MINISTRY OF HEALTH
POLICY STATEMENT

SAFE MOTHERHOOD INITIATIVE IN AFGHANISTAN

MATERNAL HEALTH SERVICES AT THE COMMUNITY LEVEL

AND

WHO SHOULD PROVIDE THESE SERVICES

REVIEWED AND ENDORSED
24 DECEMBER 2003

AMENDED
4 AUGUST 2004

Ministry of Health
TRANSITIONAL ISLAMIC GOVERNMENT OF AFGHANISTAN

Safe Motherhood Initiative in Afghanistan

Maternal Health Services at the Community Level and Who Should Provide These Services

The reduction of Afghanistan's high maternal mortality ratio is a principle objective of the Ministry of Health's Reproductive Health Strategy. A central initiative that will substantially contribute to this strategy is the country-wide expansion of maternal health services, specifically the expansion of Essential Obstetric Care (EOC) services, at all levels of the health system – from facilities to communities. To do this will require the training, deployment and support of skilled birth attendants to both rural and urban areas. Midwives and doctors must be taught the interventions that are currently thought to be the most important and will have the greatest impact in improving maternal and newborn health and preventing mortality.

Needs of the Community

The maternal and newborn health services that are necessary, feasible and thought to be effective at the community level include:

- Community awareness and support for the seeking of health services, following the principles of community-based health care;
- Limited antenatal care (basic history, examination and care provision, including birth planning, tetanus immunization, and distribution of iron and folate);
- Health education (nutrition, birth planning, danger signs) to women, families and communities;
- Postnatal care for mothers and newborns (basic history, examination and care provision, including support of breast feeding and distribution of iron and folate);
- Identification of complications and abnormalities that need emergent, urgent and scheduled referral;
- Provision of family planning methods (LAM, condoms, COCs and DMPA).

Efforts should be made to ensure that trained community-level health providers are able to provide these services, at a minimum. As well, the community must be connected to the formal health system and must be able to access the health facilities (BHC, CHC and/or hospital) that can provide them with an expanded set of appropriate maternal and newborn health services.

National Priority

The National Reproductive Health Strategy states that a central strategic directive for reducing maternal morbidity and mortality is to increase skilled attendance at birth. The

efforts of the MOH, and its implementing partners of international agencies and NGOs, are focused on developing programs that follow this strategic directive.

While increasing the supply of skilled providers there must also be efforts to generate demand for the care those providers offer, through a strategy of birth planning. Efforts at building a critical number of trained health professionals (especially midwives, community midwives and female doctors) who can be deployed to existing and planned health centers must be matched by efforts to work with communities, families and women to understand and promote positive health-seeking behaviors. In areas where skilled providers are accessible, efforts must be directed at encouraging women to deliver at facilities with these skilled providers, or developing outreach services to allow skilled providers to care for women at home. In areas where skilled providers are not accessible, efforts should be directed at decreasing the time between when a problem arises and when care is sought.

To influence positive health care seeking behaviors, efforts must be made to

- Advise **all** members of the community about normal pregnancy and danger signs in pregnancy and appropriate behaviors during childbirth
- Foster discussions about decision-making: who is empowered to make decisions about leaving home and seeking care?
- Encourage earlier decisions to seek care – especially in areas where women and families must travel many hours to reach care
- Reduce the amount of time it takes to organize transport
- Encourage communities to mobilize around the concept of birth preparedness and complication readiness.

Communication strategies, including the use of a birth planning flip chart to facilitate concrete and specific actions in preparation for the birth, should be employed by all community level health care agents.

International Evidence Regarding Who Can Best Provide Selected Services

In an effort to reduce high maternal and newborn mortality, the global health community has directed its efforts toward ensuring that appropriate maternal and newborn health services are available to women and newborns. These ideas are unified in a concept known as *Essential Obstetric Care (EOC)*. The components of basic and comprehensive EOC are detailed in Table 1.

The current consensus is that, while a community health worker can conduct birth planning activities, as well as provide appropriate health messages and non-clinical services (distribution of iron and folate, family planning, support of referrals, etc.), the management of birth, and its potential complications, is best managed by a **skilled birth attendant**.

