women), anxiety (59.3% of men and 83.5% of women) and post-traumatic stress disorder (PTSD) (32.1% of men and 48.3% of women) (Lopez 2004). An in-depth survey conducted in Nangarhar province in 2003 confirmed the high rate of depression and anxiety, in particular among women, who had elevated scores for depression (58.4% of women), anxiety symptoms (78.2% of women), and PTSD symptoms (31.9% of women) (Scholte 2004). A study conducted among widows in Kabul reported depression symptoms in 78.6% of participants (CARE International 2004).

The Mental Health Department of the MoPH assumes overall regulatory, technical and coordination oversight of Afghanistan's mental health and psychosocial support services. The BPHS already includes mental health as one of its priority components. The reproductive health strategy herein aims to prevent and manage the common maternal mental health disorders by integrating cost-effective interventions in pre- and postnatal health and

postabortion care services. This will be achieved in close collaboration with the Mental Health and Gender Departments through the following strategic directions:

- Inclusion of maternal mental health screening and psychosocial support in the pre- and in-service training curricula of health workers (ob/gyns, midwives and CMWs)
- Development of guidelines, standards, protocols and job aids in maternal mental health screening and psychosocial support for service providers in clinical and community-based settings
- Training of health workers (ob/gyns, midwives and CMWs) in provision of maternal mental health screening and psychosocial support, including framework for supportive supervision; and
- Adding maternal mental health on the list of HMIS indicator list and arranging for data collection and reporting.

## 6.5: IEC/BCC

Information, education and communication and behaviour change strategies are elements of each of the strategic components described in this strategy document. Hence IEC/BCC is a cross-cutting issue of extreme importance in RH. Nevertheless, the existing situation falls short of the ideal, and the following serious challenges confront RH authorities who are attempting to improve the situation:

- The health system lacks a standard package of IEC materials on RH.
- Health providers lack interpersonal communication and counselling (IPCC) skills.
- IPCC is a long-term intervention; it needs long-term engagement and follow-up to improve it.
- IEC materials are not properly used.

Strategic approaches that will be implemented in collaboration with the IEC/BCC Department include the following:

### 6.5.1. Strengthening IEC materials production, distribution and use

- Develop a standard package of RH IEC materials. All IEC materials produced for RH will be collated, reviewed, standardized and made available to implementing partners and RH organizations within the private sector.
- List all RH IEC materials to be included on a national M&E checklist.
- Develop a distribution and monitoring mechanism for RH IEC materials in health facilities to track availability, utilization and replacement of RH IEC materials.

## 6.6: Quality Improvement in RH Services

In order to achieve Afghanistan's MDGs, the MoPH has made quality improvement a main priority. Some of the challenges faced in improving the quality of RH services include:

- RHD lacks adequate staff for follow-up;
- Low motivation of health providers to participate in public health activities and in data collection;
- Lack of recognition of health workers who do quality work;
- Resistance to change within the health system;

- Lack of support on the part of health services management;
- Lack of uniformity of quality improvement interventions in different health facilities;
- Integration of a wide range of RH components in HMIS tool and staff trained for data collection and reporting; and
- Poor adherence to reporting system and feedback to service delivery levels.

Critical IQHC initiatives that the RHD will prioritize and work on with its partners or advocate for during the period 2012–2016 include:

- Increasing the number of female staff, particularly at the most peripheral levels of the system;
- Increasing the motivation of health care providers, including an incentive scheme;
- Advocacy within the health system to be prepared for change;
- Advocacy for stronger support from hospital management;
- Greater attention to both client and provider satisfaction;
- Improving the professional conduct of health care providers;
- Promoting a “culture of quality” among health care providers;
- Integrating quality as an essential aspect of the national RH strategy (advocacy for building leadership support as well as inclusion of quality in the provision of RH services and staff job descriptions);
- Improving leadership and managerial skills among heads of health facilities;
- Developing a quality improvement tool and supervision-based unit; and
- Developing RH services performance tools for donors and implementing partners.

