

Afghanistan

Reproductive Health Resources Assessment

Summary

Findings and Recommendations

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List of Abbreviations

AHDS	Afghanistan Health and Development Services
AIMS	Afghanistan Information Management Services
AMI	Aide Médicale Internationale
ANHRA	Afghanistan National Health Resources Assessment
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BPHS facilities	Facilities that are primarily delivering BPHS
CBHP	Community-Based Health Providers: any type of health worker providing health care in communities, not based at facilities
CHA	Coordination of Humanitarian Assistance
CHW	Community Health Worker: health worker specifically trained to provide basic health services at community level
COS	Central Statistics Office (Afghanistan)
Dai	Traditional Birth Attendant (local term in Afghanistan)
EC	European Commission
EU	European Union
GPS	Global Positioning System
HANDS	Health and Development Service
HIS	Health Information Systems
HMIS	Health Management Information Systems
IEC	Information, Education, and Communication
JICA	Japan International Cooperation Agency
MC	Mercy Corps
MCH	Maternal and Child Health
MD	Medical Doctor
MOH	Ministry of Health (formerly Ministry of Public Health)
MSH	Management Sciences for Health
MSH/E	Management Sciences for Health / Europe
NGO	Non-Governmental Organization
RH	Reproductive Health
TISA	Trans Islamic State of Afghanistan
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization

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Introduction

One of the most frequently quoted health statistics about Afghanistan is high maternal mortality (1,600/100,000 live birth)¹. Clearly, improving the availability of reproductive health care services is an urgent task to prevent such tragedy. However, due to more than 20 years of political and wartime unrest, the information about health care services in Afghanistan has become completely out of date. Identifying the priority needs of reproductive health resources based on the better understanding of the current picture throughout the country has become an obvious first step to begin the reconstruction process of health care system in Afghanistan. For this purpose, the Afghanistan Ministry of Health (MOH) and the United Nations Population Fund (UNFPA) decided to carry out “Afghanistan Reproductive Health Resource Assessment” in 2002, and Health and Development Service (HANDS), a Japanese nonprofit organization, conducted the assessment in close collaboration with MOH.

The main objectives of the assessment were to:

- Establish the first comprehensive inventory of resources of the Afghan health system for reproductive health; and
- Strengthen knowledge and planning capacity of the MOH related to reproductive health issues.

This report summarizes major findings and recommendations of the assessment including:

- (1) general issues
- (2) antenatal care
- (3) delivery care
- (4) postpartum care, and
- (5) family planning.

Findings and recommendation from the assessment will be used to expand the reproductive health care services in Afghanistan through a participatory planning process that follows the completion of the assessment.

¹ CDC/UNICEF, “Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability”, November 2002.

Methodology

Data Sources

The Afghanistan Reproductive Health Resource Assessment was designed to establish a comprehensive inventory of all known health facilities. A list of health facilities was developed prior to the data collection in the field based on the WHO health facility database, supplemented by information provided by MOH, international and local NGOs. In addition, new facilities were also identified and surveyed in the course of the field visits.

The total number of the facilities visited was 1,054 including inactive facilities. The number of active facilities whose data were analyzed in this summary report was 912, and their breakdown is shown in Table 1. The assessment placed specific focus on the situation of Basic Primary Health Service (BPHS) facilities and Community Based Health Providers (CBHP), as they are the primary health service providers for people in Afghanistan.

Assessment tools

Three questionnaires (i.e., “Health Facility Form” “Community Based Health Provider Form” and “Pharmacy Form”) were developed in English, translated into Dari. Key categories of information that were investigated in each form are as follows:

❑ Health Facility Form:

location, accessibility, infrastructure and utilities, services offered, equipment and supplies, staff and their qualifications,

patient referrals, service volume, sources of financial and material support.

❑ Community Based Health Care

Provider Form:

services offered, equipment, qualification, sources of financial support.

❑ Pharmacy Form:

availability of basic supplies including condoms, and sources of supplies.

In addition to those questionnaires, survey teams were equipped with digital cameras and hand-held Global Position System (GPS) units to record physical appearance and geographic information of health facilities to add to the assessment database and make the information more comprehensive and useful.

