This is a programmatic evaluation of midwifery education in Afghanistan to identify the strengths and weaknesses of these programs. The evaluation was funded by USAID and implemented by Health Services Support Project.
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Many thanks to the midwives, patients, community members, MoPH and NGO officials and who participated in this important assessment and contributed to any potential benefits that will arise from the contents of this evaluation.

Special thanks to the American people for their generous support to this evaluation, as well as to several other life-saving activities of HSSP that address the basic health needs of women and children in Afghanistan.
INTRODUCTION

Maternal mortality has been recognized as a public health priority in Afghanistan since 2002 when the Ministry of Public Health was revitalized. Reducing maternal deaths requires skilled birth attendants (SBA) within a functioning health infrastructure. The MoPH Human Resources Department reported in 2003 that there was a severe shortage of female SBA in general and only 467 midwives in the country. Low birth attendance by skilled providers has been confirmed in a number of studies, including the 2003 MICS re-analyses that showed that < 10% of births were attended by SBA. In response, the major donors for Afghanistan–USAID, World Bank and the European Commission--supported two pre-service education programs to train and graduate new midwives: one building on the existing the Institutes of Health Sciences (IHS) program designed for midwives who would practice largely in provincial, regional and national/specialty hospitals and another designed for midwives who would be community-based (trained in a number of Community Midwifery Education [CME] programs).

The USAID-funded REACH program and partners led the technical development of the national midwifery education program during which 26 schools opened in six years. To further guide this important training initiative, the MoPH requested an evaluation of the program. The USAID-funded HSSP program initiated this evaluation in response.

PURPOSE

The purpose of this evaluation is to improve the pre-service midwifery education program through identification of its strengths and weaknesses.

OBJECTIVES

Using a program evaluation framework, a representative sample of accredited pre-service midwifery programs were assessed in order to describe:

- Needs: Address the needs of Afghan women and their families for available and good quality maternal and newborn care.
- Processes: Develop effective processes, for example, student recruitment.
- Outputs: Increase the number of graduate midwives in Afghanistan and time estimated to reach national coverage with current output of midwife graduates.
- Outcomes: Deliver maternal health care and services.
- Impact: Estimate maternal deaths averted by the midwifery graduates.

This report describes the results of a subset of the data collection methods and analyses planned for this evaluation, as described below under objectives 1 - 5, and referred to as Phase 1 of the evaluation and report. The data was collected or analyzed between August 2008 and May 2009. The remaining analyses will be completed within 2009 as Phase 2. This proposal was approved by the Afghan MoPH IRB.

METHODS: Study Design and Rationale

To develop as complete a picture of the strengths and weaknesses of the midwifery education program as possible, a number of data collection methods were utilized to describe and assess the program. Results are presented in the next section. The data collection was carried out in two phases for feasibility reasons.
In phase 1 of the evaluation, we conducted the following data collection efforts:

1. **Description of the Midwifery Education Programs**

   All midwifery school directors were contacted by phone and email to provide information on the number of students accepted into the program for each midwifery class to date, number of graduated midwives, number of deployed midwives and number currently working as midwives. Data was cross-checked several times with the school directors, provincial health directors, sponsoring NGOs, and previously existing records. In addition, the process of the education program was described to identify lessons learned in the workings of this program – for example, the recruitment, training experience and deployment of students.

2. **Assessment of Maternal Health Utilization Indicators in Provinces With and Without Midwifery Schools**

   We assessed maternal health outcomes in provinces with and without midwifery schools using HMIS facility obstetric data.

3. **Assessment of Need for Refresher Training**

   To guide the need for refresher training, we assessed the retention of a sub-set of the core competencies that are taught in midwifery school among a random sample of practicing midwives graduated from the midwifery programs. The competencies and methods used were those developed by JHPIEGO, UNICEF, WHO and MoPH to assess competency during midwifery training. They included: 1) Manual Removal of Placenta (MROP) 2) Newborn Resuscitation (NBR) 3) Manual Vacuum Aspiration (MVA) 4) Eclampsia/Pre-Eclampsia (Ec. Mgmt), 5) Use of Partograph (Partog) and 6) Shock management. The midwives were asked to participate in a simulated practice (either on anatomical model or simulated patient) for the first four and 5-7 were assessed using written case studies. The number and sample of midwives assessed is described in section on Sample Selection.

4. **Qualitative Data Collection**

   a. **Interviews of Graduate Midwives**

      Individual interviews were conducted among graduated and working midwives to capture their perceptions on the quality of their training, their impact on the community, barriers to providing optimal care, and their recommendations to improve their pre-service education and deployment experience.

   b. **Interviews of Key Informants/Stakeholders**

      Key informants, including directors of midwifery schools, BPHS managers, Provincial Health Directors, representatives from the Afghan Midwives Association and National Midwifery Education Accreditation Board, and national level Ministry of Public Health Staff (Reproductive Health Director, representative from Human Resources Department) were interviewed to obtain their perspectives on the strengths and weaknesses of the program and their recommendations for improvement.

   c. **Focus Group Discussions among Community Members**

      Group interviews to capture perceptions of the quality of the care delivered by the midwives and ways to improve the programs were conducted among clients of a sub-sample of the sampled midwives and among female community members who were not clients of these midwives.
The following objectives will be conducted in Phase 2 of the evaluation, between June and December 2009.

1. **Documentation of the Practice Activities of a Random Selection of Midwives**

   A subsample of the practicing midwifery graduates were asked to document their practice activities for a six-month period (March-August 2009) using a register specifically designed for the purpose. The register book was developed to record the required data, while attempting to not over-burden the midwife with an additional clerical task.

   **Information collected includes:**
   - # of clients served per month,
   - # of clients served by type of care (ANC, delivery, PP care, Family planning and summary of non reproductive health services)
   - Place of delivery (home, facility)
   - Type of delivery
   - Pregnancy outcomes of patients: complication rate (by type), referral rate, maternal deaths, stillbirths, newborn deaths.

2. **Estimate of Deaths Averted.**

   An estimate of maternal deaths prevented will be extrapolated from the already existing data sources as well as the data sets generated during the study.

3. **Estimate of Cost Effectiveness of Program**

   Financial and outcome data from the already available sources as well as from the data sets generated during the study will be used to estimate the cost-effectiveness of intervention by maternal health outcome.

4. **Estimated Time Required to Provide Adequate Midwifery Coverage Nationally Given the Current Output (Graduated Midwives) Rate of the Programs**

   We will estimate the total number of midwives needed to provide skilled birth attendants for every pregnant woman in Afghanistan, and how many more midwives need to be trained to reach this coverage level.

**STUDY POPULATION**

The primary population of interest for this evaluation was the midwives who graduated from one of the currently accredited midwifery education programs since the first class graduated in 2004. The secondary population of interest is the women of the community who received care from the midwives in the study and those who did not. The third population of interest is the key informants/other stakeholders.

**SAMPLING PLAN**

The first level of sampling was the accredited midwifery Institute of Health Sciences (IHS) or Community midwifery education (CME) schools (the education programs described on page 8). In June 2008, when the sampling plan was determined with the MoPH, there were 24 midwifery schools in 23 provinces. Of the 20 which were accredited, eight representative programs were selected for this evaluation with the input of the MoPH based on the following criteria:

- Regions
- Type of program: Community midwifery education or Institute of Health Sciences (IHS)
- Donor
- Length of time program has been running
- Security.
The sites selected are depicted in the map and listed in the table below.

### Map 1: Distribution of IHS and CME schools in country and selected schools for evaluation

<table>
<thead>
<tr>
<th>Province</th>
<th>Region</th>
<th>Supporting donor</th>
<th>Type of School</th>
<th>Accreditation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saripul</td>
<td>North</td>
<td>WB</td>
<td>CME</td>
<td>Accredited 2007</td>
</tr>
<tr>
<td>Badakhshan</td>
<td>North-East</td>
<td>USAID</td>
<td>CME</td>
<td>Accredited 2006</td>
</tr>
<tr>
<td>Paktya</td>
<td>South-East</td>
<td>Cord Aid</td>
<td>CME</td>
<td>Re-accredited 2008</td>
</tr>
<tr>
<td>Nangarhar</td>
<td>East</td>
<td>EC (before 2006)</td>
<td>CME</td>
<td>Accredited 2007</td>
</tr>
<tr>
<td>Herat</td>
<td>West</td>
<td>USAID</td>
<td>IHS</td>
<td>Accredited 2006</td>
</tr>
<tr>
<td>Badghis</td>
<td>West</td>
<td>AECI/WB</td>
<td>CME</td>
<td>Accredited 2006</td>
</tr>
<tr>
<td>Parwan</td>
<td>Central</td>
<td>WB</td>
<td>CME</td>
<td>Accredited 2007</td>
</tr>
<tr>
<td>Kabul</td>
<td>Central</td>
<td>USAID</td>
<td>IHS</td>
<td>Accredited 2006</td>
</tr>
</tbody>
</table>

The second stage of the sampling plan consisted of identifying all working midwives who graduated from the schools, and taking a random sample of 20 midwives from each school. Not all schools could provide 20 midwives for the sample. When 20 or less midwives were available, all were interviewed and in schools with more than 20 graduates, randomization was carried out to select 20 participants. In total, 138 midwives were selected as our primary subjects. Of these, 92% were working as midwives and 8% working in professions other than midwifery which included faculty within midwifery school, nurse, teacher, etc. All of these selected midwives were interviewed and their competencies assessed (Numbers 2 and 3 in Phase 1 methods above.)

For the community focus groups, a subsample of the 138 midwives (2 per province, total of 14, Kabul province did not meet the selection criteria, it was therefore excluded from the list) were identified. In their catchment areas, four community groups were interviewed; two from the direct clients of the selected midwives, and two from the women who were not clients of this midwife. (Phase 1, No. 2.c.). In some provinces, due to security restrictions, we were not able to conduct all four focus groups as planned. We therefore focused on less insecure areas and were able to conduct two or three focus groups in those provinces. In total, we were able to conduct 24 focus groups in 7 provinces.

Last, subsamples of the 138 midwives (maximum 5 per province, total of 36) were given a register book to record their activities prospectively (Phase 2.).
ETHICAL CONSIDERATIONS

The evaluation was anonymous. Codes were generated for each participant to ensure that no duplication of data collection on any one participant occurred, while maintaining their anonymity. Written informed consent was obtained from each participant. The subjects were free not to participate or continue in any of the activities required for the evaluation. In order to prevent any embarrassment and/or pressure on the participants, the assessment team members were trained to fully describe the evaluation objectives and what was expected from them. Anonymity of other stakeholders and key informants will be kept and no reference will be made to specific individuals.

In addition, no reference to a specific program or implementing agency will be made in any of the reports based on the primary or secondary datasets generated during this evaluation. Computer-based files are retained within HSSP, protected by passwords. Paper-based records are kept in a secure location and only accessible to personnel involved in the evaluation. All individual identifiers were removed from the datasets cleaned for analysis.

This study did not provide any financial or other kind of benefits to the respondents. However, any actual costs incurred to the participants were reimbursed based on actual validated proof. The assessors were instructed (as per the approved protocol) to inform the interviewed midwives of their results and to provide technical advice in areas detected as weak after all their answers were recorded and sealed.

The evaluation was subjected to review of the IRB of the MoPH and approval was obtained.
RESULTS

1. Description of the Midwifery Education Programs

Two types of midwifery training programs (IHS and CME) were strengthened or established to meet the needs of rural based community health facilities as well as urban-based hospitals. The graduates are both fully-fledged professional midwives, required to show competency in the same clinical knowledge and skills, but have further focused training to help them address either the challenges of community or hospital practice. The CME graduates trained in an accelerated 18 months course, taking fewer holidays over the course of the training, in order to accelerate deployment to needy communities, whereas the 2 academic year IHS programs have not adopted the accelerated training schedule, but the students also study for a total of 18 months.

The IHS enrolls graduates of 12th grade, who are introduced through the concur (national board) exam administered by Ministry of Higher Education, and graduate fully trained midwives who are deployed to central, regional and provincial hospitals, and in exceptional cases to district hospitals or comprehensive health centers. The CMEs enroll graduates of minimum 9th grade of schooling and graduate fully trained midwives who are deployed to Basic and Comprehensive Health Centers and District Hospitals. (In provinces with critical shortages of hospital midwives, community midwives can be hired in hospitals.) Enrollment at IHS is based on an entry test administered by Ministry of Higher Education (MoHE) while at CME, a participatory approach is exercised involving local community leaders of the prospective workplace, MoPH and BPHS implementing NGOs.

Prior to 2002, only one IHS in Herat trained midwives. MoPH reported a severe shortage of female skilled health providers; only 467 midwives were known. In 2002, the Dutch Government funded a very successful pilot CME program in Nangahar, upon which the current CME program was developed. Initial funding followed by the Dutch government and EC, and USAID. Technical support supported largely from the USAID-funded REACH, ACCESS and HSSP programs and partners led the technical & quality components of the development of the national midwifery education program. In the past 7 years, 27 schools (5 IHS and 22 CME) were established in 25 provinces, serving 29 provinces. Another 5 schools will become functional and/or opening soon, for a total of 32 schools serving all 34 provinces.

Of the 27, 26 have been accredited. The MoPH and partners established a National Midwifery Education Accreditation Board (NMEAB) which developed policies for education content and quality, school staffing and management, accreditation, graduation requirements and deployment, which have been mandated for use in all schools opened in the country. Details

As of May, 2009, 676 students were currently enrolled in midwifery education programs and 1961 midwives (93% of previously enrolled) had graduated - 1103 from IHS and 858 from CME. Of the graduates, 1675 or 85% were deployed or took employment and of these, 1448 women or 86% were working as of May, 2009. The number of graduate midwives (n=1961) reflects an increase of almost four times in the number of available skilled birth attendants from the number in 2002 (n=467) and 3.5 times the number of working midwives when we use only currently working midwives.