### **6.7: RH Research**

The RHD will assess and review the RH component and identify gaps where evidence-based data is needed to guide strategic planning. However, because of resource limitations, research priorities will be based on programme needs, major health challenges, institutional capacities and capabilities, and available resources. An important role for the RHD is to advocate with partners/donors for research funds.

Some general considerations related to RH research include the following:

- Research should look at policy and mechanisms to increase and improve the quality of RH services, such as the mechanism for coordination and integration of RH-related activities and means of improving retention of female health care providers and improving the utilization of services.
- Research should look into sociological aspects of RH, such as identification of unmet need for contraception, high-risk sexual behaviour, and testing of the results of interventions for MNH and FP at the community level.
- The quality and output of research should be improved; the results of research should be regularly disseminated and utilized.
- A database for RH research will be created based on the RH action plan.

## 6.8: RH and the Private Sector

As the private sector becomes more and more significant as a provider of health services, collaboration between the RHD and the private sector becomes increasingly important to ensuring that the quality of private-sector services equals that of the public sector, that coverage of RH services is expanded beyond those services managed by MoPH, and that potential cost savings to the MoPH are realized through patient fees for private-sector patients with the ability to pay.

- The RHD will work with professional organizations and make in-service training materials, QA materials and checklists available to groups of private providers.
- Private-sector health practitioners will be invited to attend in-service programmes sponsored by the MoPH.
- Representatives from the private sector will be invited to participate on the RH taskforce and RH working groups.

# INSTITUTIONAL APPROACH

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## ***Institutional Framework***

As the steward of RH services in the country, the RHD is the lead oversight agency, setting policy and strategy, developing protocols, monitoring the actions of implementing partners and coordinating with other stakeholders. The RHD has primary responsibility for the MNH, BS/FP and STI portions of the RH strategy. In other areas, it coordinates and communicates with various parts of the MoPH, such as the Gender, Nutrition, Curative Medicine, BPHS, HMIS and HEFD, and collaborates with other ministries such as the Ministry of Religious Affairs, Ministry of Culture, and Ministry of Women's Affairs, as well as organizations such as the National Solidarity Programme. Thus, successful implementation will depend on close collaboration between different directorates and departments in the MoPH and the cooperation and support of other ministries and government agencies in various sectors: parliament, finance, public health, education, higher education, agriculture and justice, among others. Success will likewise require partnerships with nongovernmental institutions such as the media, professional organizations, religious leaders, community-based organizations and the private sector.

## ***District and Community Levels***

Increasing the impact of community-level interventions will be a major emphasis during this strategy period. Promoting the creation and ensuring the sustainability of FHAGs, advocating for an increased number of CHWs and ensuring that they are adequately supported and supervised are all elements of the strategy to be implemented at the community level. Close relations and coordination with NGO implementing partners will be key factors in this regard. In addition, promoting the reinforcement of sub, basic and comprehensive health centres and district hospitals and advocating for an increase in staff capable of delivering RH services are also essential to the success of the strategy.

## ***Provincial Level***

RHOs in each province are responsible for the implementation of the strategy at the provincial level and transmitting it to peripheral levels, providing support there as necessary. RHOs have provided significant input into the development of this strategy, and their views as to its implementation have been solicited. RHOs in turn receive support and reinforcement from the national level.

Provincial Public Health Coordination Committees (PPHCCs) have been created within each province to coordinate partners' activities in achieving MoPH priorities at the provincial level. In any given province, multiple partners participate in implementing health programmes. Under the direction of the Provincial Public Health Director (PPHD), the PPHCCs will play a critical role in ensuring effective implementation of RH programmes throughout the province.

## ***National Level***

The success of this strategy starts with strong and consistent leadership from the MoPH. The RHD will not only oversee its own part of the implementation but will advocate, coordinate, collaborate and negotiate with the other partners to accomplish the tasks that are not under its direct responsibility. However, as noted in the 2010 Capacity Assessment Report of the RHD, the Directorate's capacity to effectively plan, coordinate and communicate the national RH programme is severely restricted because of a lack of human and financial resources. The RHD will actively solicit support in this area from both governmental and nongovernmental sources.