Table 1: Type of Active Facilities Surveyed

Facility Type		Number
Referral Hospitals N=62 (7%)	Regional/National Hospital	21 (2%)
	Provincial Hospital	41(5%)
Basic Primary Health Service Facilities (BPHS) N=783 (86%)	District Hospital	114(13%)
	Basic Health Center (BHC)	353(39%)
	Sub-Center	224(25%)
	MCH Clinic (M1 or M2)	70(8%)
	Mobile Clinic	22(2%)
Specialized Centers		67 (7%)
Unclassified		2(<1%)
Total		912

Implementation

Major activities related to the assessment span between February and December 2002 as shown in Table 2:

Table 2: Assessment Process

February -March	<ul style="list-style-type: none"> • Conceptualizing the assessment • Generating support among key stakeholders
April -May	<ul style="list-style-type: none"> • Identifying collaborating partners Recruiting supervisors and surveyors • Developing assessment tools • Preparing logistics
June -July	<ul style="list-style-type: none"> • Training of supervisors and surveyors • Field testing of assessment tools
July -September	<ul style="list-style-type: none"> • Collecting data in 32 provinces by 165 surveyors (all Afghan male nationals) • Checking and entering and cleaning data • Verifying data accuracy by repeated visits to 10% of all facilities
October -December	<ul style="list-style-type: none"> • Data checking and analysis

Data Collection and Processing

Each survey team was consisted of 1 surveyor selected by the assessment team and 1 or 2 surveyor(s) recommended by MOH, AHDS, AMI, CHA, Ibn Sina, MC, SCA, or UNICEF. Each team was assigned a target area, and was given a facility list. Surveyors were also expected to search for facilities that were not listed.

After completion of the first round of field data collection, four teams of surveyors were selected to carry out 10% re-survey to verify the accuracy of the initial survey data. GPS readings of villages and health facilities were shared with

AIMS in order to identify exact locations of health facilities and to record names of villages that were not previously included in the AIMS village database.

This database has been continuously updated, and as of January 2003, the following numbers of questionnaires were entered into the database: 1,054 Health Facility Forms (includes inactive facilities) and 2,923 Community Based Health Provider Forms. In addition, 10,005 pictures of health facilities, equipment, and health workers have been stored electrically.

It is important to mention that Community Health Workers (CHW) and Community Based Health Care Providers (CBHP) are distinguished in this assessment. CHW refers to health workers that were trained according to a specific CHW curriculum. Some of these CHWs are posted at facilities, but not all CHWs operate out of health facilities. CBHP includes different types of health workers who are based in the communities ranging from medical doctors who received more than 7 years of training to traditional birth attendants (Dai), some of whom received less than 3 months of training. Detail information is shown in Table 3.

Table 3: Distribution of length of training of CBHP

Length of training	No. (%)
7 years or more	148 (5%)
3 years and less than 7 years	110 (4%)
1 year and less than 3 years	281 (10%)
6 months and less than 12 months	365 (12%)
3 months and less than 6 months	409 (14%)
Less than 3 months	1,411 (48%)
Unknown	199 (7%)

Limitations

The Afghanistan Reproductive Health Resource Assessment has various limitations. First, the assessment does not provide any information on the utilization of RH services by clients. This is because the assessment's main purpose was to understand the availability of reproductive health services provided at facilities, communities and pharmacies. Second, the source of information regarding RH services is self-reporting by hospital and clinic

directors. Surveyors did not directly observe services to confirm their actual availability. Third, even though surveyors were expected to interview as many CBHPs as possible, the number of CBHPs interviewed for this survey does not capture all CBHPs work in communities. Finally, there are some districts where surveyors could not conduct data collection due to security and accessibility reasons.

Major Findings and Recommendations

Following are the key findings from surveyed facilities and health care providers. Findings and recommendations to improve the identified problems are discussed regarding general situations as well as four specific reproductive health services (i.e., antenatal care, delivery care, postpartum care, and family planning). Definitions of each service referred in the findings are based on the Basic Package of Health Services established by MOH. (Please see attached document “Basic Package of Health Services for Afghanistan”.)

The assessment data indicates that some BPHS facilities and CBHP provide limited range of reproductive health services. However, there are a number of serious problems nationwide in the availability of services, accessibility to those services offered by women as well as the quality of services as described more in detail in this section of the report.

The immediate goal of the recommendations is to ensure that reproductive health services defined by the Basic Package of Health Services will be available for women in Afghanistan at each level of the health care system.