The numbers and proportions of students currently studying, previously enrolled in the programs, graduated, who found employment or was assigned (deployed) to a government or private health facility after graduation, and who continued to work as of the end of May, 2009 (currently working) are shown in Table 1. See Appendix A for the complete table of midwives graduates and deployment by province.
Most (86%) of the graduates who were deployed have continued to work as midwives. Map 2 below shows the distribution by district of the midwives who graduated from the programs since 2002 and who are currently working at district level. Each midwife is represented by a “dot”. We can see that there has been substantial coverage attained among most provinces, with persisting shortage in the south and central provinces.

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Current studying</th>
<th>Enrolled</th>
<th>Graduated</th>
<th>Dropouts</th>
<th>% Graduated</th>
<th>Deployed/Employed</th>
<th>Current working (as of May, 2009)</th>
<th>% Currently working of graduated</th>
<th>% Currently working of deployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHS</td>
<td>167</td>
<td>1232</td>
<td>1103</td>
<td>129</td>
<td>90%</td>
<td>890</td>
<td>81%</td>
<td>754</td>
<td>68%</td>
</tr>
<tr>
<td>CME</td>
<td>509</td>
<td>886</td>
<td>858</td>
<td>28</td>
<td>97%</td>
<td>785</td>
<td>91%</td>
<td>694</td>
<td>81%</td>
</tr>
<tr>
<td>Total</td>
<td>676</td>
<td>2118</td>
<td>1961</td>
<td>157</td>
<td>93%</td>
<td>1675</td>
<td>85%</td>
<td>1448</td>
<td>74%</td>
</tr>
</tbody>
</table>


However, notable differences are seen between CME and IHS schools. While IHS graduated 1,103 midwives and CMEs graduated 858, the proportion of students who started the program and subsequently graduated, deployed and currently working are all higher from CME schools than from IHS. (Table 2) Of students who enter the program, 7% more women graduated from CME (97%) vs. from IHS (90%); 10% more women deployed of the graduates from CME (91%) vs. IHS (81%); and 13% more women were working in May 2009 who graduated from CME (81%) vs. IHS (68%).

Hence, 16% more CME graduates were working in May, 2009 than IHS graduates. However, there is only a small difference (3%) between the CME (88%) vs. IHS (85%) for this currently working of those deployed,

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1 Due to lack of exact GPS readings for midwives workplace at the village level, the dots do not reflect the exact location of midwives in the district.

2 The data in this map reflects only geographic distribution by midwives - the greater population density in the central and eastern provinces, and lower density (more scattered, rural pop) in the west and south should be considered when interpreting this map.
indicating that the majority of midwives who are not currently working – left midwifery AFTER graduation from IHS and BEFORE deployment.

Table 2: Difference between CME and IHS Midwives in Deployment and Currently Working

<table>
<thead>
<tr>
<th>Type of School</th>
<th>% Graduated</th>
<th>% Deployed</th>
<th>% currently working</th>
</tr>
</thead>
<tbody>
<tr>
<td>CME</td>
<td>97</td>
<td>91</td>
<td>81</td>
</tr>
<tr>
<td>IHS</td>
<td>90</td>
<td>81</td>
<td>68</td>
</tr>
<tr>
<td>Absolute difference</td>
<td>7</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Proportional difference</td>
<td></td>
<td></td>
<td><strong>16%</strong></td>
</tr>
</tbody>
</table>

2. **Assessment of Maternal Health Utilization in Provinces with Midwifery Schools and Those without Schools**

To approximate the effect of midwives working in the provinces on maternal health indicators, we conducted a difference-in-difference analysis using data from HMIS in provinces with midwifery schools (treatment group) and provinces without one (control) over two points in time. Outcome indicators were skilled birth attendants (SBA) and skilled antenatal care (ANC).

In provinces with midwifery schools that had graduated students by 2007, SBA% increased by 23% between 2006-8, while provinces without midwifery schools (or had not graduated students by 2007) increased 14% - a 9% absolute difference. This represent a 40% proportional increase in the use of SBAs in provinces with graduating midwives compared to provinces without graduating midwives. (Table 3)

Table 3: Average Skilled Birth Attendants (SBA) Use by Women by Time and Treatment Group

<table>
<thead>
<tr>
<th></th>
<th>Time 1 – 2006 (before graduating a class)</th>
<th>Time 2 – 2008 (first half) (after graduating a class)</th>
<th>Difference (Pre-post difference between Treatment and Control group, respectively)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provinces w/ midwifery school with at least one graduating cohort by 2007 (treatment)</td>
<td>14%</td>
<td>37%</td>
<td>23%</td>
</tr>
<tr>
<td>Provinces w/ NO midwifery school with at least one graduating cohort by 2007 (control)</td>
<td>17%</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Absolute difference (between treatment and control at time 1 and time 2)</td>
<td>-3%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Proportional difference</td>
<td></td>
<td></td>
<td><strong>40%</strong></td>
</tr>
</tbody>
</table>

In Table 4, ANC estimates are over 100% in the second time cells, likely indicating more than one antenatal care visit. Since the over-reporting is not biased to any particular group, we can look at the change over time between the treatment and control groups. Provinces who graduated midwives before 2007 reported a 47% increase in ANC use, whereas provinces without midwives reported a 39% increase – an absolute difference of 8%. This represents an almost 20% (17%) increase in the use of skilled ANC when a province has graduated midwives by 2007 compared to provinces that have not between time 1 and time 2.
Table 4: Average Antenatal Care (ANC) Use by Women by Time and Treatment Group

<table>
<thead>
<tr>
<th>Time 1 – 2006 (pre – before graduating a class)</th>
<th>Time 2 – 2008 (first half) (post – after graduating a class)</th>
<th>Difference (Pre-post difference between Treatment and Control group, respectively)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provinces w/ midwifery school with at least one graduating cohort by 2007 (treatment)</td>
<td>64%</td>
<td>111%</td>
</tr>
<tr>
<td>Provinces w/ No midwifery school with at least one graduating cohort by 2007 (control)</td>
<td>69%</td>
<td>108%</td>
</tr>
<tr>
<td>Absolute difference (between treatment and control at time 1 and time 2)</td>
<td>-5%</td>
<td>3%</td>
</tr>
<tr>
<td>Proportional difference</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Assessment of Need for Refresher Training

We assessed the need for refresher training by measuring the scores obtained by the 138 midwives who participated in this evaluation using the competency testing tools and methods that are used to assess their readiness for graduation from the education programs. This is a very limited assessment of their current skills; we did not utilize more sophisticated methods for assessing quality of care. The competency testing tools are designed to assess all aspects of students’ knowledge and skills, including their behavior towards patients such as greeting the patient. While these are indeed important for student evaluation, as health care providers gain experience, they may act on only the most important life saving steps, especially in urgent situations. Therefore, these findings must be interpreted simply as a guide for need for refresher training.

As presented in Figure 1, reasonable scores were obtained on all competencies combined - with a mean of 62% and median of 64%. Some midwives scored 100% and some scored quite poorly.

Figure 1: Distribution of all Competency scores for all tested midwives, 8 provinces combined, May, 2009

When broken down by type of competency, we see that the competency scores ranged from a low of 35% for shock management to 81% for MROP. Shock management was the lowest score by a substantial amount, with MVA, NBR, and Partograph use with moderate scores and MROP and NBR strongest.
Table 3: Results for Each of the 6 Competency Scores for All Tested Midwives, All Provinces Combined, May, 2009

<table>
<thead>
<tr>
<th>Competency</th>
<th>All Provinces (means)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual removal of placenta (MROP)</td>
<td>81%</td>
</tr>
<tr>
<td>Newborn Resuscitation (NBR)</td>
<td>76%</td>
</tr>
<tr>
<td>Eclampsia Management (Ec Mgmnt)</td>
<td>63%</td>
</tr>
<tr>
<td>Partograph Use (Partog)</td>
<td>60%</td>
</tr>
<tr>
<td>Manual Vacuum Aspiration (MVA)</td>
<td>55%</td>
</tr>
<tr>
<td>Shock Management (Shock)</td>
<td>35%</td>
</tr>
</tbody>
</table>

Figure 2 shows that there was variation found between the midwives graduated from different provincial schools, in addition to the variation between competencies.

Figure 2: Skills Competency Scores by Province, 2009

![Skills competency scores by province](image)

We also tested/assessed retention/loss of skills in all six areas among midwifery graduates from Institute of Health Sciences and Community Midwifery Education Programs. With the exception of partograph use, CME graduates scored higher on all competencies than IHS graduates. (Table 4)

Table 4: Competency Scores by School Type

<table>
<thead>
<tr>
<th>Competency</th>
<th>Type of School</th>
<th>IHS % achieved (# respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MROP</td>
<td>CME % achieved (# respondents)</td>
<td>81% (101)</td>
</tr>
<tr>
<td>NBR</td>
<td></td>
<td>80% (37)</td>
</tr>
<tr>
<td>Eclampsia</td>
<td></td>
<td>77% (101)</td>
</tr>
<tr>
<td>Partograph Use</td>
<td></td>
<td>74% (37)</td>
</tr>
<tr>
<td>Use of partograph</td>
<td></td>
<td>64% (101)</td>
</tr>
<tr>
<td>MVA</td>
<td></td>
<td>61% (101)</td>
</tr>
<tr>
<td>Shock</td>
<td></td>
<td>39% (36)</td>
</tr>
</tbody>
</table>
There are a number of factors, informed by the qualitative data in the following section, that may contribute to the results in the competency testing. These are presented in the discussion section.

4. Qualitative Interviews:

A. Interviews of Graduate Midwives

We conducted qualitative interviews with 138 midwives graduated from IHS and CME programs since 2005 in 8 representative provinces. The goal of the standardized 27-question interview was to improve the existing midwifery education program and professional deployment experience of the recently graduated midwife. The interview guide is attached as Appendix B.

The interviewers were midwives from the Afghan Midwifery Association and midwifery faculty from provinces not being assessed. They were trained in qualitative interviewing techniques by the study team in the field, led by co-investigator PM. Inter-assessor and intra-assessor reliability checks were performed (83% and 98% respectively) to ensure homogeneity of the assessors’ cohort. In order to check ensure homogeneity of the assessors group, a series of representative questions were given to them, playing the roles of assessors and midwives in turn. The exercise was repeated once again. Similarity of responses for the same assessors in the two attempts was 98% (intra-assessor reliability). The final responses of the assessors were compared to the “Gold Standard” i.e. responses developed by Pashtoon Azfar who is considered the most qualified midwife in the country. The responses of the second attempt have been on average, 98% similar to the Gold Standard. The interview responses were transcribed in Dari and translated into English. Theme analysis was done by co-investigator JR, who read both Dari and English translation transcripts. For quality control, co-investigator NA reviewed a random sample of 25% of the transcripts in English (n = 35, from all 8 provinces), validating JR’s thematic analysis.

The information collected was categorized under the following main headings:

- Strengths of the Midwifery Education Program
- Areas of the Midwifery Education Program in Need of Strengthening
- Midwives’ Perceptions of Community Impact of their Program
- Midwives’ Barriers to Provision of Care & Challenges to Impact
- Midwifery Graduates’ Recommendations for Improving Pre-service and Refresher Training Midwifery Education/Support.

i. Strengths of the Midwifery Education Program

a) General Assessment

Most of the midwives interviewed were highly satisfied with the quality of their education, rating their program on average from very good to excellent. Notable strengths of the midwifery program mentioned were: quality of faculty (who taught standardized care and used modern teaching techniques such as case studies), classrooms, learning aides such as anatomical models, and clinical training sites. The midwifery program graduates appreciated the living facilities for students whose homes were far from the school and amenities such as childcare centers.

Most of the midwives reported being able to apply the knowledge and skills they acquired during the program to their job settings. Clinical training was perceived to be strong in antenatal and postnatal care; the management of normal deliveries, retained placenta, and breech deliveries; and family planning services, whereas about half of midwives expressed preparedness in management of preeclampsia/eclampsia, shock, and hemorrhage.

There were many examples of midwives relaying stories of competence, confidence, and professional autonomy, particularly from community midwives, such as the two quoted below:
“I repaired cervical and vaginal lacerations, inserted an I.U.D that another midwife could not do, did episiotomies, removed retained placentas, did many breech deliveries, delivered twins, and managed a case of shock. All have been done on my own. This is a source of pride for me.”

“After graduating from this program, I have the ability to solve the complicated health problems of my sisters in the community.”

b) Special Strengths of the Program

**Latest Standards of Care:** Use of the partograph was repeatedly mentioned as an example of a new standard of care not previously used by previously trained physicians and midwives. Many of the midwives interviewed reported opportunities to share their updated knowledge and clinical skills, sometimes even mentoring doctors and medical students in these skills. Teaching new standards of care had a positive effect on the midwives’ levels of confidence. One hospital midwife stated: “I am really happy and feel proud that I can teach students from the medical school some of the vital skills related to gynecology and obstetrics.”

She reported that the medical student said to her, “You are lucky attending midwifery school and being trained in this new approach, because we are deprived of these kinds of opportunities.”