Coordinating a programme that has a limited budget of its own and depends on other partners for funding its priorities presents a significant challenge. During this cycle, the RHD will take a more proactive approach with its NGO partners. Rather than planning their own agendas independently of the RHD, agencies with their own resources have been invited to contribute to the development of this strategy. During the coming five years, they will be asked to develop their work plans as a function of this strategy and its priorities, to which they themselves have contributed.

# INVOLVEMENT OF OTHERS

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## ***Partnerships within the MoPH***

The MoPH, as steward of the health sector, sets policies and standards, develops guidelines, and coordinates actions with all MoPH departments as well as with all partners, implementing NGOs, and donor agencies. In line with national policies, the MoPH has established the Consultative Group for Health and Nutrition (CGHN). This group is the key, high-level group within the MoPH to coordinate the actions of the various parts of the Ministry regarding RH.

The MoPH has established task forces, such as the Reproductive Health Task Force (RHTF), to provide focused technical input on specific topics. Their objective is to provide policy and implementation guidelines, intervention strategies, and programme recommendations. Recommendations are then forwarded to the CGHN and the Technical Advisory Group for review before being forwarded to the Executive Board for approval. The RHTF has developed this strategy document.

The strategy calls for the RHD to have partnerships with several units of the MoPH. These include the Nursing and Midwifery Directorate, Nutrition, Expanded Programme of Immunization, HIV/AIDS, Malaria, Research, Human Resources, CBHC, M&E, HEFD, and HMIS. Where partnerships are needed that go beyond RHTF membership, specific working groups will be created.

## ***Other Ministries***

The collaboration of numerous other ministries, including the following, will be needed to ensure the success of this strategy:

- Ministry of Women’s Affairs (MNH, FP, STIs, Gender, etc.)
- Ministry of Education (pre-service training, IEC/BCC in schools)
- Ministry of Higher Education (pre-service training)
- Ministry of Communication and Information Technology (IEC/BCC)

The ministries listed below will play an important, if less prominent, role:

- Ministry of Agriculture, Irrigation and Livestock (nutritional status of women, infants)
- Ministry of Commerce and Industry (breast milk substitutes, food safety)
- Ministry of Justice (breast milk substitutes, maternity leave laws)
- Ministry of Rural Rehabilitation and Development (services in rural areas)
- Ministry of Haj and Awqaf (enlisting support of religious leaders)
- Ministry of Culture and Information (IEC/BCC messages)

## ***Other Partners***

The RHD collaborates with numerous partners apart from governmental agencies to realize the goals of the RH strategy. Some of these are listed below.

## International and Bilateral Agencies

The RHD collaborates closely with several United Nations agencies, such as the United Nations Population Fund (UNFPA), UNICEF, and WHO, and with bilateral aid agencies such as the United States Agency for International Development and the Japan International Cooperation Agency (JICA). The Directorate also collaborates with the World Food Programme and the Food and Agricultural Organization on nutritional issues.

## NGOs

In its role as steward of RH services in Afghanistan, the RHD guides and gives direction to NGOs that implement the RH strategy. Numerous NGO partners operate the BPHS and EPHS throughout the country. Since women's and newborns' health are a major part of BPHS and EPHS services, working with the NGOs that support them is essential to the strategy's success. Recognizing these NGOs as key collaborators, the RHD has invited many of them to participate in the process of strategy development.

## Associations of Health Professionals

Health professional associations, especially AFSOG and the AMA, play an important role in carrying out the RH strategy. Both of these associations have participated in the development of the strategy and will support its implementation. In addition, they will continue to contribute by:

- Assisting in the development of implementation and action plans for the strategy;
- Advocating and collaborating with the private sector and parliament;
- Establishing an RH network at the regional and global levels;
- Educating their members in appropriate professional behaviour;
- Providing in-service training;
- Collaborating in the development of IEC/BCC materials;
- Advising the RHD as to policy, strategies and best practices; and
- Participating in operational research.