(1) General Issues

Service and Access

<Findings>

- Availability of basic reproductive health services at 783 BPSH facilities² (antenatal, delivery, postpartum and family planning service) defined by the Basic Package of Health is extremely limited (17%: 131). In the worst 7 provinces, there are no BPHS facilities that reported to providing basic reproductive health services.
- Availability of basic reproductive health services by surveyed CBHPs³ is only 2%.
- Considerable discrepancies in the access to health facilities exist among provinces. For instance in Takhar province, the minimum walking time from the nearest drivable road to a BPHS facility was 1 minutes, while the maximum time was 8 hours.
- Seventy three percent (574) of all 783 BPHS facilities reported that they organize community health meetings. Forty nine percent reported organizing school health education.
- Approximately 35% (319) of all facilities (912) present some physical damages to the building caused by war or by earthquake.

² Basic reproductive health services at BPSH facilities refers to following services: Antenatal (TT vaccination, iron supplementation, blood pressure check), Delivery (assisted delivery in home), Postpartum (Anemia check, vitamin supplementation, breastfeeding counseling, family planning counseling), Family planning: (A least 3 family planning methods)

³ Basic reproductive health services by CBHPs refers to following services: Antenatal (iron supplementation), Delivery (assisted delivery in home or assisted delivery in facility), Postpartum (Anemia check, vitamin supplementation, breastfeeding counseling, family planning counseling), Family planning: (Family planning counseling, condom, pills)

- Thirty percent (213) of total BPHS facilities do not have separate waiting areas for men and women. This may be discouraging women from visiting health facilities.
- Low referral rate was observed at all types of facilities. Only 1.7% and 1.3% of all patients are reported to be referred from district hospitals and from basic health centers respectively to higher level of health facilities.
- The definitions of public, NGO, and private health sectors are not clear in Afghanistan. MOH owns approximately 39% (350) of total health facilities, and NGOs own 44% (401) of total health facilities in Afghanistan. However, among 350 MOH-owned facilities, 74% (92) are relying on non-MOH sources of support including NGOs and UN organizations.
- Various types of patient records are used at BPHS facilities, and those are not standardized. It is likely that uncoordinated record keeping is putting unnecessary burden on health workers and weakening the overall health information system in the country.

<Recommendations>

- Issues of RH should not be dealt with in isolation. Rather they should be integrated under the overall health system development.
- Operational standards for basic RH care should be developed based on the BPHS. These standards should include lists of essential equipment and materials necessary to perform basic RH services at each level of the system.
- Essential equipment and materials for basic RH services defined by the standard above need to be available at BPHS facilities and for CBHPs. In addition, health workers have to be properly trained in order to fully and correctly operate the equipment.

- Distribution of health facilities should be re-examined considering the equity in access as the basic principle.
- Community participation should be encouraged and linked to development of decentralized health system that promotes quality and sustainable RH services. In this context, possibilities to establish community-based emergency transport systems could be discussed with community leaders as a priority issue to reduce maternal mortality.
- Rehabilitation of health facilities damaged by war and earthquake should be undertaken expeditiously.
- The layout of health facilities should be sensitive to women's needs (both patients and female health workers) such as creating gender segregated waiting areas and wash rooms, and a wash room near delivery room.
- Operational policy and systems regarding referral system should be examined including development of treatment and referral protocols for RH conditions.
- Current health system in Afghanistan is supported by mixture of government, international organizations, and NGO sources for fund, human resources, and technical support. Therefore, any plan to expand RH services rapidly in Afghanistan must take into account existing private-public partnership under the coordination by MOH. For instance, a mechanism can be explored in which all NGOs are required to register with MOH before starting operations, then according to MOH priority, they go to provinces where services are scarce so that health services are more equally distributed through the country. Private sector should also follow the same procedure, i.e. registration to MOH with proper documents and licensing.
- National Health Information Management Systems (HIMS) need be developed to provide accurate information at provincial level, and to create monitoring system for better planning at national level.
- The form of patients' record at BPHS has to be standardized based on the plan for the National Health Information Management System.
- Effective approaches to behavior change and communication (BCC) to promote women's health have to be explored and implemented targeting both women and men. Male involvement and community participation are essential for increasing RH services.
- School health education can be examined as a potential entry point for this purpose. Adolescent sexual and reproductive health education needs to be carefully and slowly introduced and implemented within a long term strategic framework.