**Cultural Sensitivity & Professionalism:** Many midwifery graduates noted that their education program had been sensitive to local customs and values, resulting in more competent care delivered to clients. One midwife interviewee, who attributed her cultural sensitivity to training she had received in a professionalism module, said, “My client told me that you are really nice and caring, and I have not been treated this well before by other providers.”

ii. Areas in Midwifery Education Program in Need of Strengthening

a) Educational Preparedness of Students

Many of the midwives interviewed mentioned the poor educational preparedness of midwifery students who had not finished high school. Because the Community Midwifery Program initially accepted students with 6 years of schooling and Hospital Midwifery required 9 years (now increased to 9 years and 12 years minimum of schooling, respectively), students with lower literacy and numeracy skills often had difficulty grasping technical terminology and theory. Their challenges with knowledge acquisition reportedly hindered the uptake of knowledge by other students as teachers had to slow down lessons for the less prepared students.

b) Readiness of New Schools to Commence Teaching

Some midwives reported delays in arrival of training materials to new schools, including books and anatomical models, affecting the quality of their programs at start up. In addition, study participants indicated that some schools did not have adequate numbers of faculty at the beginning of the program.

c) Quality of Teaching

The data from interviews indicates that the quality of teaching offered at some established midwifery schools required strengthening. The interviewees reported that some faculty lacked modern teaching skills and could not effectively use audiovisual aides such as handouts, flipcharts, white boards, and overhead projectors. Examples of teaching weaknesses reported were: when faculty were not able to explain technical terms to students and when they did not use practical examples to ensure students had mastered the theory component of the
program. Furthermore, some faculty reportedly behaved disrespectfully toward their students, including insulting them in front of their peers and patients.

d) Clinical Rotations/ Practical Sites

The study findings reveal that some students had limited opportunities to practice midwifery skills during their clinical rotations. Sometimes, students merely observed while faculty conducted clinical care. In other locations, preceptor-to-student ratios were higher than the recommended 1:4-6 outlined in the educational standards. Low patient volume was occasionally reported as an impediment to students’ practice. The foremost challenge reported in the clinical training was incongruence between the standards of care that they were taught in midwifery schools and care witnessed in some of the clinical sites. In some hospitals, interviewees reported incidences where they observed care that was not according to standards, and sometimes life threatening to the patients, e.g. lack of compliance with infection prevention practices.

iii. Midwives’ Perceptions of Impact of their Program

a) Women’s Health Care Utilization and Community Appreciation

Since their deployment to community clinics and hospitals, the midwives have noticed a vast increase in the utilization of general health care by women in the community, with a particular rise in maternal and child health services. Prior to the arrival of the midwives, community women with no other access to female providers sought care from traditional healers, religious leaders and traditional birth attendants. In communities where midwives have been introduced, women are now much more likely to deliver at the health facility or at home under supervision of a skilled midwife. One midwifery graduate noted that the number of deliveries in the health facility where she was working, increased from 0 to 30-35 each month.

Outreach activities conducted by midwives; good community relations between the midwife and religious leaders, elders, teachers, and other influential figures; and the person-to-person spread of information have all contributed to this increased utilization of health services by community women according to the interviewees. One midwife reported that health messages have even reached some of the men in the community, who as a result of their wives’ information are now requesting family planning themselves when they visit the health clinic.

Midwives reported many examples where the local communities and those seeking care have expressed great appreciation for the quality care they have provided to their clients. In a few instances, they received public appreciation including being awarded letters of appreciation by community leaders and senior officials at the Ministry of Public Health at provincial level for their high quality care provided to women. This recognition has been a source of pride for the midwives, and has motivated them to make extra efforts on behalf of the women in their communities. For example, one community midwife reported that she walked three hours on a weekend with medicines in hand to reach a woman in prolonged labor. As a result of the midwife’s episiotomy, both the mother and her child were safely delivered.

Another midwife shared that she used a horse or motorbike to reach distant villages. In one delivery, she was summoned to the client’s home after the husband delivered the baby, resulting in the newborn’s death. “I went there with my own money, purchased serum, and removed this woman’s placenta, which had been retained. I probably saved the mother’s life and they were all very grateful.”

A third midwife relayed “In the beginning, people thought that I might be a dayee (traditional birth attendant) and would not be effective. At present, they know me as a women’s specialist and they respect me and say that I solve their women’s problems.”
b) General Community Impact: Women's Freedom of Mobility and Education

After introduction of the midwifery programs in local communities, there was a trend toward seeing more women outside their homes in some rural/conservative communities, as reported by study participants. Family restrictions against women’s mobility eased for women seeking care at the health facility and even for those attending school. As a result, the applicant pool to the midwifery programs increased. A midwife noted that when she became a midwife, the women of her community told her: “We wish to become midwives like you.”

“In the beginning, people were dubious regarding the midwifery program but after my graduation and my working amongst them, they became interested in sending their women to the program because they were surprised by my positive results,” said a community midwife.

Another echoed her words and added, “Now I am able to support my family and they are motivated to help me.”

A third said, “At first, when I wanted to study midwifery my mother-in-law didn’t want to allow me, but later she was so impressed that she sent her own daughter to midwifery school.”

iv. Midwives’ Barriers to Provision of Care/Challenges to Impact

a) Getting to clinic

**Insecurity:** The respondents reported insecurity as a big impediment to their clients’ access to care, as well as their own provision of care (particularly making home visits). Due to the re-emergence of anti-government elements, particularly in Southern Afghanistan, movement outside the homes, particularly for women, has been moderately to severely curtailed, decreasing their access to basic amenities including skilled birth attendants. Midwives’ mobility is also limited in these cases to providing only institutional-based care.

**Cultural and Family Restrictions:** Midwives reported that women in some families were still not allowed to go outside their homes without a male escort, hindering their ability to access care when needed.

**Geographical Factors & Transport Issues:** There are provinces with scattered, remote populations and unpaved roads that are not adequately served by community health clinics. Weather factors, lack of transportation options, and cost of transportation were noted by midwives as barriers to health care access for some of their clients.

**Cost Barriers:** In addition to the cost barriers of providing transportation to the health facility, some clients don’t come to see the midwives because of the expectation of informal extra payment, even though the care provided is supposed to be free of charge.

b) Barriers at Clinic

**Inappropriate Community Expectations:** It was mentioned by the study participants that at times communities requested midwives to provide sophisticated care that was beyond their scope of practice. They provided several examples, such as when they referred a severe case of pre-eclampsia / eclampsia which required hospital care including cesarean section, the relatives became upset with the midwife because she could not treat the patient herself.

**Paucity of resources at health facilities:** The interviewed midwives reported inadequate resources in the health facilities as a big impediment to the provision of quality care for women. Particular emphasis was made on the unavailability of supplies in their Maternal and Child Health (MCH) section e.g. Manual Vacuum Aspiration (MVA), family planning methods (they were sometimes limited to only one or two methods), and some basic medication to treat rudimentary ailments related to reproductive health.
c) Treatment by Other Health Providers & Position Within Ministry of Public Health

**Discrimination by other health providers (e.g. doctors):** The majority of practicing midwives report feeling discriminated against by other providers in their job setting, especially doctors. At times, their education program was belittled by their peers, particularly the limited length of training. Findings from the interviews reveal that in some health facilities midwives were openly insulted by doctors who are often in-charge of the health facility. In other instances, they were treated like dayees (traditional birth attendants). One midwife said, “The hospital director told me I don’t see a difference between you and a cleaner in this hospital.”

Almost all midwives practicing in health facilities with doctors expressed frustration at the restrictions placed upon their scope of work. Despite being trained to provide life-saving treatments such as post abortion care, management of eclampsia/ pre-eclampsia, and shock management and newborn resuscitation, the majority of midwives indicated that they were not permitted to realize their full job description as endorsed by the Ministry of Public Health because of jealousy, turf wars, and ignorance on the part of the senior physicians with regard to their program. This was a greater concern for midwifery graduates from the Institutes of Health Sciences than community midwives practicing in Basic Health Centers. Furthermore, the midwives felt stymied by job descriptions that limited their ability to prescribe simple medicines for women’s health problems.

**Lack of Team Work:** The findings from the interviews reveal that there was often a lack of cohesiveness among team members in the health facilities. According to the interviewees, the management system rarely had transparent communication channels between all members of the team, often did not understand the role of midwives, and did not share their vision and mission for the health facility.

**Lack of Civil Service Recognition by Ministry of Public Health:** Almost all study participants from the Community Midwifery Programs were concerned about not being recognized as formal civil servant employees by the Ministry of Public Health. They indicated that they felt they were not given an appropriate amount of respect by the MOPH and not treated as fully-fledged health care professionals. Some community midwives did not practice midwifery for this reason, working in other health-related jobs (such as emergency room nurse). One community midwife said, “Because I have not graduated from twelfth grade, I am working unofficially, my salary is very low, and lots of my classmates do not work. If initially I was informed about this fact, I would never have studied this midwifery program.”

v. Midwifery Graduates’ Recommendations for Improving Education Program and Integration into the Health System

- Improve educational preparation of future midwifery students by increasing minimal education requirement to 12th grade when possible (latter part, our rec)
- Strengthen curriculum and consider expanding its duration by adding depth to anatomy, physiology, pharmacology, basic out-patient women’s health problems, English, and computer classes, as well as clinical rotations.
- Ensure adequate numbers of qualified faculty are available to teach at commencement of programs.
- Strengthen faculty training before employment and offer regular refresher training to faculty.
- Ensure training materials are available before commencement of new midwifery programs.
- Standard of 4-6 students per preceptor should be enforced.
- Ensure quality clinical training, which includes provision of respectful quality care to all patients.
• Ensure that trainers in clinical sites and their supervisors understand their role as clinical trainers and are taught how to give constructive feedback. Consider merit-based incentives to clinical preceptors for quality teaching.
• Ensure MoPH clinics and hospitals are supplied with proper equipment.
• Offer regular refresher-training courses for practicing midwives, with occasional on-site clinical supervision and practical feedback by senior staff.
• Develop pre-service and refresher training for all health care providers on professional code of ethics guiding behavior towards both patients and other health care professionals. Study respondents proposed that all providers should be trained in a professional code of ethics (PCoE), as the midwives were. Their training focused on behavior towards their clients, but they noted that a similar code of ethics should be developed for inter-professional interactions, and taught to other health professionals, especially physicians as a strategy to promote healthy teamwork. (deleted part could be incorporated into discussion)
• Performance-Based Incentives and Hardship Allowances.
• Study participants proposed establishment of performance based incentive system to reward best practices, both for faculty and practicing midwives. They also proposed a hardship allowance for their peers who work in very remote, underserved and insecure areas of the country. They noted that the majority of midwives working in remote and underprivileged communities are paid relatively low salaries compared to their counter parts in urban areas, which has resulted in brain drain from public health facilities to private institutions, leaving a huge service delivery gap in those underserved communities.
• MoPH should consider increasing prescribing privileges of midwives.
• Given the scattered distribution of much of the Afghan population, coupled with unpaved roads and poor household economy; midwife interviewees suggested serious consideration should be given to discussion with MoPH on extending their right to prescribe from a short and focused list of medications, such as community health workers have.
• MoPH should recognize community midwives as full status civil servants with equal status to midwives trained by the Institutes of Health Sciences. Midwives should be allowed to practice to the full extent of their job descriptions.

vi. Interviews of Key Informants

We conducted qualitative interviews with 20 key informants from different institutions including, Midwifery School Program Directors, Provincial Health Directors, and Basic Package of Health Services Managers for each of the 8 representative provinces, as well as members of the Afghan Midwifery Association, National Midwifery Accreditation Education Board, and national Ministry of Public Health officials (Reproductive health director and representative of Human Resources Directorate). The goal of the structured interviews was to capture key stakeholders’ perceptions about the quality of the midwifery training programs and the field experience of the recently graduated midwife. The tailored interview guides are attached as Appendices C, D and E.

The interviews were all conducted by co-investigator JR in person or by phone. Where possible (i.e. face to face interviewees who consented), interviews were tape-recorded (n=13). The remaining interviews (n=7) were transcribed and translated into English. Co-investigator NA then listened to all recorded interviews, reviewed notes from the remaining interviews, and analyzed key informant main themes. Of 28 planned key informant interviews, 20 were successfully conducted. The remaining 8 interviewees were considered either non-respondents (n=4, because they were contacted at least three times and failed to be interviewed within the time constraints of the study) or inaccurately identified as key informants (n=4, because they had recently been hired and had little experience with the midwifery program). Key informant interviews included at least one person from each of the 8 studied provinces, 7 of the 8 midwifery-program-implementing NGOs, and all Kabul-based MoPH staff (RH director and representative from HRD).
The information collected was categorized under the following main headings:

- Program Descriptions; Differences between the IHS and CME Programs, including Strengths and Areas of Improvement
- Community Impact of Midwifery Programs
- Perceived Roles of the Afghan Midwifery Association and National Accreditation and Education Board in regards to strengthening midwifery education programs in the country
- Recommendations for Improving the Midwifery Programs/ Lessons Learned

vii. Differences between IHS and CME Programs, including Strengths and Areas of Improvement

All key informants understood the basic differences between IHS and CME programs—student selection process, qualifying education level of students, standards based curriculum, deployment strategy, and likely future site of work. However, few seemed to understand that the curricula are virtually identical (95% similarity) and that both programs require 18 months of study. In addition, a majority of key informants with the exception of the program directors of midwifery schools incorrectly believed that the IHS program lasted three academic years versus two.

The overwhelming majority of interviewees identified strengths of the CME program versus the IHS program, praising CME policies and practices such as appropriate student selection according to the needs of the rural communities versus an impersonalized high school qualifying exam/selection by the Ministry of Higher Education for the IHSs, successful deployment, and retention of midwifery graduates in the field. For example, one non-midwifery school program director employee at the MOPH said: “I’m very impressed with the quality of education in the CMEs. I observed several CMEs directly. They have good results with deployment and according to the feedback we’ve received from the community, everyone is satisfied.”

A CME program director articulated the feelings of many of the key informants: “The students are very much committed which is a sign of the sustainability of the program. There is also ownership of the program, because the program is implemented in close collaboration with and support from the local communities. In contrast, the IHS program is mostly urban focused, not implemented with communal support, has poor deployment results, and does not meet the needs and cultural norms of the locals. As a result, these IHS programs have exacerbated the geographical imbalance of providers in the country, as most providers are accumulated in cities leaving a huge gap in remote areas.”

One program director did not make a distinction between IHS and CME in assessing the midwifery program: “The strengths of the program are proper selection of students, a conducive and enabling environment both in theory and clinical sites, provision of facilities for students and faculty in the program, and proper deployment. Areas to be improved include establishment of monitoring and supervision system for students once they are graduated and a complete and consistent learning resource package acceptable to all stakeholders.”

Other strengths of the CME mentioned were decentralized selection of student and faculty, the diversity of midwifery students and faculty chosen, and closer coordination with the NGOs providing basic health services in their target communities. Several interviewees mentioned student selection at the IHSs and CME programs close to Kabul were more likely to involve nepotism, favoritism, and a non-transparent selection process. An MOPH employee mentioned that they planned to implement a community nursing program that replicates the principles of the CME because it was so effective.