## Private Sector

The private sector's role in RH must be entirely in line with all components of this RH strategy (see Strategic Component 6.8). Health services are increasingly being offered by private practitioners. Collaboration with this group will be essential to ensuring that national standards of care are maintained. In addition, the private commercial sector needs to be especially involved in the provision of pharmaceuticals and family planning methods.

## MECHANISMS OF COORDINATION

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Effective coordination mechanisms will be used to ensure implementation of the RH strategy. Coordination will be managed through existing coordination bodies and mechanisms, strengthening them as required.

### ***Steering Committees***

The RHTF is the central point for coordination. This group is made up of staff of the RHD as well as representatives of international and bilateral organizations and NGOs. Its terms of reference will be reviewed and revised as necessary to strengthen its support of strategy implementation. The RHTF also has the capability of forming ad hoc and permanent working groups that deal with a single subject area. These groups will perform coordination activities in their areas. The subject-area working groups (e.g., MNH, FP, STI, etc.) that were formed to provide input into this strategy may be maintained as permanent steering committees as necessary to guide the implementation of the strategy. They are further reinforced by the addition of members from implementing NGOs and the private sector.

Consideration will be given to the revitalization of the Reproductive Health Coordination Committee. Its membership, which would meet monthly, would include all bilateral, international and NGO partners, professional associations, related ministries and the private sector. The national and provincial Maternal and Child Survival Committees will also have a role in monitoring, advocating for and determining the direction for implementation of the strategy. Broad coordination among various sectors of the MoPH will be ensured by the MoPH's Health Coordination Committee, which meets monthly.

Provincial Reproductive Health Coordination Committees will be strengthened to oversee strategy implementation at the provincial level. Provincial Health Officers (PHOs) and provincial level RHOs will receive in-service training to enable them to monitor and support implementation of the strategy in their provinces. The RH Directorate will also continually support RHOs to deepen their knowledge base of RH to assist in implementation.

### ***Intersectoral/Sectoral Liaison***

The success of the RH Strategy depends heavily on the participation of numerous other sectors if health status of women and newborns is to be improved. The Ministries of Women's Affairs, Education, Higher Education and Communication and Information Technology top the list, but others are also involved. Where more than simple advocacy is required with another ministry, a coordinating committee of representatives of the RHD and the involved sector(s) will be set up.

# IMPLEMENTATION

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## ***Action Plans***

This strategy serves as a roadmap to arrive at the RH status that the Ministry of Health wishes to achieve. Once approved, more detailed planning will take place. An overall implementation plan will be developed for the Directorate at national level, which will indicate what actions will take place in what general time frame and which units will be responsible for them. Each unit within the RHD will also develop an annual work plan that will identify in further detail the actions to be undertaken by that particular unit during the course of that year.

Provincial Public Health Offices will develop their provincial implementation plans in consultation with their implementing NGO partners, using the national strategy as a starting point. These plans will be negotiated with the RHD to ensure that they are comprehensive and that they contribute to the achievement of overall goals. Implementing NGO partners will in turn develop their own annual action plans to contribute to the achievement of the provincial plans.

## ***Advocacy and Support***

Advocacy is a significant component of this strategy. Achieving strategic objectives in areas such as STIs, infertility, obstetric fistulae, breast and cervical cancer, RH in emergency situations, gender issues, nutrition, IEC/BCC, quality assurance and RH research will be accomplished primarily through advocacy with the key ministry departments, other ministries, funding agencies, implementing NGOs and other partners, since the RHD does not exercise decision-making control over these areas, nor does it have funds for them. RHD will identify members of its staff to serve as focal points for each of the critical areas over which it does not have direct control. These staff members will be responsible for promoting their area and advocating with the appropriate ministry or agency to achieve desired outcomes. They may also create joint committees or task forces representing all the concerned agencies in order to move the strategy ahead.