Human Resources

<Findings>

- Nearly 40% of 783 BPHS facilities have no female health care workers. Only 24% (188) of total BPHS facilities have at least one female physician, 21% (166) have at least one female nurse, and 20% (155) have at least one midwife.
- Female health workers are geographically unevenly distributed across the country. For instance, there is one female nurse per 58,988 populations in Balkh province, while there is only one female nurse per 470,500 populations in Ghor province. Also, 59,000 populations share one midwife in Wardak province, while 475,100 populations share one midwife in Helmand.
- Only 1% (20) of the pharmacies had at least a female attendant at the day of the survey (1436). In most provinces all of pharmacy attendants were male, except a case in Faryab where 10% (5) were female.

- The result shows that 62% (1820) of surveyed CBHPs received less than 6 months of training.
- Among all BPHS facilities, only 16% (128) of them reported to provide some kind of CHW training.

<Recommendations>

- The number of female health workers need to be rapidly increased, especially nurses and midwives at BPHS facilities and in communities. The sex ratio of health workers should be at least one female worker for every 4 male health workers.
- Refresher training for existing health workers, in particular, to TBAs and midwives are crucial to increase availability of quality RH services. At the same time, opportunities for women to study at medical and nursing schools have to be increased.
- For successful recruitment of female candidates for health workers, additional socio-cultural information is needed to inform policy makers key factors that

encourage or discourage Afghan women from working as health care providers at facilities and in communities.

- Provision of supportive package to encourage female staff work and remain active even in rural areas should be considered. Possible options may include accelerated promotion of female staff, husband's recruitment simultaneously, support for education of their children, and accommodation provided by communities and local governments.
- CBHPs play a crucial role in the provision of RH services in Afghan communities. In order to maximize the utilization of available human resources, good community-based health care systems should be developed. Creation of these systems should include functional supervisory system, standardizing CBHP's job descriptions, specific job titles, and provision of essential training and materials. CBHPs must be trained in the provision of family planning and basic curative care and supplied with necessary drugs and supplies.

(2) Antenatal Care

<Findings>

- Although 80% (624) of all BPHS facilities reported that they provide some kind of antenatal care services, only 65% (407) of them offer the complete set of basic antenatal care service defined by the Basic Package of Health Services⁴. Furthermore, among facilities that claimed to provide basic set of antenatal care service, only 62% (252) of them have minimum set of equipment necessary to perform antenatal care.
- The total number of BPHS facilities that reported providing basic antenatal care services with female health worker⁵ and have minimum set of equipment was 220 (28%).
- Only 32% (941) of the 2,923 surveyed CBHP claim to provide some kind of antenatal care service.
- Availability of tetanus toxoid vaccination for pregnant women is limited to 57% (445) of BPHS facilities.
- While CBHP is expected to provide iron supplement for pregnant women, only 23% (680) of them reported to provide such service.
- Among BPHS facilities, 72% (567) of them can diagnose malaria, 72% (562) provide treatment for simple malaria cases, and 59% (459) provide anti-malaria education.

<Recommendations>

- Operational standards for antenatal care based on the BPHS should be developed. Such standards should include lists of

essential equipment and materials for each level of the system.

- Essential equipment and materials for antenatal care services defined by the standard above should be made available to BPHS facilities and CBHPs.
- The number of nurses and midwives at BPHS facilities and in communities should be rapidly increased. Additional socio-cultural research is required to inform policy makers about key factors that encourage or discourage Afghan women from working as health care providers at the facilities and in communities.
- The availability of tetanus toxoid should be improved at BPHS facilities.
- For anemia prevention, regular provision of iron supplement should be improved at both the BPHS facilities and community level.
- As malaria is one of the serious public health problems in Afghanistan and pregnant women are the main adult risk group for malaria, BPHS facilities and CBHPs have to be able to provide an appropriate preventive and treatment services.
- Effective interventions for behavioral change and communication (BCC) needs to be explored and implemented to make women, and their families understand the complication readiness (i.e., dangers and the danger signs of pregnancy related complications, and importance to seek necessary care immediately), birth preparedness (i.e., items needed for the birth, money for transportation, skilled attendant, and importance of maternal nutrition), and health promotion (family planning information and HIV and other STIs).