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3 The IHS program is offered over two academic years with 6 months total break (3 months in each year) for 18 months of active training, whereas, the CME program occurs in a compressed timeframe of 18 months with fewer vacations.
Perceived weaknesses of the CME in contrast to the IHS program included weak preparation of some students who entered midwifery school with lower than 12th grade education and the fact that CME graduates were not given equal civil servant status by the MOPH.

viii. Community Impact of Midwifery Programs

All interviewees emphatically praised the positive impact of the midwifery programs on the communities they served. “Midwives are the pillars of our health system,” said one MOPH employee. “This program is 100% effective,” said another.

“Villagers are extremely supportive, appreciative, and optimistic about the impact of our midwifery programs,” said a Kabul-based reproductive health stakeholder.

Several interviewees quoted studies showing that antenatal care coverage has increased in rural areas since introduction of midwives with a concomitant decrease in infant mortality. They attributed the increase in skilled birth attendants from 5% to 19% to the midwifery program, which has increased the number of practicing midwives to over 2000 vs. less than 500 during Taliban times (another frequently mentioned statistic).

Provincial health directors were particularly complimentary about the midwifery programs, noting huge increases in the number of institutional deliveries at provincial hospitals. In one province, the PHD remarked that only 1% of women used to deliver in facilities, but now 30% do.

There was general consensus among all interviewed that newly trained midwives have played a major role in maternal death reduction, although many mentioned that this anecdotal claim couldn’t be proven unless a maternal mortality study was repeated.

According to several key informants, there were many factors limiting midwives’ impact in the community and their job satisfaction: discrimination by supervising physicians (especially at the provincial hospitals) which prevented them from living out their job descriptions and caused low morale; lack of recognition of non-high school graduated community midwives as full status civil servants by the MOPH (see end of section 1); low pay; overly heavy case load including consultation for non-maternal/child health problems; gender and cultural limitations limiting mobility; and general insecurity limiting freedom of movement, home visits, and hours of operation.

One interviewee from the MOPH admitted, “Our support to the midwifery programs are not adequate but we are committed to having more coordination with them because midwives are the back bone of our health system and if we don’t empower them, we can’t improve health in Afghanistan.”

ix. Perceived Role of the Afghan Midwifery Association (AMA) and National Midwifery Accreditation and Education Board (NMEAB)

Stakeholders universally appreciated the role of the AMA in providing technical assistance to the midwifery programs, advocating for midwives at the policy level, assessing and improving midwifery programs, and increasing community awareness about the midwifery program.

A few mentioned that the National Midwifery Accreditation and Education Board contributed to the high standards of the midwifery programs. One interviewee recommended that the NMEAB can do more to help midwives receive recognition by “Doing more education and public relations work, advocating for higher salaries and more refresher training for the midwives, and decreasing the tensions between midwives and physicians.”
**Recommendations for Improving the Midwifery Programs: Lessons Learned**

About half of the key informants’ interview time was spent on lessons learned, innovative practices, and recommendations for improving the midwifery programs. With the exception of the last recommendation in the list, those shared below were mentioned by at least three interviewees:

- **Inappropriate selection of midwifery students leads to inappropriate deployment.** The IHS selection process should be better coordinated with the Ministry of Higher Education, involve more community participation, and be more transparent in selection of students in the programs, particularly IHSs.

- **CME programs should strive to enroll high school graduates where possible.** For communities that lack sufficiently educated female candidates, strengthening literacy and numeracy prior to entrance to midwifery school is recommended.

- **When possible, married and older midwifery students should be chosen over younger and single candidates to increase the mobility of midwives upon their graduation and community respect.** It also increases the likelihood of their retention in their communities for longer periods.

- **Deployment could be improved by requiring schools to follow the successful CME model where practice sites are selected at the enrollment of the students and a contractual agreement signed by the student that obligates them to work in their selected community for five years or have to pay back the cost of their training.**

- **There is a need for more community midwifery graduates to work in provincial hospitals to improve the standardization of care at clinical practice sites.**

- **Discrimination by physicians towards midwives should be countered by in-service trainings in professionalism and ethics, and greater promotion of team-work by hospital managers.**

- **There should be greater advocacy for midwives at the MOPH level, including granting of community midwives full civil servant status, granting them basic drug prescription privileges, giving them more leadership roles, and involving them in more reproductive health policies via the AMA and NMEAB. Members of the MOPH should be oriented about the specifics of the CME program.**

- **More midwives should be trained through IHS and CME programs until there are at least 8,000 midwives (a rough estimate projection) working in MOPH facilities or a sufficient number to ensure skilled deliveries can take place 24 hours a day/7 days a week with adequate rest time for midwives between night shifts (i.e. 2 midwives assigned to the basic health centers instead of 1).**

- **Increase in-service refresher training for midwives and midwifery faculty. Eventually provide opportunities for midwives to advance their studies beyond the undergraduate level, perhaps by sending them abroad.**

- **Provide regular evaluations and supportive supervision of midwives practicing in the field. Allow them to visit other practice sites.**

- **Consider hardship pay for midwifery faculty and midwives practicing in very remote and insecure areas.**

- **There should be improved transportation for midwives and pregnant patients and a more reliable replenishing of clinic supplies.**

- **NGOs and communities should be encouraged to employ the maharam (husband or male relative) of midwives in the health facility to improve the mobility and security of midwives.**

- **Regional collaboration between midwifery schools should be encouraged with respect to faculty training, sharing of learning materials, and clinical practical sites (especially when there are problems with inadequate patient exposure and insecurity making clinical practical sites less available).**

**Innovative ideas mentioned only once:** 1) job fairs for IHS graduates may improve deployment; 2) if sufficient numbers of female physicians can’t be trained to do C-Sections in a timely way, the MOPH should consider training midwives to do C-Sections in rural areas; and 3) enrollment in midwifery schools increased when community leaders, including
religious figureheads, had their wives and daughters enroll in the program. 4) A maternal mortality study should be repeated so that the impact of the midwifery programs can be measured on maternal mortality rates.

B. Focus Group Discussions with Women in the Community

Twenty focus group discussions were conducted with female community members from 7 provinces. Assessors were midwives from AMA and midwifery faculty. They were trained by PM, JR and PA and intra-assessor and inter-assessor reliability checks were performed (88% and 100% respectively). For this purpose, towards the end of the training, the assessors were randomly assigned to four groups. Imaginary scenarios of typical health experiences of women were given to the groups. The groups played in turn the roles of assessors and clients. Consistency in eliciting similar themes during the interviews were compared among the four groups (average 88% intra-group similarity in two consecutive trials) and between the groups (in first trial 75% and in second trial 100% similarity achieved).

Women selected for the focus group discussions were in the catchment area of one of the 138 midwives interviewed and lived at least one hour’s distance from the health clinic. Because Kabul was sufficiently urban that all women lived within an hour of the midwife’s clinic, and we were not able to determine the catchment area for each facility located in the province, this province was therefore excluded from the focus group discussions. Female community members were divided into two subgroups: those who had been patients of the studied midwives (“clients”) and those who had not seen these midwife (“non-clients”). The goal of these qualitative interviews was to gauge the impact of the midwifery program--both the quality of training and post-graduation experiences--on the community, particularly on the lives of the women. The interview guide is attached as Appendix F. Questions asked focused on eliciting community women’s opinions and perceptions on their health care problems, their access to health care, their interactions with midwives, how the quality of their health care experiences with midwives could be improved, and the recruitment of future midwifery students.

General Results:

There were very few inter-group regional differences observed between provinces or between opinions of clients vs. non-clients. In some regions, malaria was more prevalent (e.g. Nangarhar) and women were under more restrictions by their husbands to go to the clinic (e.g. Saripul).

i. Health Problems Reported:

Women in all groups shared stories about pregnancy complications including bleeding, miscarriages, infections, retained placentas, and neonatal mortality. There were some anecdotal cases of maternal mortality reported among their relatives. Non-pregnancy problems mentioned most frequently were tuberculosis, malaria, mental problems, and chronic pain.

Health problems faced by their children were generally infectious disease in origin: tuberculosis, malaria, worms, skin infections, diarrhea and respiratory infections. There were many stories shared of children dying from these problems.

ii. Accessing Health Care:

Women in all groups reported poverty, transportation problems, remoteness of clinics, limited hours of the clinics’ operation, and occasionally, lack of providers as major barriers to accessing health care. A few women in the more conservative provinces (such as Nangarhar, Pakta, and Saripul) noted needing their husband’s permission to go to the clinic and occasionally being denied permission.

Common complaints about access to health care were verbalized by one woman from Badakhshan: “I am pregnant after four years and I want to deliver at the clinic, and my husband says that we do not have a donkey, money, or car. I don’t know what to do, since all the women deliver at home here. We have lots of economical problems. The poor must surrender to God’s will.”
iii. Alternatives to Accessing Conventional Health Care:

As an alternative to seeking care from a midwife or doctor, women reported seeing the mullah, dayee (traditional birth attendant), or community health worker when one existed. They bought medicines from local pharmacies and sometimes used amulets and herbal medicines.

A woman from Parwan explained, “People here are poor and wretched and do not have a school or clinic here and when they fall ill we boil herbs to cure ourselves.”

iv. Experiences of Care Provided by Midwife:

High Level of General Satisfaction: An overwhelming majority of women who had seen a midwife were very satisfied by the experience and expressed gratitude for care received, highlighting midwives who made home visits, walked 3 hours or took a donkey to see them, and worked night hours.

A satisfied patient in Saripul summarized the feelings of most women: “I am happy with the midwife. Previously there was no midwife in our village and women were suffering bleeding and their children were dying. Now thanks to God, we have got a midwife and since have not seen a pregnancy death.”

Another woman from Paktia explained the generally positive reception of midwives in her village: “People in the village are happy with them since they are female, because we cannot talk to male doctors about our problem. If we go and see a male doctor, our men will kill us. These midwives are everything for us.”

Occasional Complaints: There were a few anecdotes about experiences of poor treatment by midwives. These included being verbally insulted, being turned away because the client didn’t have enough money, and slapped in the face. In one case, a woman complained about her midwife being too young to do the job.

A client from Badghis expressed the strongest dissatisfaction: “When I was pregnant, I had a punch like pain. I went to the clinic; they told me that I was OK….There were few ladies, who were just sitting doing nothing and did not prescribe me any medicine, and I delivered at home. When we are taken to the clinic, they will not give us anything unless we die there. The midwife’s attitude was not proper with us; we have not been to the clinic since then.”

v. Improving the Quality of Care Delivered by Midwives

As general patient satisfaction was high, there were only a few recommendations about how to improve the quality of care delivered by the midwife. Most suggestions related to improving the community’s access to the health clinic (better transport, closer clinic, improved security, increasing the number of midwives serving the area and expanding the midwife’s hours of operation). A few women noted dissatisfaction with the lack of supplies in the midwife’s clinic. Many women expressed their desire for greater availability of medicines dispensed by the midwife and expanding the range of problems treated by the midwife.

A client from Herat said, “They can only solve minor problems. They cannot cure diarrhea, vomiting, abdominal pain, kidney pain and sore throat for children and adults. There should be a midwife who can help us with all these sicknesses.”

vi. Recruiting Future Midwifery Students from the Community

Overwhelmingly, women interviewed expressed enthusiasm about having their daughters and female relatives attend school and become midwives. Lack of female teachers and schools for girls, insecurity, as well as occasional male relative disapproval, were described as barriers to their daughters’ education.
DISCUSSION:

Substantial efforts by the MOPH, donors, technical partners and implementing NGOs revitalized a non-functional midwifery education programme that launched 27 midwifery schools in 29 provinces in 6 years. Another 5 schools will become functional soon, for a total of 32 schools serving all 34 provinces. Almost 2000 women have graduated as midwives (n=1961) - an increase of almost four times the number in 2002 (n=467). This is a notable achievement reflecting both on the motivation of Afghan women and their families and on the quality and cultural acceptability of the education programs.

The distribution map of midwives shows that the supply of skilled birth attendants is substantial in most provinces, with the greatest density in the eastern part of the country and Kabul and moderate density in the west. A number of provinces, notably the Southern and west central provinces – Ghour, Daikundi, Uruzgan, Helmand, Nimroz, Kandahar, Zabul, Paktiya and Ghazni - continue to have very low coverage of midwives. This is heavily influenced by the insecurity in this region, however, five provinces (Faryab, Ghour, Daikundi, Uruzgan and Helmand) are planning to open schools. The schools in these provinces, which are more challenging to access due to insecurity and rural geography, will begin to address the shortage.

We found that 16% more graduates from the CME programs were working in May, 2009 than IHS graduates, indicating an area for strengthening. The graduates who are actually deployed from either CME or IHS have close to the same success at continued employment. This indicates that the IHS programs have less success in deploying women who graduate, i.e. a greater number of IHS graduates have not utilized their training as midwives. The CME programs that use the community buy in process for student recruitment and deployment have up to 100% of their students still working as of the end of the Phase 1 evaluation period (Appendix A).

The analyses of HMIS data shows that in provinces with midwifery schools that had graduated students by 2007, ANC visits increased by 17% and delivery with a skilled birth attendant increased by 40%. While these estimates should be interpreted with caution due to other factors which could have impacted on increasing usage of SBA. For example, in the more secure and geographically accessible provinces where schools were more likely to be established, general development efforts such as improved roads, transportation, communication, clinics, and educational campaigns may have also contributed to the use of skilled birth attendants and antenatal care. However, it is reasonable to assume that the presence of new midwives has contributed to this success. Data from health surveys support this: A cross-sectional study reported in American Journal of Public Health on Determinants of Skilled Birth Attendant Utilization in Afghanistan indicated that among other factors like income and literacy, women who lived within 60 minutes of a facility with a female skilled birth attendant had significantly higher rates of deliveries with a SB, whereas women who lived near facilities that had a male health attendant had significantly lower rates of delivering with a SBA. (Mayhew M., 2008)

We employed one of the competency testing methods that is used to assess students’ skills and knowledge prior to graduation. An important difference, however, is that students are given multiple chances to attain the passing grade required of 100%, whereas in our assessment we allowed only one chance. The mean score for all competencies and all provinces was 62%, however, the data reveal that scores ranged widely by the individual, the type of school that they graduated from, province, and the competency assessed - some scores were very poor while 100% scores were also achieved. Shock management was consistently the lowest score, eclampsia management, use of partograph and MVA were of intermediate level, and MROP and NBR the highest. We found that CME graduates scored higher on almost all competencies than the IHS graduates.