Table 1: Components of Essential Obstetric Care

Basic EOC	Comprehensive EOC
Provision of normal antenatal, intrapartum, newborn and postpartum care Management of obstetrical complications through the following interventions: • Administration of parenteral antibiotics • Administration of parenteral oxytocic drugs • Administration of parenteral anticonvulsants • Intravenous therapy including fluid replacement • Basic surgical procedures: o Assisted delivery (vacuum extraction) o Manual removal of placenta o Removal of retained products of conception	All elements of Basic EOC *plus* • Anesthesia • Blood transfusion • Surgical Obstetrics, including: o Cesarean delivery o Repair of high vaginal or cervical tears o Laparotomy (surgical treatment of sepsis, hysterectomy, removal of ectopic pregnancy

The WHO, in collaboration with UNFPA, UNICEF and the World Bank make the following statement regarding the skilled attendant[1].

> *"The term 'skilled attendant' refers exclusively to people with midwifery skills (for example midwives, doctors and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications. At minimum the person must be competent to manage normal childbirth and be able to provide emergency (first line) obstetric care. Not all skilled attendants can provide comprehensive emergency obstetric care although they should have the skills to diagnose when such interventions are needed and the capacity to refer women to a higher level of care."*
>
> *"Traditional birth attendants, either trained or not, are excluded from the category of skilled attendant at delivery."*

By this definition, a skilled provider in the Afghanistan context would include a:

- Community midwife,
- Midwife, or
- Doctor.

Again, by this definition and by international consensus and experience, the traditional birth attendant (trained or untrained) would not meet the criteria for skilled attendant. The main reason is that traditional birth attendants (TBAs) do not possess the necessary skills to manage the obstetrical complications that can result in maternal mortality. In the past 10 years important information has been presented which supports this decision.

[1] http://www.who.int/reproductive-health/global_monitoring/skilled_attendance.html

- The metanalysis of 63 TBA training[2] programs showed that while training has a positive effect on TBA's knowledge, attitude, behavior and advice, this training actually had a negative effect on maternal mortality and a marginal effect on perinatal/neonatal mortality.
- A study of TBA training in Ghana[3], showed that while TBA training resulted in a significant decrease in intrapartum fever and retained placenta, this was counterbalanced by an increase in the rate of women with prolonged labor >18 hours. The authors conclude that "the evidence for beneficial impact of TBA training on the health of mothers and newborns is not compelling."
- A study comparing the practices of trained and untrained TBAs in Bangladesh[4] showed that, although trained TBAs were more likely to practice clean delivery, the infection rates among patients of trained and untrained TBAs was no different. This is likely due to the fact that the factor most directly affecting postpartum infection is length of labor and duration of ruptured membranes.

As well, international opinion has shifted from viewing TBAs as providers of delivery services, to one in which health infrastructure must be developed in and attempt to ***provide skilled attendance for all pregnant women*** and ensure access to emergency obstetrical care services.

- The substantial reduction in maternal mortality in countries such as Malaysia, Sri Lanka, China and Honduras have all included, among other things, a policy of enhancing skilled attendance and reducing the utilization of traditional birth attendants at birth.
- The 1997 Global Conference on Safe Motherhood in Colombo, Sri Lanka stated that "maternal mortality is an issue of health infrastructure" and efforts should be directed to "ensure a medically skilled attendant at every birth".
- UNICEF and WHO have adopted a policy, especially in situations where resources are limited, of enhancing the availability of emergency obstetric care, and not training TBAs.
- In most programs around the world, USAID has discontinued the support of TBA training programs.

The Role of the Traditional Birth Attendant and the Community Health Worker

The exact percentage of births in Afghanistan that are attended by TBAs is unknown. The most reliable data comes from the 2003 MICS[5] survey by the Central Statistical Office and UNICEF, which suggests the following:

[2] Sibley and Sipe, 2002; TBA Training and Effectiveness, A Meta-analysis.
[3] Smith, JA, et al, The impact of traditional birth attendant training on delivery complications in Ghana, Health Policy and Planning; 15(3): 326-331.
[4] Goodburn, EA, et al, Training traditional birth attendants in clean delivery does not prevent postpartum infection, Health Policy and Planning; 15(4): 394 – 399.
[5] Central Statistical Office, Transitional Islamic State of Afghanistan/UNICEF; Progress of Provinces, 2003 Multiple Indicator Cluster Survey.