## ***Information Dissemination***

Many of the approaches in this strategy require that strategy implementers at all levels of the system develop new skills, and that recipients of services become increasingly aware of their own health needs and the services that are available to respond to them. For this reason, a major activity at the national level will be to collaborate with the IEC Department and other partners to produce effective messages in areas such as STIs, cancer, gender and nutrition. The RHD will also collaborate with its bilateral and international partner agencies to develop LRPs for doctors, midwives, CHWs, CHSs, FHAGs in order to equip them with the knowledge and skills they need to successfully implement the strategy.

## ***Building Capacity***

Building capacity at the community level will be a major focus of this strategy, so that communities will become equipped to meet many of their own reproductive health needs. The RHD will encourage the Provincial Reproductive Health Officers (PRHO) to collaborate with the implementing NGO partners to make sure that this capacity-building occurs. At the same time, the RHD will collaborate in the development of much of the support material that will be needed to strengthen community-level reproductive health services.

Yet another important capacity-building need is that of the RHD itself. The September 2010 RHD Capacity Assessment Report indicated numerous areas that urgently require strengthening in order for the Directorate to fulfill its mission. Two particular areas of concern were:

- The capacity of the Directorate's senior management to effectively plan, coordinate and communicate the national RH programme needs to be strengthened and supported, and
- The need for systematic, operational or human resources support in order for the RHD to function in an effective way as the stewards and technical experts for RH nationally.

The RHD will actively seek the reinforcement that it needs in these areas in several ways. It will endeavour to increase its resources, both from governmental and nongovernmental sources. It will also work on strengthening the skills of its own staff so that they will be better equipped to carry out their responsibilities. In addition, it will encourage its partner agencies to participate in this capacity-building objective.

### ***Resources Required***

As has been the case in the past, funding sources for the RH strategy will be many and varied. The funding for the human resources, infrastructure, equipment, supplies, transport and support needed to achieve the strategy's interventions will be determined. Government's costs will be identified. The resources needed and those available to implement the strategy in different parts of the country will vary, but the RHD will collaborate with PHOs to ensure that reproductive health is adequately represented in provincial health plans and budgets. The MoPH will proactively disseminate the strategy to PPHDs and BPHS/EPHS-implementing NGO partners, and determine the implications for the strategic plan in each province through a series of regional or provincial workshops.

Individual activities of each intervention will be planned and costs and sources of funds for each activity will be determined. In many instances, multiple sources will be tapped for a single intervention.

### ***Human Resources and Development***

The emphasis on training of community midwives will continue, and in general, graduates will be deployed in or near their home area. Working with relevant ministries, the RHD will explore ways to improve CHWs' and facility-based health workers' counselling skills and skills in working with community groups. As CHW roles in the community become more extensive, the RHD will also seek partners to train CHSs in the content of the CHWs' community-based interventions as well as in methods of supportive supervision.

National and provincial trainers have already been trained in the knowledge, skills and standards contained in the national adaptations of the WHO manuals *Managing Complications in Pregnancy and Childbirth* and *Managing Newborn Problems*. The RHD will now work with the Ministry of Higher Education to incorporate these skills and standards into the pre-service training of university-level health care providers, particularly general physicians, ob/gyns and paediatricians, as appropriate.

# MONITORING AND EVALUATION

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## ***Policy***

A key element of M&E policy will be to demonstrate the use of evidence-based practices where they exist and to advocate for them where they are not being used. Effective M&E will be conducted both by regular monitoring and by periodic surveys. The results of these surveys will be used for progress reviews. This approach to M&E already exists, but it has not operated effectively to date. The RHD will revise and strengthen the system to provide useful feedback to all levels of the health system with an eye to improving its performance.

## ***Internal MoPH Processes***

In order to ensure that data will be used for better planning and decision-making, the RHD will collaborate closely with HMIS and M&E departments to ensure adequate monitoring and evaluation of the RH strategy. The specific mechanisms for data collection, use and documentation will be detailed in the implementation plan.