Information from the qualitative data elucidated the results of the competency testing. Midwives reported that there were limited opportunities in the education program to practice certain skills (in particular MVA and shock management) due to the low patient volume and greater than recommended student/preceptor load in some clinical sites, and also because of barriers to practice procedures such as MVA and manage shock in some work settings. In addition, unavailability of equipment, supplies and instruments also contributed to lack of practice of MVA. Finally, delayed employment and consequent inability to practice skills was also reported by some midwives as contributing to their discomfort with some procedures.

The competency testing was a very limited assessment of the midwives current skills as we did not utilize more sophisticated methods for assessing quality of care such as direct clinical observation and patient exit interviews. The competency testing tools are designed to assess all aspects of students’ knowledge, including their behavior towards patients such as greeting the patient and asking them to sit. While these are indeed
important for student evaluation, as health care providers gain experience their practice changes, becoming more intuitive and reflective. Practicing midwives are likely to be in situations where they need to act urgently to save lives, and thus as they become more experienced and proficient, act only on the most important life saving steps. Therefore, these findings should be interpreted simply as an indicator of the need for strengthening pre-service education, particularly during clinical training, and for continuing education or refresher training, and supportive supervision after graduation - recommendations that were strongly supported by the information from the qualitative interviews. A more in-depth analysis of clinical quality of care could be considered to better guide quality of care improvement activities.

The three groups interviewed— midwives, key informants and community members- provided remarkably similar information on their attitudes and knowledge of the midwifery education program and recommendations.

The midwives reported high overall satisfaction with the quality of their training, in particular the standards-based practice curriculum, the cultural sensitivity with which the programs are organized (safe, private housing for the students, availability of a crèche for childcare) and appreciation for the professionalism with which they were treated and were taught. They reported a high level of appreciation from the community. While they said that insecurity and cultural restrictions were a barrier to accessing their clients (and vice versa), particularly in the southern and southeast provinces, they reported increased utilization of health services by the women in communities that they served, and increasing enthusiasm by community members for female education since their deployment to those communities.

Noteworthy areas for strengthening include their observation that students with less than 12 years of education had greater difficulty with the curriculum. Perceived discrimination by other health providers, especially doctors, and lack of recognition of the community midwives as equal civil servants were frequently mentioned subjects in need of improvement.

The key informants praised the CME program as particularly successful, especially regarding community involvement with student selection (where practiced), geographical representation throughout provinces with CME, and the high deployment and retention of graduates. They also identified discrimination by other doctors and lack of civil service status (MOPH status) as challenges to the program that should be addressed.

The women in the communities reported a high level of satisfaction with the care received from the midwives. They expressed the wish that midwives could prescribe medicines and attend to other common general health problems. Poverty, transportation challenges, insecurity, cultural restrictions in movement, and limited hours of clinic operation were identified as the main barriers faced to accessing care from midwives, more so in some areas than others. When asked about other positive effects on the community in addition to access to midwifery care, an important finding was that the midwives had a positive impact as role models - women reported increased support for girls’ education by the community in general, and the vast majority said that they were willing to send their female family members to midwifery school.

Important recommendations were shared by midwives and key informants:

- **Improve educational preparation of future midwifery students by:**
  - Increasing the minimal education requirement to the 12th grade for CME program when possible or
  - Providing supplemental literacy/numeracy courses prior to midwifery school enrollment.

- **Improve student selection of IHS program by working with Ministry of Higher Education.**

- **Improve deployment by requiring all schools follow the successful CME model where practice sites are selected at the enrollment of the students and a contractual agreement signed by the student and their community.**

- **Continue quality improvement of pre-clinical and clinical training and initiate refresher training and supportive supervision**

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- Consider expanding the midwifery curriculum to include basic primary care
- Expand the list of allowed medications which midwives may prescribe.
- Provide hardship allowances to faculty and midwives in difficult settings (rural and/or insecure)
- Offer professionalism and ethics courses for all health personnel, especially doctors
- Community Midwives should be recognized as full status civil servants by MOPH

In addition, the midwives offered a number of specific recommendations on strengthening the education programs (pages 20, 21) including expanding the scope and possibly length of the curriculum by adding depth to anatomy, physiology, pharmacology, basic out-patient women’s health problems, English, and computer classes; ensuring adequate number and quality of qualified faculty are available to teach; ensuring training materials are available before commencement of new midwifery programs; ensuring quality clinical training where a standard of 4-6 students per preceptor is not surpassed, and respectful quality care for all patients is enforced; and ensuring that MOPH clinics and hospitals are supplied with proper equipment.

The key informants also offered a multitude of helpful recommendations (pages 24, 25), including selecting married and older students when possible who can travel more easily to communities and who are met with greater respect by communities, continuing and expanding midwifery programs until a sufficient number exists to ensure skilled deliveries can take place 24 hours a day/7 days a week in all MoPH facilities, encouraging NGOs and communities to employ the maharam (husband or male relative) of midwives in the health facility to increase midwives security and mobility, and planning for regional collaboration between midwifery schools. Other innovative ideas mentioned included holding job fairs for IHS graduates which may improve deployment; consider training midwives in underserved areas without physicians to do C-Sections; repeat a maternal mortality study to measure progress in mortality reduction, and encourage community leaders, including religious figureheads, to enroll their wives and daughters in midwifery education which was seen to increase enrollment in some areas.
CONCLUSION

Clear and substantial progress has been made in Afghanistan since 2002 when the international community responded to the emergency health and development situation after the fall of the Taliban. With maternal health the primary priority of the MoPH, motivation to increase skilled birth attendance stimulated the development of an innovative midwifery education program.

Despite daunting challenges including increasing insecurity and cultural restrictions on women’s education, employment and mobility, the program has been remarkably successful. All 34 provinces currently have or soon will have access to midwifery schools, the number of professional midwives quadrupled and are deployed across the country.

The relatively higher rates of skills retention and successful deployment for CME graduates in comparison to IHS graduates indicate that involvement of community members in selection of student for midwifery education programs is a valuable approach for increasing female human resources for health. This approach can be considered in other programs such as IHS and community nursing programs in future.

The midwifery program not only delivered services to women, substantial health system strengthening was accomplished through capacity development of MoPH staff, particularly at central level (human resources department) and provincial MoPH and health facilities to support the provincial schools.

A number of useful recommendations came from this evaluation – largely directly from the midwives, key informants and community members. The information gathered indicates that the midwifery education program, especially the CME was well conceived and implemented. Coverage and utilization of maternal health services has improved, overall and more so in provinces with midwifery graduates. Informants reported fewer maternal deaths in facilities and communities with midwives than seen previously. While not documented quantitatively as yet, midwifery has likely also reduced maternal and newborn morbidity, disability and mortality. There are clear areas for strengthening in the midwifery education program, which will further reduce maternal and newborn mortality in a sustainable manner.
Annex 1: Data collection tools

Interview Questionnaire for Graduated Midwives working in health facilities

بخش A: با استفاده از سوالات ذیل با جواب دهنده گان مصاحبه نمایید

ورق معلومات را برای هر یک جواب دهنده گان خانه پر نمایید

• جوابات را باید یک طرف ورق سفید بنویسید
• کود مخصوص ورق جوابات را باید هر صفحه ورق جوابات بنویسید
• ورق جوابات را شماره گذاری نمایید

در اینجا بگذارید تا جواب دهنده گان به ت매یل خود جواب دهنده و بعد با پرسشات بیشتر فراخوانید، هیچگاه سوالات ثلثی (به همانندی کننده) را مطرح نازند.

• در سری‌نهایی جواب دهنده نظر دیگر نداشت، مشاهدات خود را بنویسید.
• مشاهدات خود را از جوابات جواب دهنده با یک خط مستقیم جدا مسازید.
• جوابات مشابه را با دو خط موارد جدا مسازید.

Education Program description

تفصیل پروگرام تربیوی

• موضوعات در جریان پروگرام تعلیمی قابلیت گی شناختن کدامها چه بودند در مورد هر یک معلومات مختلف دهد؟
• زمانیکه شما محصل بودید آیا در پروگرام شما کدام نگرانی عده صورت گرفت؟

Effectiveness of education program to prepare students for practice

موثریت پروگرام تربیوی در آماده سازی محصلین برای فعالیت عملی

• درباره کیفیت تعلیم و تربیت که حاصل کردنی چه نظر دارید؟
• در کدام یکیکی کلیدی خود را بیشتر راحت احساس می‌کردید؟
• در کدام یکیکی کلیدی خود را کمتر راحت احساس می‌کردید؟
• برای اینکه محصلین آمده از موارد مکنون منفی پنهان یا بهبود پروگرام جه مشوره می‌دهید؟
• چه نوعی تعلیمی که حاصل کردنی به نظر شما کدامها است؟
• چه نوعی تعلیمی که حاصل کردنی به نظر شما کدامها است؟
• هنگام که فارغ شدید، ایا خود را بیانی انتظار خدمات متقابل به خلیم ها شما کمایی کرده؟
• چه فناکیکی که چگونه می‌توانیم پروگرام را بهبود بخشیم تا فارغان آمده خود را بهتر آماده کار کنند؟

Moanings in Barriers to quality care in line with the program

Barriers to ability to deliver quality MNH care

• موانع در برابر عرضه خدمات با کیفیت برای مادران و نوزادان

• موانع در برابر عرضه خدمات به پیشنهاد شان می‌گردد، در اینجا بگذارید تا جواب دهنده به تمامی خود جواب دهد بهداشت سال مانند حسن، می‌تواند محور جنیام در جرعت دادن تروریسم و سیل به مهاجران و غیره.
• ایا می‌توانید راه‌هایی را پیشنهاد کنید که این موانع را کمتر سازد.
Impact

13. Is the programme delivered by a certain entity having an impact on site or not?
14. Is the programme target meaningful by any other means during the programme?
15. Is the programme delivered with any other entity that benefits from the programme?
16. Is the programme delivered by different entities?
17. Is the programme delivered by different entities?
18. Is the programme delivered with other entities?

Lessons learned

19. From the experience of providing services, do you think it can do any better?
20. From the experience of delivering services, do you think it can do any better?
21. From the experience of delivering services, do you think it can do any better?
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<td>شماره سوال (27) را در بالای پارتوفگراف که جواب دهنده می‌کند بنویسید</td>
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<th>بخش C: مشاهدهات مهارتها</th>
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<td>1. ورق معلومات □</td>
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<td>2. جوابات سوالات 1 الی 27 □</td>
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<td>3. پارتوفگراف (سوال 28) □</td>
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<td>4. تمام اراظ جوابات سوال 29 □</td>
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<td>5. چک لست خانه بری شده احیا مجدد طفل نوزاد □</td>
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<td>6. چک لست خانه بری شده خروج پلاستیا با دست □</td>
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Page | 26
(Manual Vacuum Aspiration)

7. چک لست خانه بري شده
8. چک لست خانه بري شده تداوی بري آكليپسيا

پيش از آغاز مصاحبه بعدي و يا خارج شدن از كليسه، لطفا خود را مطمن سازيد كه مراحل ذيل را تكميل نموده ايد

9. تمام اوراق ذكر شده فوق را در يك پاکت گذاشته
10. اسم خود را و کود مخصوص را در بالای پاکت بنويسيد
11. پاکت را ببينيد
12. هر دوارزيابي كننده بالاي پاکت سيل پاکت امضا نماید


**سوال 28 پارتودیآف را جواب بدهید:**

*دستورالعمل عادات* به تاریخ 29/8/2000، ساعت 05:00 داخل پاسخگویی.

- تمرکز جعبه استوانه‌ای به ساعت 04:00 صورت گرفته است.
- گزارش‌های پدیده (P. پادشاه 3، پادشاه 2+0 عادات 3) + عادات 2
- شمار شناخته‌ شده 7868

در زمان دخول سر جنین به اندازه 4/5 بالای ارتفاع عانه قابل جنین بوده و عمق رحم به اندازه 2 cm (۲ سانتی‌متر) توسع داشت.

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<td>رأس جنین به اندازه 5/3 بالای ارتفاع عانه جس می‌شود. عق浓度 به اندازه 5 سم توسع نموده است.</td>
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- سه تقویف در 10 دقیقه هر 20 دقیقه دوام دیگه.
- حرکت قلب جنین (FHR) 120/min (FHR) در دو دقیقه است.
- تمرکز جعبه و مامی‌بایین شونده است.
- درز های استخوان های جمجمه مانند هم‌دست چهار دارند.

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<th>فشار خون</th>
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<td>نبض</td>
<td>80 دقیقه</td>
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- مقدار ادرار 200 ملی‌لیتر، پروتئین و استون متفق.

**معلومات دقیق در پارتودیآف ترسیم نمایید:**

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حرارت 37°C

جه شناسی 2/5

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<td>13:00</td>
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<td>90/min</td>
<td>حرارت 37°C</td>
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سر جنین به اندازه 5/0 بالای ارتفاق عانه قابل حبس است.