Table 2: Distribution of Birth Attendants

Type of Attendant	% of Births Attended
Doctor, midwife, nurse	8.0%
Trained or untrained TBA	8.8%
Relatives, friends, others	83.1%

A 2003 WHO survey used a broader definition of "family TBA" or daya to refer to any woman identified as the person to attend births in a village. Through interviews with family TBAs, asking them what percentage of the births in the community they believe they attended, WHO estimated that together TBAs and dayas may attend as many as 63% of births.

These findings suggest that recognized TBAs do not currently provide broad support to the birthing process in Afghanistan, but that informal TBAs or dayas may be more widely used. Therefore, any initiatives for improving maternal health that are directed at the community must be directed at the entire community, not simply at TBAs. Focused training or mentoring of TBAs will reach a minority of households and families.

TBAs and CHWs can and do still serve a vital role in the lives and experiences of pregnant women. The efforts of community level workers can be focused along the lines of the CHW job description. Their efforts can be directed to focus on the following elements, all of which are in the job description of the CHW:

- acting as community educators to lend support for accurate maternal and neonatal health messages (e.g., nutrition, TT vaccination, etc.);
- identifying pregnant women in the community and linking them with appropriate maternal health services;
- partnering with skilled providers (especially midwives and community midwives);
- promoting birth preparedness and complication readiness;
- providing directed, limited antenatal care, including the distribution of iron and folate, and tetanus immunization, etc., and
- identifying and referring sick newborns;
- understanding and accessing referral systems more readily, and ensuring the continuum of care during the referral process;
- providing selected family planning methods.

The majority of the above listed activities are already done by TBAs now. If TBAs wish to become CHWs in their village, they can take on the additional listed tasks. If, however, they cannot or should not become female CHWs, they can still perform the above functions that they now do perform. As well, their role can be enhanced by partnering CHWs with TBAs to help the TBAs become better health educators and implementers of birth planning activities. Each TBA can be given a copy of the Birth Planning Flip Chart

The activities of TBAs in attending births will continue for many years. No one is advocating a policy suggesting that TBAs activities should be stopped or not permitted. It

is recognized that in many communities throughout Afghanistan the TBA will continue to be a support person to pregnant women and should be encouraged in that role. The evidence, however, does not suggest that scarce resources should be devoted to training, supervising or equipping them as birth assistants.

The Position of the Ministry of Health of Afghanistan

The scope and practice of community based workers (CHWs and TBAs) must be directed away from one that is exclusively or predominantly one of attendance at birth to one that supports the national strategy of skilled attendance at delivery and the provision of effective care. TBAs should take up the role of the female CHW, a role that focuses on interventions before and after delivery that have been shown to have greater impact on maternal health and survival.

The flow diagram in appendix 1 may be employed in selecting female candidates for CHW training.

To remain consistent with international thinking and the preponderance of evidence, the Ministry of Health proposes a strategy of

- **promoting skilled attendance** at birth,
- enhancing the skills and roles of community health workers (CHWs) to provide appropriate health services according to her/his job description and **support the health-seeking behaviors of a pregnant woman** and her ability to access skilled delivery services
- **partnering with TBAs** to enhance their support roles to pregnant women, and
- **facilitating birth planning** activities by CHWs and TBAs to help educate families and communities about good birthing practices and to increase demand for skilled attendance.

Midwives and community midwives must be recruited, trained[6], deployed and supervised as skilled attendants to serve the needs of the rural areas. Community midwife training programs should be implemented in rural areas, especially those provinces that currently have a large percentage of births attended by TBAs. These newly deployed community midwives should

How to Foster Partnership with TBAs

- Provide TBAs with Birth Planning Flipcharts to direct and improve their educational interactions with women and families
- Provide TBAs with Clean Delivery Kits that they can supply to/use with pregnant women, in conjunction with birth planning
- Invite TBAs to tour nearby health facilities to know what services they provide and what staff is available
- Encourage TBAs to accompany their clients to the health facility and allow the TBA to stay with the woman during her labor and birth
- Work with clinical staff at facilities to appreciate the role of TBAs and to invite them warmly into the facility
- Support regular meetings between the midwives or CHWs and the TBAs

[6] Training curricula have been prepared and the new and expanded training program for midwives and community midwives is underway.

make additional efforts to work with women and communities that have relied on TBAs and build their own place and role as skilled providers. There should be a dynamic, active and bi-directional **partnership** between the facility-based skilled attendant and the community-level health workers that she supports.