⁴ The minimum set of antenatal care service at BPHS facilities includes: TT vaccination, iron supplementation, and blood pressure check.

⁵ Female health worker: Doctors (except surgeons), doctor's assistant, nurse (3 years), mid-wife, trained dai, medical technician, community health worker.

(3) Delivery Care

Service and Access

<Findings>

- On the whole, half (393) of BPHS facilities responded that they do not provide delivery care.
- CBHPs play a critical role in delivery care services. For example, in Nimroz province nearly 100% of CBHP claim to provide delivery services at home, while none of BPHS facilities in the province claims to provide delivery care services.
- Availability of transportation for seeking health services is very limited in Afghanistan. The costs of transportation for emergency delivery care are mainly paid by women and their families (86%).

<Recommendations>

- Operational standards for delivery care based on the Basic Package of Health Services should be developed and should include lists of essential equipment and materials for delivery care services at each level of system.
- Essential equipment and materials for delivery care services defined by the standard above should be made available to the BPHS facilities and CBHPs.
- CBHPs must be trained in the provision of family planning and basic curative care including counseling and interpersonal communication skills, and supplied with the necessary drugs and supplies.
- Community participation should be encouraged to establish quality and sustainable RH services. This should include the community development of equitable and sustainable emergency transportation systems for pregnant women.

Human Resources

<Findings>

- Among all the BPHS facilities that reported providing delivery care services, only 19% have at least one female physician, 16% (124) have at least one midwife, and 15% (120) have at least one female nurse. In Nimroz, Paktika and Khost provinces, there is no BPHS facility providing delivery care services with female physician, doctor's assistant, nurse nor midwife.
- The result shows that 62% (1820) of surveyed CBHPs received less than 6 months of training. Especially among female CBHPs who assist deliveries at home, 78% (1,145) of them received less than 6 months of training.
- While 93% (1,476) of interviewed female CBHPs reported that they provide delivery care services at home, 64% (942) of those female CBHPs received less than three months of training.
- Sixteen percent (126) of all BPHS facilities reported that they offer Dai trainers.

<Recommendations>

- The number of female health workers who can properly manage delivery care need to be rapidly increased at facilities and in communities.
- Since most deliveries take place at home in Afghanistan, TBA (Dai), midwives, and auxiliary midwives in the communities play crucial role as front lines to protect women's health during deliveries. Policy decisions needs to be made regarding the role of these categories of health workers. However, based on the lessons learnt from other developing countries' experiences, the training of TBA (Dai) should be considered only within a short term framework. More focus should be placed on the training of midwives and auxiliary midwives within a long term framework.

Emergency Obstetric Care (EOC)**<Findings>**

- Although every district hospital is expected to provide Basic Emergency Obstetric Care (EOC), only 13% (15) of district hospitals are capable of providing basic set of EOC services: placenta removal 32%, operating table available 35%.
- Only 18% (11) of regional, national and provincial hospitals have capacity to perform Comprehensive EOC: Cesarean section 40%, placenta removal 50%, blood transfusion 39%, blood bank 45%, vacuum extraction 26%. In 9 provinces, there are no regional, national or provincial hospitals that are performing cesarean section, and in 18 provinces out of 32 do not have any vacuum extractors.
- Since the most frequent cause of maternal death in Afghanistan is hemorrhage during the pregnancy or childbirth⁶, availability of blood transfusion and functioning laboratory (i.e., to type and cross-match blood) are the essential factors to prevent such death. Survey result shows that only 32% of a total of 62 regional/national/provincial hospitals reported to have both functioning laboratory and blood transfusion service. Sixteen provinces out of 32 provinces do not have any regional/national/provincial hospitals with functioning laboratory with blood transfusion service. Two major reasons for lack of functioning laboratories are: (1) facilities do not have laboratory technician (86%: 31), and (2) laboratories do not have adequate supply of equipments and commodities (85%: 29).

<Recommendations>

- Basic equipment and materials should be available at comprehensive EOC at all national, regional, provincial hospitals, and for basic EOC at district hospitals.
- The number of laboratory technicians need to be rapidly increased and deployed at hospitals that are responsible for comprehensive EOC.
- Focused training for EOC should be provided for midwives and auxiliary midwives to work at basic emergency obstetric care facilities.
- Blood bank system should be established at comprehensive emergency obstetric care facilities. At least all provincial hospital should have the blood bank system.
- The importance of blood testing should be promoted, and screening of blood for HIV/AIDS, syphilis, and hepatitis B should be widely available.