- عمق رحم کامل‌اکنون‌توسع شده.
- مابع امینوتیک شفاف
- درز استخوان های جمجمه مقابل هم‌دیگر قرار گرفته
- فشار خون 100/70 mmHg
- مقدار آدرار 150 ml پروتئین و استون آدرار منفی

ملاحظات ذیل در پارتوگراف ثبت گردید:

13:20: تولد بنفسهی کودک به جنسیت دختر بوزن 2850 g
استفاده از پارتوگراف، کلید جواب
Case Study Shock Due to Hemorrhage

M. M. A. 29. ماينغ هول. مكتوبه: شاك آباد خونرزي مهبلی بعد از ولادت

خانم عاصمه 4 ساعت قبل یک توزون کامل به تم راه در خاک به دنیا آورده است و یک محل در داخل داده است. او فعالی را به شفافیت آورد است زیرا او وارد خونرزي شديد مهبلی دارد. مدت درد حالت یازیم 12 ساعت بوده است، ولادت نمرال و پلاستی نیز. دفعات بعد از ولادت نوزاد خارج شده است. خانم "عاصمه" دفعات یک اسب قرارداشت و یک دفعه در امکان ملاقات داشته و در حالت کاهی اسب درآمده است. در روز روز دارند محصول در این خانم به مرحله یازیم داخل میشود به خاک و همچنین از خواهر رخ نزدیک تحقیقات مهربانی خونرزي یا نمود و درصورت ضرورت به خون خواهش را متوقف به دانگ خون کرده بود.

ارزیابی (تاریخچه، معاینه فزیکی، طرز عمل های تولید بون/معاینه لابراتواری)

1. کدام مشکل را در ارزیابی تان از خانم عاصمه شام خواهید نمود و چرا؟
2. کدام فست خاص معاینه فزیکی خانم عاصمه شما را کمک خواهید نمود تا تشخیص را عاجلی نموده و با مشکلات و ضروریات او را مشخص نمایید و چرا؟
3. کدام بروسیکه تی که تشخیص/معاینه لابراتواری (در صورت موجودیت) را شما در ارزیابی خانم عاصمه شما می سازد و چرا؟
4. به اساس این دریافت ها تشخیص خانم عاصمه چه است و چرا؟
5. به اساس تشخیص پلان مراقبت و تداوم شما برای خانم عاصمه چه است و چرا؟

تشخیص (مشخص ساختن پرایم های‌یا اساس)

شما ارزیابی تان را از خانم عاصمه تکمیل نموده اید و دریافت های اساسی شما قرار دار می باشد:

• سرعت نیش 120/minute، فشار خون 80/60 mm Hg
• تعداد حرکات تنفسی 24/minute
• درجه حرارت خانم عاصمه 36.8°C
• او خاص است و عرق دارد.
• رحم وی نرم است و با صعبه غور رحم، تقلیل نیمی کند. او خونرزي شديد مهبلی که داری رنگ سرخ وروس است دارد.
• دایه محل وی میگوید که او فکر می‌کند که پلاستی نیز اگر و اغتش مکمل بوده است.
• چرا؟

تیپه مراقبت (پلاتگارژی و مداخلات)

5. به اساس تشخیص پلان مراقبت و تداوم شما برای خانم عاصمه چه است و چرا؟

ارزیابی:

پازده دفعه بعد از شروع تداوی رحم وصورت شده ومددار خونرزي کاهش یافته است، سرعت نیش 110/minute، فشار خون 80/60 mmHg است. مرض خاص، عرق آبود ومتوجه به نظر می‌رسد. مقدار همگلی پن دریافت شد وشاید در حدود 3 باشد.

• گروپ خون خانم با گروپ خون خواهرش یکسان می‌باشد.
• چرا؟

6. به اساس این دریافت ها ادامه پلان تداوی شما برای خانم عاصمه چه است و چرا؟
ورقة ثبت جوابات
شکایت بیان خونریزی مهیله بعد از ولادت

ارزیابی (تاریخچه، معاینه فزیکی، طرز عمل‌های تلوزیونی/معاینات لارتروانی)

۱. کدام مسالی را در ارزیابی تأثیر خانم عاصمه شامل خواهید نمود و چرا؟

<table>
<thead>
<tr>
<th>نمره مجموعه: ۱</th>
<th>بر ۱۱</th>
<th>احوال پرسی</th>
<th>مهربانی و احترام</th>
</tr>
</thead>
<tbody>
<tr>
<td>نبض سریع و ضعیف</td>
<td>فشار خون &lt; ۹۰ mmHg</td>
<td>خسافت</td>
<td>چلد عرق دار و سرد</td>
</tr>
<tr>
<td>چلد هموار خانم ناک</td>
<td>تنفس سریع</td>
<td>اختلال حواس</td>
<td>دیدن خروج پلاستیک و سختی رحم</td>
</tr>
<tr>
<td>کامل بودن پلاستیک و آغشه آن</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

۲. کدام قسمت خاص معاینات فزیکی خانم عاصمه شما را کمک خواهید نمود تا تشخیص را عاجلاً نموده و یا مشکلات و ضروریات او را مشخص نماید و چرا؟

<table>
<thead>
<tr>
<th>نمره مجموعه: ۱</th>
<th>بر ۶</th>
<th>دیدن تقلیل و سختی رحم</th>
</tr>
</thead>
<tbody>
<tr>
<td>اگر هم تقلیل نکرده باشد، مسّاز رحمی هر چه عاجل تر شروع گردد</td>
<td>معاینه بخاطر یاره</td>
<td>عجان</td>
</tr>
<tr>
<td>گی ها:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

۳. کدام پروسچر های تشخیصی/معاینات لارتروانی (در صورت موجودیت) را شما در ارزیابی خانم عاصمه شامل می‌سازید و چرا؟

<table>
<thead>
<tr>
<th>نمره مجموعه: ۱</th>
<th>بر ۲</th>
<th>تشخیص (مشخص ساختن پراپلم‌های/نیازها)</th>
</tr>
</thead>
<tbody>
<tr>
<td>به اساس این دریافت یا تشخیص خانم عاصمه چه است و چرا؟</td>
<td>مشکوک به رحم اوتونیک</td>
<td></td>
</tr>
<tr>
<td>شکایت از اسیب خونریزی بعد از ولادت</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
به اساس تشخیص بلان مراقبت و تداوی شما برای خانم عاصمه چه است و چرا؟

<table>
<thead>
<tr>
<th>فعالیت‌های کمک و همکاری شود</th>
<th>مراقبت باید نهایت گذاشته شود</th>
</tr>
</thead>
<tbody>
<tr>
<td>اکسیژن توسین به مقدار 10 یونیت از طریق عضله</td>
<td>مراقب به یک پهلو‌فر و داده شده</td>
</tr>
<tr>
<td>تطیق اکسیژن به مقدار 8-6 L/minute</td>
<td>مراقب گرم نگهداری می‌شود</td>
</tr>
</tbody>
</table>

بی‌خیال، فشار خون، و ضایعات خون را در 15 دقیقه تحت نظر قرار گیرید.

محولات وریدی با استفاده از سریعه‌سازی کلات: یک لیتر محلول سوپر کلورید و یا محلول رنگر لکتات در ضرورت (10-15 دقیقه تطیق نمایید).

بنابراین مقدار معادلات گرفته و مقدار ادرار با تطبیق کنترل.

<table>
<thead>
<tr>
<th>تهیه خون برا ی مراقب</th>
<th>تغییر هموگلوبین</th>
</tr>
</thead>
<tbody>
<tr>
<td>گرفتن خون از مراقب</td>
<td>تعیین گروپ خون و گزارش</td>
</tr>
</tbody>
</table>

توجه تأمین مراحل که برای تداوی یا منجمد.

امتحانات که شود: 40 یونیت اکسیژن در تهیه مراقب، تشوب مراحل جهت نگهداری 60 ساعت.

بی‌خیال: گوش داده به نمی‌باشد با دقت، حمایت عاطفی و اطمینان دادن.
Newborn Resuscitation

20. احتیاج مجدد نوزاد

<table>
<thead>
<tr>
<th>مرحله/وظیفه</th>
<th>تمرین</th>
</tr>
</thead>
<tbody>
<tr>
<td>آماده‌گی</td>
<td></td>
</tr>
</tbody>
</table>

1. لباس‌های نوزاد را کشیده، نوزاد را به خوب خشک نموده و با لباس‌های گرم و خشک به‌پوشانید.
2. نوزاد را بالای یک سطح پاک و گرم گذاشته و تمام توانای آن را به استثنای ویژه یا صدای‌پوشانید.

استفاده از ماسک و bag

1. راس نوزاد را اندازی بخاطر سمت قرار دهید تا طرف تنفسی باز گردد.

2. طرق تنفسی را با سکش‌پراک نمایید طوریکه: 
   - کنتر را داخل دهن نوزاد نموده و در انتای خروج آن از سکش نمایید.
   - در انتای سکش کردن باز خوب دفت شونده‌ای خون و موکوکسیون اگر از افراد بینی و دهن موجود می‌باشد دبه.
   - اگر بعد از سکش‌کردن طریق تنفس هنوز هم نوزاد تنفس نکرده نمی تواند به عمل ان تخته تنفس مصنوعی شروع نماید.

3. "فوای" وضعیت راس نوزاد دوربای چک گردتا مطمئن شید که گردن در وضعیت اندازی بست قرار دارد.

4. ماسک سایز 1 برای نوزادان که وزن نوزادان که وزن کمتر دارند(اضافه گردید).

5. نظر به سایز خریده انا فقط با دو انگشت و یا با همه دست فشار می‌دهم.

6. بعد از هر دو ساعت تنفس مصنوعی دوردور ماسک را با بالا آمدن صدر را چک نماید.

7. اگر صدر نوزاد در انتای تنفس بالا نماید:
   - تنفس مصنوعی 40 بار در یک دقیقه داده شود.

8. اگر صدر نوزاد در انتای تنفس بالا نماید:
   - وضعیت راس نوزاد دوربای چک گردتا مطمئن شید که گردن در وضعیت اندازی بست قرار دارد.
   - ماسک را بالای وجه نوزاد دوباره وضعیت داده تا تمام این "ماسک باحال وجه، گرفته و کدام سرویک با دری باقی نماند.
   - خروج پلاک یا با همه دست فشار می‌دهم با bag گردید.
   - سکش‌کردن و بینی تکرار کنید تا مخاط، خون، و موکوکسیون از طرف تنفسی خارج گردد.

9. 
   - با مسدود ید دقیقه برای نوزاد تنفس مصنوعی داده شود و در صورت مسئول درک کنی از آن استفاده
   - گردد و عملیات را توقف داده فوراً "نوزاد رابغاط تنفس تنفسی به‌پوشانید و نگه گذاری ارزیابی نمایید:
   - اگر تنفس مصنوعی 40 - 60 نسمت (در دقیقه) تنفس مصنوعی را توقف داده و نوزاد را به‌پلیوی مادر گزارید
   - تا نتمس نوزاد به جلد تامین گردد.
   - اگر نوزاد سیاه‌پویی کرده (central cyanosis) یا لیپا و زبان کرده، فرمول‌گی چرب صدری (chest in) دارد اگر نوزاد سیاه‌پویی کرده (central cyanosis) یا لیپا و زبان کرده، فرمول‌گی چرب صدری (chest in) و تعداد حرکات تنفسی کمتر از 30 در دقیقه، ناسی نمایید.

grunting و (drawing)
<table>
<thead>
<tr>
<th>مرحله/وظیفه</th>
<th>تمره</th>
</tr>
</thead>
</table>
| 10. اگر نوزاد شروع به گری نماید، تنفس مصنوعی را توقف دهید و بعد از ختم گری تعداد حواکبه تنفسی وی را ابراش مدت یک دقیقه شمارید: | چکرتن نوزاد سلامت در گرد (60-20 تنفس در دقیقه) تنفس مصنوعی را توقف دهید.  
اگر نوزاد سیالوزمرکی (central cyanosis)  
اگر نوزاد سیالوزمرکی (grunting)  
زجرت تنفسی زفری (drawing) و تعداد حواکبه تنفسی کمتر از 20 آن 30 در دقیقه تاسس.  
نمایید و را ابرای مشکلات تنفسی تداوی نمایید.  
اگر تنفس gasping دارد، دارد دارد  
اگر تنفس gasping دارد  
ناکب کیوی  
ناکب کیوی  
ناکب کیوی  
دیدار دیدار دیدار  
دیدار دیدار دیدار | چکرتن نوزاد سلامت در گرد (60-20 تنفس در دقیقه) تنفس مصنوعی را توقف دهید.  
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اگر تنفس gasping دارد، دارد دارد  
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ناکب کیوی  
ناکب کیوی  
ناکب کیوی  
دیدار دیدار دیدار  
دیدار دیدار دیدار |
| 11. اگر نوزاد بعد از گرمایش با اسکایجی کردن تنفس مصنوعی بطور منظم تنفس کرده نمی‌تواند: | تنفس مصنوعی را همراه با اسکایجی ادامه دهید.  
در صورت امکان انتقال نوزاد را تنظیم نموده و وی را به یک مرکز که خدمات بهتر را ارائه می‌دهد.  
(tertiary center) | تنفس مصنوعی را همراه با اسکایجی ادامه دهید.  
در صورت امکان انتقال نوزاد را تنظیم نموده و وی را به یک مرکز که خدمات بهتر را ارائه می‌دهد.  
(tertiary center) |
| 12. اگر نوزاد بعد از گرمایش تنفس مصنوعی را برای 20 دقیقه تنفس مصنوعی با اسکایجی  
ونفس موجود نباشد بايد تنفس مصنوعی را پايان دهد: | مادر و فاصله از نظر عاطفي قطعی گردد. | مادر و فاصله از نظر عاطفي قطعی گردد. |

**Procedure**

1. کنتر سکشی را برای 10 دقیقه در محلول کلروفین 0.5% یخالت می‌گذارید.  
2. سطح ما سک و خریطه تنفس مصنوعی را همراه به اوک دار 90-60 با کلروفین 0.5%پک نموده و فوراً  
شسته شود.  
3. دست ها اه همراه آب و صابون کامل" بشوید و همراه به انتهای تمیز و پاک خشک نمایید و با کراپی تا در هوا  
خشک گردد.  