The MOH requests that:

- Training of TBAs as birth attendants be discontinued;
- TBAs be invited to participate in CHW training, thus becoming female CHWs;
- Illiterate TBAs/CHW candidates be able to participate in specially-designed CHW training programs for low to no literacy;
- Highly literate women currently serving as TBAs will be encouraged to enroll in community midwife training programs;
- Information campaigns regarding safer pregnancy and delivery be directed at the community in general;
- All community-level health providers embrace a strategy of birth preparedness and communicate that with appropriate audiences:
    - Female CHWs: with women, families, communities, and TBAs
    - Male CHWs: with husbands, mullahs and community leaders
    - TBAs: with mothers-in-law, pregnant women and decision makers
- CHWs, especially female CHWs, be competently trained in activities which promote maternal and newborn health including basic antenatal care, identification of problems or complications, and realistic strategies for referral, including postpartum referral;
- Linkages between CHWs and health facilities be strengthened through mechanisms such as resupply, clinical supervision, reporting, participation in the development and implementation of health facility's workplans, etc.;
- Midwives and community midwives be trained and deployed to meet the needs for skilled care at birth, and to provide the necessary linkage with the community health workers, and;
- Health facilities be supported to provide care for pregnant women, especially basic or comprehensive essential and emergency obstetric care, as appropriate.

In such cases that TBAs are not able or willing to enter CHW programs, there should be outreach efforts directed toward them that address their roles in supporting identification of danger signs and early referral. Midwives, community midwives and other health workers should make outreach visits to communities and meet with TBAs to discuss their activities. This does not suggest a strategy of training or supervising TBAs, but instead informal encounters to try to influence their practice of appropriate behaviors.

Identification, training and certification of new trained TBAs should not occur. If the MOH or an NGO has access to a community and chooses to provide training to a community-level health worker, it should develop a CHW. Training new TBAs diverges from the national strategy of skilled attendance, by encouraging communities to have a TBA present at the birth. Training TBAs without encouraging their use is a questionable use of resources. Training them with campaigns to encourage their use contradicts national strategy.

Efforts of demand generation and CHW training must be closely coordinated with initiatives to improve the quality and accessibility of health services. This strategy to shift toward professional care at birth must be supported by messages to families and communities about the value of skilled care at birth and the avoidance of dangerous practices. Given that the percentage of births attended by familiy members is overall rather high, messages that recommend positive practices and discourage harmful practices must be directed to the community as a whole, not only to CHWs or TBAs. Male as well as female CHWs must work with broad sectors of the community to promote birth preparedness and complication readiness and support women in the reasonable development of birth plans.

Conclusion

Consistency is crucial for achieving behavior change regarding health seeking decisions in an traditional area such as pregnancy and childbirth. Women and families should be encouraged to seek skilled care for antenatal, childbirth, postpartum and newborn care. Communities will doubt the credibility of skilled providers if they are encouraged to seek professional care for ANC, and supported to use traditional care providers at the time of birth. They will be less likely to change behaviors if traditional workers are promoted in one strategy and then professional workers are promoted in a subsequent strategy.

It is recognized that this is a long-term vision for the improvement of maternal care in Afghanistan. Short-term strategies, however, must support the long-term vision. It would be unwise to devise a short-term strategy that temporarily promotes the use of TBAs knowing that this strategy will be reversed in the coming years. There is a real potential that promoting opposing strategies (one that supports the use of TBAs followed by one that discourages the use of TBAs) could result in confusion at the community level and loss of trust in the health system.

In the coming decade, with the growing availability of peripheral health services and community midwives, communities will be encouraged to seek the services of skilled attendants, and TBAs should be encouraged to facilitate that contact rather than position themselves as the birth attendant.

Additional technical information regarding this policy and strategy is available from:

- Dr. Mehr Afzoon Mehr Nessar, Director, Women's and Reproductive Health, MOH
- Dr. Hedayatullah Stanakzai, Director, Policy & Planning, MOH
- Dr. Ferozuddin Feroz, Deputy Technical Minister, MOH
- Safe Motherhood technical advisors from UNICEF and USAID/REACH.

APPENDIX 1

Figure 1: Flow diagram for the selection of Female CHW Candidates from Among Local TBAs