⁶ CDC, UNICEF, and Afghanistan MOH, "Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability", 2002.

(4) Postpartum Care

Service and Access

<Findings>

- As a national average, nearly 82% (643) of all BPHS facilities and 84% (2441) of surveyed CBHP reported providing some kind of postpartum care services. However, only half (403) of all BPHS facilities and 17% (497) of CBHPs are providing the complete set of basic postpartum care services defined by BPHS⁷.
- While CBHPs are expected to distribute vitamin supplements, only 20% (583) of them reported distributing vitamin supplements routinely.

<Recommendations>

- Operational standards for postpartum care based on BPHS should be developed and should include lists of essential equipment and materials for postpartum care services for each level of system.
- Essential equipment and materials for basic postpartum care services defined by the standard above should be provided to the BPHS as well as to CBHPs.
- Training should be provided for health workers to practice postpartum care services properly.

⁷ The basic set of postpartum care service at BPHS facilities includes: anemia check, vitamin supplementation, breastfeeding counseling, birth spacing counseling.

(5) Family Planning

Service and Access

<Findings>

- Although the percentage of BPHS facilities that reported providing at least one family planning services is relatively high (76%: 594), family planning counseling accounts for the most part of those services (60%: 470).
- BPHS facilities that are offering at least 3 family planning methods are limited to only 29% (229). Moreover, only 7% (199) of total BPHS facilities provide at least 3 family planning methods with female health workers.
- Available non-counseling family planning methods at BPHS facilities are pill (46%:358), injectable (35%:277), condom (34%:270), IUD (16%:122), vasectomy (4%:30) and tubal ligation (4%:30). Most frequently available family planning methods at BPHS facilities were pill, injectables and condoms. Similarly, 21% (601) of the 2923 interviewed CBHPs reported providing condoms, 17% (483) and 12% (359) for pills and injectables respectively.
- While five of the essential drugs (Mebendazole, Cotrimoxazol, Paracetamol, Chloroquine and ORS) were available on average at more than 90% of the surveyed 1436 pharmacies, condoms were only present at 15% (212) of the surveyed pharmacies.
- Availability of family planning commodities at private pharmacies varied. In several provinces, none of the pharmacies surveyed had condoms available, while up to 40% (53) of pharmacies were providing condoms in Hirat.

<Recommendations>

- In order to reduce the maternal mortality rate through the promotion of birth spacing, the provision of family planning services must be expanded, especially at community level.
- Minimally, all health facilities should have at least one female health worker who can provide basic family planning service.
- Technical guidelines for BPHS should include lists of essential equipment and materials for family planning services at each level of the system.
- Essential equipment and materials for family planning services defined by the guidelines above should be provided to the BPHS as well as to CBHPs.
- Additional information is needed to understand major factors related to low availability of family planning services, both from the providers and clients perspectives. Based on such information, expansion of family planning services should be planned through social mobilization and awareness raising, including promotion of male involvement.
- Expansion of family planning programs needs good coordination with NGOs (e.g. Afghan Family Planning Guidance Association, an IPPF affiliate in Afghanistan) on logistics as well as monitoring and evaluation activities. Family planning programs should also be promoted principally through community based programs as privacy and trust are key factor for success.
- Condoms are poorly available and differences among provinces are marked. However, there is good potential to establish an efficient private sector supply system for condoms. Successful expansion of family planning services in Afghanistan could be realized through an effective public-private partnership.

Conclusions

Afghanistan Reproductive Health Resource Assessment describes how isolated many Afghan women are from basic yet necessary means to protect their health and even their lives. The gap in the access to basic health facilities existing within Afghanistan is far wider for women than men. This is because many health facilities in Afghanistan, even where they exist, are not women friendly.

The number of female health care providers at BPHS facilities is absolutely inadequate in total, and they are geographically unevenly distributed. Thirty percent of facilities do not have gender segregated waiting areas so that women feel comfortable to visit health facilities. There are many health facilities providing no health and family planning services for women. Even if facilities reported that they provide some kind of basic RH services, such as antenatal, delivery and postpartum care, many do not have essential medical equipment to perform safe and quality care.