Population-based surveys that are undertaken during this period will include RH impact and outcome indicators wherever possible. Monitoring data will include RH output and process indicators. The data from these sources will be fed back to relevant levels, from health posts to the national level, to be used in quality assurance and planning activities. In this regard, support will be provided to the various levels to be able to use these sources of data effectively.

## ***Monitoring Indicators***

For all the activities listed in the implementation plan, indicators of impact, outcome, output and process will be used to enable the RHD to measure progress. Selected indicators include the following 31 reproductive health indicators approved by the MoPH to monitor reproductive health:

- Maternal mortality ratio (annual number of maternal deaths per 100,000 live births)
- Percentage of births attended by skilled health personnel (excluding trained or untrained traditional birth attendants)
- Antenatal care coverage (percentage of women attended at least four times during pregnancy by a skilled attendant)
- Contraceptive prevalence rate (percentage of women or their partners using a contraceptive method at a particular point in time)
- Unmet need for family planning (proportion of married women 15–49 years who do not want any more children during the next two years but who are not using any method of contraception)
- Adolescent birth rate (number of live births per 1,000 population of women 15–19 years)
- Crude birth rate (births per 1,000 population)
- Neonatal mortality rate (deaths up to 28 days per 1,000 live births)
- Perinatal mortality rate (perinatal deaths per 1,000 total births)
- Low birth weight prevalence (percentage of live births of newborns weighing less than 2,500 grams)

- Percentage of institutional deliveries
- Caesarean section deliveries as a percentage of all deliveries
- Prevalence of anaemia in pregnant women (percentage of screened women with haemoglobin levels below 110 g/L)
- Total fertility rate (total number of children a woman would have by the end of her reproductive period if she experienced currently prevailing age-specific fertility rates)
- Percentage of pregnant women receiving two doses of tetanus toxoid
- Obstetric and gynaecological admissions owing to abortion (percentage of admissions owing to abortion among all ob/gyn admissions)
- Percentage of women knowing at least three risk factors/danger signs of pregnancy-related complications
- Percentage of government expenditures directed toward RH (out of total government health expenditures)
- Number of facilities with functional comprehensive essential obstetric care per 500,000 population
- Number of facilities with functional basic essential obstetric care per 500,000 population
- Number of skilled birth attendants per 1,000 population (excluding trained or untrained traditional birth attendants)
- Increase in midwife knowledge score on Integrated Management of Childhood Illness competencies of midwifery (balance score card)
- Mandatory notification of maternal deaths ( i.e., exists as a national policy or does not exist a national policy)
- Percentage of health care facilities providing at least three modern family planning methods
- Existence of policy on cervical cancer screening (yes/no)
- Existence of policy on breast cancer screening (yes/no)
- Percentage of health service delivery points providing youth-friendly services
- Percentage of health providers trained in youth-friendly service provision
- Percentage of women of reproductive age (15–49 years) screened for cervical cancer during the past five years
- Prevalence of infertility/sub- infertility (percentage of women 15–49 years of age, at risk of pregnancy, who report trying for pregnancy for two years or more)Percentage of young men and women age 15–24 years at risk for HIV who have correct comprehensive knowledge of HIV prevention
- Numbers of obstetric fistula cases detected
- Percentage of postpartum women accepting family planning
- Percentage of women received at least two PNC visits
- Couple year protection rate

These are primarily outcome and impact indicators and data for many of them will have to be collected from special surveys. From the above set, therefore, the RHD will develop a more proximate set of indicators to measure process and output. Data for these indicators can be collected by the HMIS and used in regular progress reports.

### ***Operational Research***

When an important question related to the strategy arises for which monitoring and surveys do not provide the answer, operational research may be employed. A study would be designed and carried out to find the answer, which would then be fed back to the appropriate levels of the health system as part of the normal feedback mechanism. Special studies such as these would be funded by one or more partners in coordination with the RHD.