مجموعه از (17)
دست برای خروج پلاسنتا وظایف

<table>
<thead>
<tr>
<th>مرحله/وظیف</th>
<th>تمره</th>
</tr>
</thead>
<tbody>
<tr>
<td>آماده‌گی</td>
<td></td>
</tr>
<tr>
<td>۱. سامان آلات مورد ضرورت تهیه نماید.</td>
<td></td>
</tr>
<tr>
<td>۲. کار اکریلیک نگهداری انجام داده بی‌خانم گوگرد، به وی گوش داده به سوالات و تغذیه‌های با دانشجوی پاسخ دهد.</td>
<td></td>
</tr>
<tr>
<td>۳. تا حد امکان تقویه عاطفی دوستان و آمیختگی با خانم فراهم نماید.</td>
<td></td>
</tr>
<tr>
<td>۴. از خانم تلقی شود تا ماهانه خودرا تخلیه نماید و در صورت ضرورت کنتر ماهانه تطیف گردد.</td>
<td></td>
</tr>
<tr>
<td>۵. انتظار داده شود (رندهی و داریمیان از طریق ورد).</td>
<td></td>
</tr>
<tr>
<td>۶. یک دوز واحد اسید پونچیک داده شود:</td>
<td></td>
</tr>
<tr>
<td>• امپیلین ۲ گرم از طریق ورد جمع میترودازول ۵۰۰ میلی گرام وریدی.</td>
<td></td>
</tr>
<tr>
<td>• سیفازولین ۱ گرم وریدی جمع میترودازول ۵۰۰ میلی گرام وریدی</td>
<td></td>
</tr>
<tr>
<td>۷. مانه‌های محافظتی شخصی را بپوشند.</td>
<td></td>
</tr>
</tbody>
</table>

کشیدن پلاسنتا توسط دست

<table>
<thead>
<tr>
<th>مرحله/وظیف</th>
<th>تمره</th>
</tr>
</thead>
<tbody>
<tr>
<td>۱. دولت ها و ساده‌ها را کامل‌اندازه و راهنمایی‌های پزشک و دی‌پزشک را با یکدیگر تا در این مهارت‌ها آموزش دهید.</td>
<td></td>
</tr>
<tr>
<td>۲. سکشک‌های معمول سطح عالی‌ترین جراحی را در هر دو دولت بیوپسی ثبت نمایند. (یادداشت: در صورت موجودیت، سکشک‌هایی که تا آنجای استفاده شده است)</td>
<td></td>
</tr>
<tr>
<td>۳. حبل سروی را با یک پنس بگیرید.</td>
<td></td>
</tr>
<tr>
<td>۴. حبل سروی را با مالیم تن‌ریزی کنید که اطمینان کننده نماید.</td>
<td></td>
</tr>
<tr>
<td>۵. انجکتیون پس‌دست را داخل ماهی و جفت رحم نموده و حبل سروی را تعیین نمایید تا به جایی پلاسنتا قرار دارد و بررسی.</td>
<td></td>
</tr>
<tr>
<td>۶. موقعیت پلاسنتا در جفت رحم نشیب گرفته و حبل سروی را با یکدیگر تا دست خود را بیش از یک باند بفروش. (یادداشت: رحم جلوگیری uterine inversion جدایی را تا جایی از حادثه شود و از حبل و رحم تلقی جلوگیری شده باشد.</td>
<td></td>
</tr>
<tr>
<td>۷. انجکتیون دست را داخل جفت رحم قرار داده تا جایی که یکی یا دو قسمت از صورت پلاسنتا در جفت رحم قرار دارد.</td>
<td></td>
</tr>
<tr>
<td>۸. انجکتیون دست داخل حبل در جفت رحم را برای زندیک بهم گرفته و با مالیم تن‌ریزی کنید. پس از ورود به پلاسنتا در حیات و حفظ رحم قرار دهد.</td>
<td></td>
</tr>
<tr>
<td>۹. تدریجی دست را به طرف قدم و خلق با حرکات جنبی ماهی انجکتیون در جفت رحم نمایید از جدار رحم جدا شود:-placenta مشکوک شود و ترینتیات داخل جراحی را بگیرید.</td>
<td></td>
</tr>
</tbody>
</table>
10. موقع که پلاستنی کاملًا چند گردید:
   • داخل جوهر رحم را جس‌نمایی تا مطمئن شوید که تمام پارچه‌های پلاستنی کشیده شده باشد.
   • دست را همراه پلاستنی به آهستگی از هم پشتی کنید.
   • کشیدن مقابلی را در وحی رحم بطور دوامدار با تهیه نمودن غور به جهت محالف دست که خارج می‌نماید، فراهم نمایید.

11. ۲۰ بون، اکسی توسین را در یک لیتر محلول وریدی مخلوط نموده بمقادیر ۹۰ کریپت در دقیقه تطبیق نماید.

12. از یک اسپینتان نفاشا گردید که غور رحم را مسائل به‌دست در انت‌نیک تحريك شده و تخلص نمایید.

13. در صورت که خون‌ریزی دوامدار باشد، بمقادیر ۲ ملی‌گرم ارغونموایی پرستاگالاکلیدین از طریق عضله تطبیق گردید.

14. سطح حجمی پلاستنی را معاونهتمامی که مطمئن شوید که مکمل است.

15. خام赛车 جیب چرخ عنق رحم، و مهیلرا ترمیم نمایید و با آیژی بیوتومی را ترمیم نمایید.

وظایف بعد از عملیه

1. هر دو دست‌خورده‌که دستکش دارد در محلول۲۰٪ کلورین برای مدت زمان کم داخل نمایید و بعداً
   • دست‌خورده‌که دستکش دارد در محلول۲۰٪ کلورین برای مدت زمان کم داخل نمایید و بعداً می‌باید منا می‌نماید و بعداً استفاده‌کنند.) اثربدها در یک خریداری‌پلاستیکی و یا قطی سربامی دارد که نهایت ناشی بدحال. می‌باشد و در صورتی که دست‌خورده‌که دستکش دارد در محلول۲۰٪ کلورین برای ام‌فاکت‌که دست‌خورده‌که دستکش دارد در محلول۲۰٪ کلورین برای مدت ۵٪ کلورین در دهید.

2. دست‌ها را آب و صابون کاملًا بشوید و با یک پارچه پاک نمایید و با یک‌ناریدن تا در هوا یاک گردید.

3. علامت‌های خون‌ریزی مسیلا را تحت نظارت قرار دهید و علامت‌های خودخواندی برای دست نمایید.
   • هر ۱۵ دقیقه برای ۱ ساعت.
   • بیش از ۱۲ دقیقه برای ۲ ساعت.

4. مطمئن شوید که رحم خوب تغییر نموده است.

مجموعه از (۲۴)
### Manual Vacuum Aspiration [MVA]

#### مرحله/وظایف

<table>
<thead>
<tr>
<th>مرحله</th>
<th>وظایف</th>
</tr>
</thead>
<tbody>
<tr>
<td>١٠.</td>
<td>با خانم با احترام و مهربانی احوال پرسی نماید.</td>
</tr>
<tr>
<td>١٠.</td>
<td>مریض را با خاطر شک و دیگر حالات که جایی را مورد تهدید قرار می‌دهد ارزیابی نماید.</td>
</tr>
</tbody>
</table>
| ١٠. | در صورت تشخیص هر نوع اختلالات وضعیت مریض را پایان ساخته و در صورت ضرورت به مراکز درمانی می‌رود.

#### ارزیابی طبی

| ١. | تاریخچه صحت باروری گرفته شود. |
| ٢. | معاینات محدود فیزیکی (قلب، ریتان و بطن) و حوصلی را انجام دهد. |
| ٣. | معاینات لایازنارتیه ضروری را انجام دهد. |
| ٤. | به خانم در مورد وضعیت اش و توقع که می‌رود معلومات داده شود. |
| ٥. | در صورت که مناسب باشد وظایف سیستم تناسیل وی را تشییر نماید. |
| ٦. | اگر برای میزان UUD در نظر گرفته می‌شود: |
| ٦. | یا راه‌پیمایی ضروری لازم بوده و در صورت تشکیل UUD پاپا وی مشوره لازم است. |
| ٦. | تصمیم در مورد تطیف UUD بعد از عملیه MVA ارتباط با وضعیت کلینیکی دارد. |

#### آماده گی

| ١. | کار را که می‌خواهید انجام دهد به خانم (و پایانی) تشییر نماید و یا را تشییر داده نماید. |
| ٢. | سخنران خانم با لیگاگی گوش به به آوالات و نوعی های هری پیش دهد. |
| ٣. | به مریض قبل از اورژانس گردید که ممکن وی در جریان بعیض از مراحل عملیه احساس راحتی نماید. |
| ٤. | به خانم ٥٠٠ میلی گرام پارسیمیون الی یک طرفی قدر قابل افزایش یافته بوده ای از شوی سیویا داده شود. |
| ٥. | در مورد حساسیت با مواد انتی سینتیک، ها و ادویه پیشوندیها استرس ترین ها پاسیون شود. |
| ٦. | پایه سیستم آنتی سرتوبر و بیمار به سطح عالی که برای پروسیجیر ضروری است آماده باشد. |
| ٧. | مطمئن شوید که کنونا سازنامی داشته و دادگاه مربوطه آماده باشد. |
| ٨. | سرنج MVA را چک نموده و چک تایید (وکیوم را آماده نماید) |
| ٩. | چک تایید که خانم مشاهده خود را انجام نموده است. |
| ١٠. | چک تایید که خانم کاملاً نواحی عجانی خود را یک‌شانه است. |
وقایف قبل از عملیه

1. بمقادیر 10 و 14 هکتار اکسیژن و یا 0.2 میلی‌گرم از گویوتروپین، دو روز پیش امتحان نمود.
2. معاینه‌های حوزه‌ای با میانی‌ال، چک نمودن جسمات در رحم موقت و محل معامله رحم و درجه اندازه‌گیری رحم را انجام دهد.
3. سبک‌پوشی را در داخل محلول خان نموده خون و انجام اضافی را با استفاده از استخراج فورسپس و گاز خارج می‌نمایم.
4. عقق رحم و همبستگی را در محلول انتی‌سپینک و گاز با کتان سریل بازنماید.
5. تمام محصولات حمل را از فوهة عقق رحم کشیده و عقق رحم را با خاطر پاره گیا چک نماید.

اجرا بلاک پارا سرویکل (در صورت ضرورت)

1. 60 سی وسی محلول لیگونیاکس 5% به نیم ادرینالین و یا به 50%.
2. 100 سی وسی محلول ادرینالین 5% را با دارنده سرنج خیاطی.
3. در هر بیمار تک نیتراتوکسید ای استفاده شود بمقادیر 1 سی وسی محلول لیگونیاکس را در لبه قدامی و خلفی عقق رحم برای نماید (بیشتر موضع 10 بهره با 12 بهره استفاده شود).
4. فورسپس خلوتی با اسپینک ال استفاده می‌شود.
5. 61 نوع نیتراتوکسید در عقق رحم اندازه‌گیری کش وارد نموده و نیتراتوکسید را در هر حالت دهید. نمایندگی نماید.
6. در حدود 2 میلی‌لیتر محلول لیگونیاکس را در تحت پرداخت داخل نموده و پستون را یا نمایندگی به عقب بکشید تا مطمئن شوید که سوزن داخل وارد نامیم.
7. در حدود 3 میلی‌لیتر وسی محلول لیگونیاکس را در تحت پرداخت داخل نموده و پستون را یا نامیم شوید که سوزن داخل وارد نامیم.
8. 07 و 05 دو و نیم دقیقه انتظار بکشید و بعداً عقق رحم را یا فورسپس با پیچیده ای گرفته انتظار بکشید و دوباره نمایید.

MVA

پروسیجر

1. قبل از اجرای هر مرحله به خانم معلموش داده شود.
2. در عقق رحم یک کش ملازم را ایجاد نماید تا عقق رحم و جوف رحم مستقیم گردد.
3. در صورت ضرورت عقق رحم را متوسط سازید و به باکس اندازه‌گیری کرده که مهم‌اند کوپ‌نترین استفاده شود.
4. هنگام با گردن عقق رحم توسط فورسپس بطور دوباره، کوپ‌نترین انتخاب را با احساس و مراقبت داخل دخیل جوف رحم نمایید تا که به غیر رحم نماید. (ضمناً از یک مسیر نباشد).

بعداً کپولوکس را با احساسی از غیر رحم دور سازید.
سرنگ آراد نماید تا از طریق کنولا کشش در جوف پرید شود. 

pinch valve

وظایف بعد از پروسیجر

کنولا استفاده شده را با سرنگ و کویم وصل نموده و هر دو را با محلول کلورین 0.5٪ نشسته می‌دهیم.