For most people who know Afghanistan well, however, these findings may not be new and surprising. But what this assessment accomplished is to make it possible for all parties concerned with health of Afghan women to communicate and work together for addressing problems based on objective, updated and comprehensive information regarding what Afghan women are experiencing every day.

The assessment also revealed facts that previously did not receive much attention. After long period of political turmoil and military conflicts in Afghanistan, a number of individuals and organizations survived to continuously provide basic health care services to people by mobilizing all available means. For this, Afghan and international NGOs and local communities are, and will be, playing extremely important role. Also the assessment documented that some forms of family planning services have been provided in Afghanistan despite outside world perception that strict cultural norms in the country makes it extremely difficult for health facilities to provide family planning services and also for Afghan women to access them. These are some examples of encouraging facts for all of us who are faced with enormous challenges to rebuild health care system in Afghanistan to maintain optimism and commitment.

Based on the findings from the assessment and discussion above, we recommend following approaches to addressing women's health needs in Afghanistan through rebuilding the national health care system:

- “Equity” should be the fundamental principle in establishing health care system in Afghanistan. Reduction of existing wide discrepancies in access to quality health between different geographic areas and gender should be the priority goal for Afghan

- government and international community.
- Reproductive health issues should not be dealt with in isolation, but should be integrated under overall health system development. In view of acute need for training female health care personnel, close coordination and collaboration between health and education sectors should also be seriously considered.
 - With regard to the goal to make deliveries safe and healthy for all women in Afghanistan, improvement of facility-based health services and strengthening community-based health services should be simultaneously pursued. Health facilities should become more women friendly through improving both health personnel's communication skills to care female clients better and physical infrastructure of health facilities. Health personnel should also be able to deal with life threatening obstetric situations properly.
 - At the same time, availability and quality of health care services that are closer to women's home, namely in communities should be improved. To this end, policy decisions have to be made and an operational plan needs to be developed regarding the role of community-based health providers, TBA, auxiliary midwife at community level.
 - To increase availability of family planning services, more information is necessary on demand side of such services. Based on such studies, if appropriate, an expansion of outlets for family planning commodities and services at community level can be examined including NGO and local commercial outlets. Culturally appropriate behavioral change and communication strategy should be also developed.
 - The role of NGOs, both local and international, continues to be important in expanding and sustaining health care coverage for Afghan population. Future strategies for rebuilding health care system in Afghanistan have to be based on collaborative relationship between the government and NGOs.

SECOND DRAFT
Document for discussion

**A BASIC PACKAGE OF HEALTH SERVICES
FOR AFGHANISTAN**

PART II – THE PACKAGE

MAY 2002

<Attention: Only Reproductive-Health-related pages from “Basic Package of Health Services (Second Draft)” are attached here>

1. INTERVENTIONS ON MATERNAL AND NEWBORN HEALTH

1.1. ANTENATAL CARE

ACTIVITY	LEVEL OF CARE			
	COMMUNITY	SMALL HEALTH CENTREL	LARGE HEALTH CENTREL	RURAL/PROVINCIAL HOSPITAL
Information, Education, and Communication (IEC)	Y	Y	Y	Y
Diagnostic of pregnancy ¿????	Presumption	Y	Y	Y
Antenatal visits. Weight, height ??	N?	Y	Y	Y
Immunization against Tetanus ??routine	Outreach	Y	Y	Y
Iron and folic acid supplements	Y	Y	Y	Y
Multi-micronutrient supplementation ?what	Y	Y	Y	Y
Intermittent presumptive treatment against malaria –no	N	Y	Y	Y
Screening for syphilis-?ANC	N	If lab available	Y	Y
Blood pressure measurement	N	Y	Y	Y
Simplified urinalysis	N	Y	Y	Y
Diagnosis of anaemia	Clinical-refer	Clinical/lab	Blood test	Blood test
Treatment of intestinal worms - marginal	Y	Y	Y	Y
Treatment of malaria	Presumptive	Presumptive	Lab	Lab
Treatment of Asymptomatic Urinary Tract Infections ??	N	Y	Y	Y
Treatment of Symptomatic Urinary Tract Infections	N	Cystitis	Pyelonephritis	Pyelonephritis
Treatment of anaemia	Iron	Iron	Iron	Iron/Blood transf.
Management of STD ?consider syndromic	N	Clinical	Lab	Lab
Treatment of hypertensive disorders of pregnancy	N	Y	Y	Y
Treatment of pre-eclampsia/eclampsia	N	Refer	Mild	Mild/severe
Treatment of incomplete miscarriage/abortion	N	Refer	MVA	MVA/curettage
Treatment of ectopic pregnancy????Dx TBA	N	Refer	Refer	Y
Reporting	Y	Y	Y	Y
Supervision and monitoring	N	?	Y	Y