### ***Overall Strategy Review Mechanism and Timing***

The information generated by the M&E system will be used to assess progress toward implementation of the RH strategy on a regular basis and make necessary adjustments. Progress will be reported to relevant authorities and partners, both for issues of accountability and also to provide motivation. A national-level review workshop will be conducted annually, at which the M&E unit will provide the analyzed M&E data for the year to the MoPH and its RH partners. This data will be used in the preparation of the next annual work plan.

Progress on the implementation of the strategy will also be reviewed at the regional level through regional workshops. The Provincial Health Coordination Committee will review the M&E data annually at the provincial level. Information on progress in RH will also be provided to the CGHN and the Technical Advisory Group for their feedback and recommendations.

## **CONTACT DETAILS**

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The Director of Reproductive Health is primarily responsible for the implementation of this strategy. The MNH portion of the strategy will be under the guidance of the Safe Motherhood Initiative Department of the RHD, and the BS/FP portion under the RHD's FP unit.

# ANNEX 1: References Cited and Documents Consulted

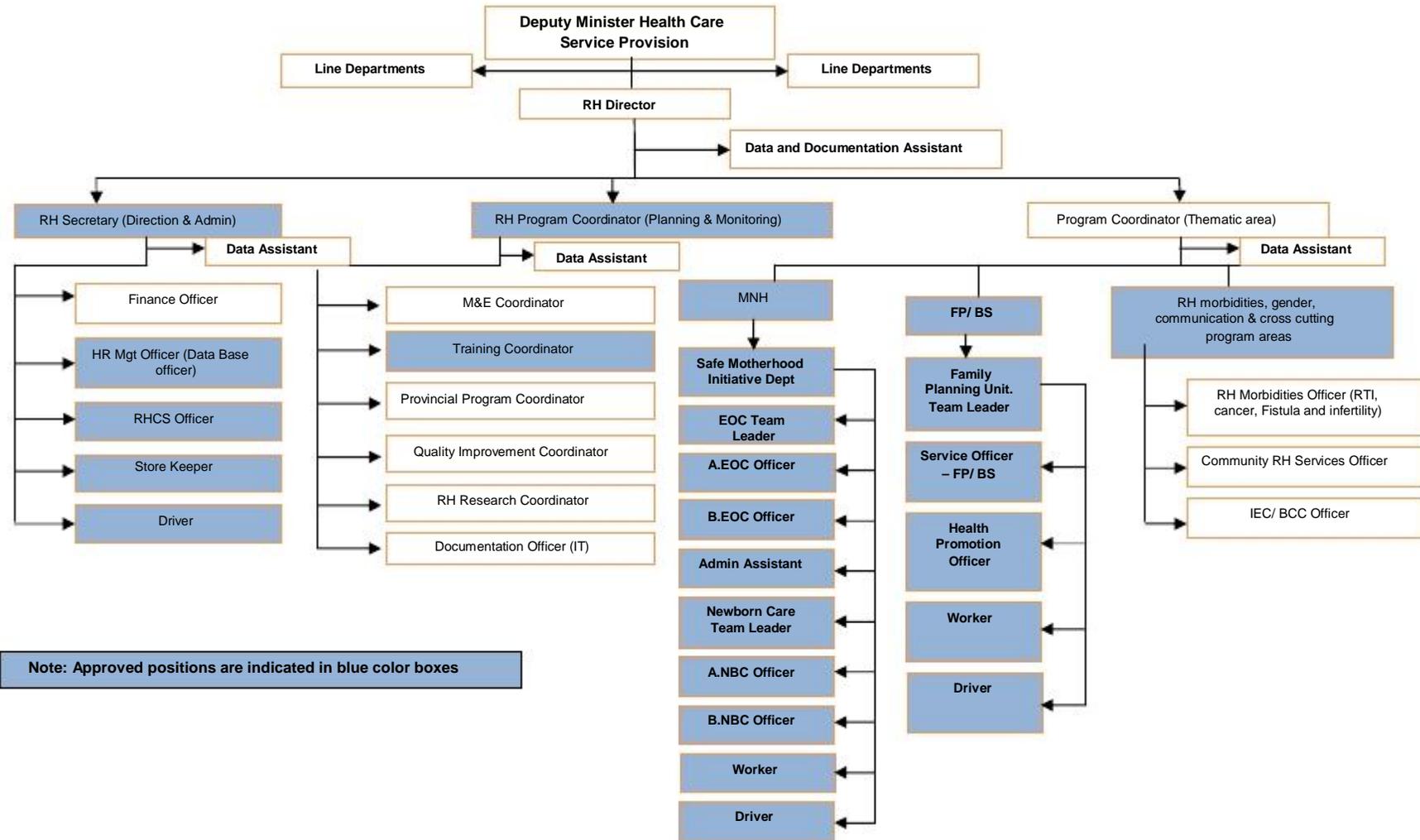
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# ANNEX 2: Reproductive Health Directorate Organizational Chart