1.2. DELIVERY CARE

The care provided at the time of delivery focuses on the clean assistance to normal deliveries, and the identification of and action against the most common obstetric emergencies (haemorrhage, prolonged labour, puerperal sepsis, pre-eclampsia/eclampsia, complications of abortion)

ACTIVITY	LEVEL OF CARE			
	COMMUNITY	SMALL HEALTH CENTREL	LARGE HEALTH CENTREL	RURAL/PROVINCIAL HOSPITAL
IEC	Y	Y	Y	Y
Monitor progression of labour	Y	Y-refer?	Partograph	Partograph
Identify foetal malpositions	Y-refer	Y-refer	Y-refer	Y
Assist normal delivery	Y	N--¿why not?	Y	Y
Assisted vaginal delivery	N	N	Y	Y
Intramuscular oxytocin	N	N	Y	Y
Bimanual compression of the uterus	Y	Y	Y	Y
Controlled cord traction	Y	Y	Y	Y
Suturing tears	N	Vaginal	vaginal/cervical	vaginal/cervical
Provision of intravenous fluids	N	Y-transfer	Y	Y
Blood transfusion	N	N	N?	Y
Manual removal of placenta	N	N	Y	Y
Curettage	N	N	MVA	Y
Hysterectomy	N	N	N	Y
Management of prolapsed cord, shoulder dystocia	N	N	Y-transfer	Y
Vacuum extraction	N	N	Y	Y
External cephalic version	N	N	Y	Y
Symphiotomy?	N	N	N	Y
Cesarean section	N	N	N	Y
Craniotomy	N	N	N	Y
Antibiotics	N	Oral	Oral/i.v.	Oral/i.v.
Reporting	Y	Y	Y	Y
Supervision and monitoring	N	?	Y	Y

1.3. POSTPARTUM CARE (immediate postpartum included in delivery care)

ACTIVITY	LEVEL OF CARE			
	COMMUNITY	SMALL HEALTH CENTREL	LARGE HEALTH CENTREL	RURAL/PROVINCIAL HOSPITAL
IEC	Y	Y	Y	Y
Vitamin A supplementation	Y	Y	Y	Y
Detection of anaemia	Y-refer	Clinical	Lab	Lab
Detection of puerperal infection	Y-refer	Y	Y	Y
Breast examination	Y-refer	Y	Y	Y
Treatment of anaemia	N	Iron	Iron/Blood trans.	Iron/Blood transf
Antibiotics - ?FOR FEVER AND DISCG?	N	Oral	Oral/i.v.	Oral/i.v.
Counselling on family planning and breastfeeding	Y	Y	Y	Y
Reporting	Y	Y	Y	Y
Supervision and monitoring	N	?	Y	Y

1.4. FAMILY PLANNING

ACTIVITY	LEVEL OF CARE			
	COMMUNITY	SMALL HEALTH CENTREL	LARGE HEALTH CENTREL	RURAL/PROVINCIAL HOSPITAL
Counselling on FP method	Y	Y	Y	Y
Physical examination	N	Y	Y	Y
Screening for STD	N	Clinical	Lab	Lab
Treatment of STD	N	Oral	Oral/I.V.	Oral/I.V.
Condoms	Y (distrib.)	Y	Y	Y
Oral contraceptives	Y (distrib.)	Y	Y	Y
Depot progestogen inj.	N	Y	Y	Y
IntraUterine Devices	N	N	Y	Y
Female Sterilization	N	N	N	Y
Male Sterilization	N	N	N	Y
Reporting	N	Y	Y	Y
Supervision and monitoring	N	?	Y	Y

Appendix II

District Population Per Health Facility

November 2002