## PROPOSED ORGANOGRAM OF REPRODUCTIVE HEALTH DIRECTORATED





# ANNEX 3: Terms of Reference of Technical Working Group Drafting Revision of the National Reproductive Health Strategy

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## Background

Article 52 of the Constitution of Afghanistan recognizes that “The state is obliged to provide the means of preventive health care and medical treatment, and proper health facilities to all citizens of Afghanistan in accordance with the provisions of law.” This is an affirmation of the political commitment of the Government to improve the health status of all citizens. The Afghanistan National Development Strategy (2008–2013) is the roadmap by which Afghanistan will progress toward the achievement of the Millennium Development Goals (MDGs). The Ministry of Public Health has formulated its Health and Nutrition Sector Strategy (2018–2103) which sets out its mission and vision in improving the health of the people of Afghanistan. The current Reproductive Health Strategy was developed for the period 2006–2009. Hence, the strategy needs to be revised to achieve the goals and targets set out in the Health and Nutrition Sector Strategy (2018–2103).

The Ministry of Public Health has constituted a Technical Working Group (TWG) to revise the existing strategy.

## Expected output

The expected output of the TWG is final version of the Revised National Reproductive Health Strategy

## Composition of the Technical Working Group

Members of the Technical Working Group represent various concerned members of the DoHS, relevant Ministries of the Government and civil society. The Chairperson of the Working Group will be Director Reproductive Health, MoPH

UNFPA will function as the Secretariat.

## Scope of work of the Technical Working Group

1. The TWG will be responsible for the preparations for a National Consultative Meeting to take stock of the current situation with regards to reproductive health in Afghanistan, identify gaps in existing policy documents and to make recommendations for the development of the new strategy. This will include preparation of working documents, organization of the meeting and recording the outcome of the meeting.
2. The TWG will ensure that the revised strategy is in line with the guidelines identified at the National Consultative Meeting. Sub-groups may be formed as agreed by the Working Group members to work on different components of reproductive health such as gender, HIV AIDS, adolescent health based on their experience in the area. Representatives of donors and international agencies should also be members of the working group but they can be invited as needed.
3. The copies of the draft strategy will be disseminated to stakeholders and developmental and NGO partners for comments. Involvement of other Ministries such as Ministry of Women’s Affairs, Deputy Minister of Youth, senior politicians, involvement of health care providers, local academic institutions, will be sought proactively by the chair of the TWG. The TWG will

particularly seek the inputs from women's groups, men and adolescents through regional consultation[s].

4. The draft strategy will be translated into Dari and Pashtu which will be reviewed by TWG to ensure consistency with the original document.
5. All submissions that have been made within the given timescale as set by the Working Group are to be considered by the TWG and those submissions are to be included as an appendix to the policy whether or not the submissions found favour with the Working Group.
6. It is at the sole discretion of the TWG whether or not to accept the ideas in the submissions that it receives, provided that it has duly considered those ideas.
7. The TWG will organise a national consultation to share the final draft National RH Policy. After the consultation the Working Group would integrate the feedback into the draft strategy.
8. The Chairperson of the TWG will submit the finalised strategy document to the Minister of Health for endorsement.

## ANNEX 4: Principal Contributors

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