کنولا را از سرنگ جدا نموده و در محلول ۰.۵٪ کلورین برای ۱۰ دقیقه بخاطر decontamination.
<table>
<thead>
<tr>
<th>محتوی حمل‌رای در چای مناسب، یا یک فضای سربزدار محکم در نمایید.</th>
</tr>
</thead>
<tbody>
<tr>
<td>۷ هر دو دست را که پوشش با دستکش می‌باشد داخل محلول کلورین ۰.۵ درصد و دستکش‌ها را بطور سرچه‌ای ازدست خواهد شد. در صورت که دستکش‌ها دست‌پوش‌پوشان یک قطعه‌ای محفظه و یا خریده‌ای پلاستیکی اندام‌شده شدند در صورتی‌که از دستکش‌ها دوباره استفاده گردد آنها را در محلول کلورین ۰.۵ درصد ده دقیقه به‌گذاری ده.</td>
</tr>
<tr>
<td>۸ دست‌ها را با آب و صابون کاملاً پوست و با یک پارچه خشک این نمایید و یا در هوا خشک نمایید.</td>
</tr>
<tr>
<td>۹ به مرض اجازه داده شود تا برای ۳۰ دقیقه بطور راحت استراحت نمایید و به‌نهضت وی تحت نظارت قرار داده شود.</td>
</tr>
<tr>
<td>۱۰ خورنیزی یا چک گردد و قبل از رختش صند مطمئن شوید که دردهای کرم‌مانند کاهش یافته باشد.</td>
</tr>
<tr>
<td>۱۱ به مرض در مورد مراقبت بعد از سقط و علایم خطر آگاهی داده شود.</td>
</tr>
<tr>
<td>۱۲ در صورت ضرورت به کنترل به مرض وقت مراجعه دوباره گلفته شود و هم‌و هم وقت که کدام نگرانی می‌باشد مراجعه کرده می‌توانند.</td>
</tr>
<tr>
<td>۱۳ اهداف بیماری بیماری شوید و در صورت مناسب در مورد رهتمای خانواده معلومات ارائه گردد.</td>
</tr>
</tbody>
</table>

مجموعه از (65)
Interview guide

رهنمای مصاحبه

• با یک دوستان به‌طور معمول در بحث می‌باشیم.
• با استفاده از فرم‌های پرسش هدف‌مندی‌ها را با یکدیگر می‌پرسیم.
• گزارنده به‌طور معمول می‌تواند به‌طور محدود این سوالات را با یکدیگر می‌پرسیم.
• اگر ورق معلومات واقعی نبود یک ورق معلومات دیگر استفاده شده اولیه را پاره کرده می‌باشد.
• با اجازه پاسخ ورق هارا شروع می‌کنیم.
• از روز سال نامه از 10 (23) میخوایم و جوابات را در ورق های سفید می‌نویسیم.
• برای هر ورق سفید شماره ورق معلومات را در ج میکنیم.
• ورق هارا هنگام نوشتن اول شماره جزئی می‌کنیم.
• هنگامی که یک ورق به سوال به‌طور کلی جملات انگلیسی به کار می‌رود مثل: خوب تشریح حالا سوال دیگری دارم، از طرف دیگر، ضمناً حالا بیانی عرض دارم و غیره.
• در روز ساله از 22 واقعی تکنیک می‌تواند در دوسمه میگرایی (برای قابلیت بعدی).
• روی پاره گراف شماره مخصص ورق معلومات را می‌نویسیم.
• بار توضیحات داده شده در هر جواب یا پاسخ‌های میگرایی می‌آوریم.
• بعداً با قابلیت واقعی شان را می‌دهیم.
• برای قابلیت ورق‌های سفید کافی (5 یا بیشتر) می‌دهیم که جواب‌های شان را نویسیم.
• در روز قابل استفاده را تفریح داده کنیم یا از روز ورق نموده دهی شان جواب‌های اولیه تمرین می‌دهیم.
• ورق‌های جوابات را شماره گزارش می‌کنیم.
• کد مخصوص را هم روی ورق‌های جوابات قابل هم بر روی ورق نموده تمرین می‌دهیم.
• ورق‌های جوابات ورق نموده دهی یا همراه جوابات ورق می‌گزاریم.
• حالا از قابلیت شوک می‌یابیم که روی مدل طول نورا احیا جوابات می‌دهیم.
• در روز ورق نموده دهی از روی کارت خورده که قابلیت می‌کنیم از در ورق نموده می‌دهیم.
• در روز شماره کد مختص ورق معلومات را روی ورق نموده دهی شده نوشته آن را به ورق های جوابات ورق می‌گذاریم.
• حالا روی مدل قابلیت MPOP را کار می‌کنیم.
• در روی ورق نموده دهی یا در هر می‌یابیم.
• در ورق نموده دهی شماره مختص ورق معلومات را نوشته آن را همراه دیگر اوراق جوابات ورق می‌گذاریم.
• اگر قابلیت نخست باشد تفریح می‌کنیم.
• این بار قابلیت مدل MVA را کار می‌کنیم.
• شماره مختص ورق معلومات را روی ورق نموده دهی شده نوشته آن را به اوراق جوابات ورق می‌دهیم.
• حالا یک شرکت ثالث را دعوت می‌کنیم که روی مرضی که یک میکد اگر شخص ثالث نباشد یکی از شما این رول را بزی می‌کنیم.
• مرضی در روی اکلسمیا می‌باشد.
• قابلیت سوال‌های معنی‌دار و اهمیت‌یابی اکلسمیا را روی شخص ثالث تمین می‌کند و ما مشاهده می‌کنیم.
• هنگامیکه قابل‌ه و شخص ثالث تمیز می‌کنند ما در ورق نمره دری ای او را نمره میده‌نیم.
• روي ورق نمره داده شده کود مخصوص ورق معلومات را می‌زنیم.
• جواب را همراه جواب‌های دیگر می‌گذاریم.
• از قابل‌ه و شخص ثالث تحقیک می‌کنیم و ختم مصاحبه را اعلام می‌کنیم.
ضریمه د: فورمه موافقت‌الف: قابلیت
نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمات قابلیت‌ها و پروژه تقویه خدمات صحي (HSSP)

توصیه‌ها در مورد ارزیابی:
سلام تام من ____________اکست و من به تماشایی از وزارت صحت عامه و پروژه تقویه خدمات صحي افغانستان که پروگرام تربیه قابلیت‌ها در افغانستان مساعدت می‌نماید در خدمات شما می‌باشیم. ما برای بهبود پروگرام تربیه قابلیت‌ها در سراسر کشور کار می‌نماییم. منحنی بخشی از کار خوش فعل می‌خواهیم با یکدیگه از فارغ‌التحصیل جدید مکاتب تربیه قابلیت‌ها ملاقات داشته باشیم تا از شبان درباره تجارب شان در مکاتب قابلیت‌ها و کارشناسی پرسیدم.
هدف کلی این ارزیابی دانستن این است که بهبود تربیه قابلیت‌ها قبل از خدمات روی دسترسی و کیفیت خدمات صحي برای مادران و نوزادان چه ناتی نشانه و می‌خواهیم بدانیم که این پروگرام چگونه بهبود یافته می‌تواند تا شاگردان آینده بار که خدمات بهتر به جامعه آماده گردد.

سوال تقریبی:
آیا شما فعلی به حیث قابلیت‌ای وظیفه می‌کنید؟

□ پلی
□ نخیر

در صورتی که جواب نه باشد توضیح نما ید چرا:

از شما چه خواهد شد که انجام دهید:
من شما را دور نمی‌گیرم در این مطالعه ارزیابی اشاره کنید از شما چند سوال در رابطه تعلیم وکار فعالی تان خواهیم پرسید. می‌خواهیم در یک بازی مشابه با یک مدل اتوماتیک شما را مشاهده و یک فرم که نهایی را خانه بری نه نما که این پروگرام در مورد استفاده از پاپور کراف، جلوگیری از خروجی جریان حمل و نواده از ولادت می‌باشد.

خطرات، دردسری و فاقد این گفتگو:
هیچگونه خطر و یا فاقد مستقیم در اشتراک این ارزیابی می‌توانه تان خواهد بود. اگر کدام سوالی شما را ناراحت می‌کنند و یا هر سوالی دیگری که باشد شما می‌توانید از جواب دادن امتیاز وریزید. اگر احساس ناراحتی کرده‌اید شما می‌توانید مشاهده را را در زمانی که خواهست باشید توقف دهید.
در خانم ای ملاحظاتی هم که در مورد کارتان مشوره خواهیم داد مطلع این ارزیابی بار بهبود تربیه قابلیت‌ها و کیفیت خدمات صحي برای مادران و اطفال در افغانستان به کار خواهد رفت.
محمديت

اشتراک در این ارزیابی کاملا اختیاری و محرم است معلوم مانیکه شما عرضه می‌نمایید تنه به کارکنان این مطالعه قابل دستری خواهد بود. نام، آدرس و دیگر معلومات شخصیتان را هر چه فرم، ورق و یا راپوری بیان دهید. این مطمئن می‌شود که معلومات شما از نظر کارکنان این مطالعه مطمئن نخواهد شد.

با آمرتان و یا همکارانتان شریک نخواهید شد و بالای وظیفه‌تان هیچ اثر نخواهد داشت.

ما از اشتراکتان در این ارزیابی قدردانی می‌نماییم زیرا معلوم‌کنیم که بندهای بسیار مهم است. مصاحبه، مشاهده، فرم‌های سروی و یا بیانات آن حدود دو هفته وقت شما را می‌گیرد. اگر هر زمانی سوالی داشتید، هر پرسیده‌نامه بزرگ‌تر شما به‌خواهید اشتراکتان را خانه‌های داده می‌توانید. می‌خواهید کدام سوالی در رابطه به این ارزیابی از من بکنید؟

اگر موافق هستید که در این ارزیابی حضور گسترده لطفا اظهار نمایید. اگر رضایت شفاهیتان را در این فرم بیان دهید، می‌توانیم که شما آ نرا امضا خواهید کرد.

تصمیم می‌نماییم که از فرم‌های رضایت اشتراک کننده رو در حضور اشتراک کننده خواندم و ایشان پذیرفتن که اشتراک نمایند.

__________________________
امضا شاهد (سوال کننده)

__________________________
تاریخ

صرف بعد از امضا و مهر (IRB) (قابل اعتبار میباشد.

یکسال بعد از تاریخ فوق از اعتبار ساقط است.

نوت: اگر کدام سوال در رابطه با حقوق مشترکین این ارزیابی داشته‌باشید، با شکایتی در رابطه با این تحصیل داشته‌باشید لطفا با ما تماس بگیرید.

نصرت الله (اصاری) به تلیفون (0799878691) در تهران شوید.
ضریمه ۵ : فورمه موافقه الف: قابلته

نام بروزه: ارزیابی برنوگرام تربیوی قبل از خدمت قابلته - و بروزه تقویه خدمات صحي (HSSP)

توجهات در مورد ارزیابی:

سلام. نام من ____________ است و من به نامندگی از وزارت صحت عموم و بروزه تقویه خدمات صحي افغانستان که برنوگرام تربیه قابلته ها را در افغانستان مساعدت می‌نماید در خدمت شما می‌باشم. ما برای بهبود برنوگرام تربیه قابلته ها در سراسر کشور کار می‌نماییم. منتحب خیشی از کار خوش خیال بهداشت و درمان بهداشت و درمان کار راه‌اندازی ها ملاقات دانشی باشم تا از پیش درباره تجربه شان در مکان قابلته گی و کارشناس برسیم.

هدف کلی این ارزیابی دانست این است که بهبود تربیه قابلته ها قبل از خدمت روی دسترسی و کیفیت خدمات صحي برای مادران و نوزادان چه تاثیر داشته و میخواهیم بنانیم که این برنوگرام جهان بهبود یافته میتواند تا شاگردان ایندی پرای خدمت بهتر به جامعه آماده گردد.

سوال تفریقی

آ یا شما فعلا به چه قابلیت ایفای وظیقه میکنید؟

□ بیل

□ نخیر

در صورتی که جواب نه باشد توضیح نما یک چرا:

از شما چه خواهد خواهید که انجام دهید:

من شما را دعوت می‌نماییم تا در این مطا وی به ارزیابی اشراف کند از شما چند سوال در رابطه به کلام فعلي تا ناخوایم پرسید. میخواهم در یک باری ثبتی با یک مدل انتزاعی شما را مشاهده و یک قسم که تا اینه یک فرم که می‌توانیم یک نامه برای گزینه‌هایی که از شما قبلا در راجع مورد استفاده از رایانه گرفته، جلو گیری از خورشید چریان حمل وی می‌باشد.

خطرات ناتrabحتی و داعی این گفتگو

هیچگونه خطر و یا فاقدی مستقیم در اشراف این ارزیابی موجه یه درخواهش است. اگر کدام سوالی شما را ناراحت می‌کند و یا هر سوالی را درخواهش داشته که به شما می‌توانیم از جواب دادن امنیت و ورزید. اگر احساس ناترابحتی کردنی شما می‌توانند مشاهده را در زمانی که خواسته باشند توقف دهید.

در خانه چه ملاقات من به شما در مورد کار نه مشوره خواهم داد. معلومات این ارزیابی برای بهبود تربیه قابل ها و کیفیت خدمات صحي برای مادران و اطفال در افغانستان به کار خواهد رفته.
محرمیت

اشتراک در این ارزیابی کاملاً اختیاری و محروم است. معلومات شما اчиکه می‌شود، این مطالعه قابل دسترسی خواهد بود تا، آدرس و دیگر معلومات شخصی شما روز هیچ فرم، ور و یا رابطه باشند، نخواهد شد. هیچ معلومات در رابطه به طرز کار شما با آمر شما یا همکاران شما در رابطه با باید وظیفه تان هیچ اثری نخواهد داشت. 

ما از اشتراک‌گذاری این ارزیابی قادرتر می‌شیم. ارزیابی می‌تواند مهم است. مصاحبه شما با ما، فرم‌سازی و باشند. نمود و حداکثر وقت شما را بیشتری و بیشتر به زمانی که در این سوالات رابطه نشانداشت، تا خانه داده می‌شوند. میخواهید کدام سوال در رابطه به این ارزیابی از من بگذیرید؟

اگر موافق هستید که در این ارزیابی حجم بی‌گیریند لطفاً اظهار نمایید. این رضایت شفاهی تا نما در این فرم بهداشت می‌باشد که شما آن را امضا خواهید کرد.

توزیع متن می‌باشد که این ارزیابی به رضایت اشترک‌کنندگان در حضور اشتراک‌کنندگان و ایشان پذیرفته که اشترک‌کنندگانی.

امضا شاهد (سوال کننده)

[آری]

تاریخ

ظرف بعد از امضا و مهر (IRB) قابل اعتبار می‌باشد.

کمک‌ال بعد از تاریخ فوق از اعتبار ساقط است

نوت: اگر کدام سوال در رابطه با حقوق مشترکان این ارزیابی داشته باشید یا شکایتی در رابطه با این تحفظ داشته باشید لطفاً با دکتر نصرت‌الله (الصراوی) به نمر تلفن: (0799878691) در تماس شوید.
توظیحات در مورد ارزیابی:
سلام. نام تام و م.م. پرداختنی از وزارت صحت و علوم ایران، پروژه تقویه خدمات صحت و موسسات درگیر کرده برای ارزیابی قابلیت ها در افزایش خدمات اجتماعی در دست اندرکاران مختلف (روشی صحت عاشورا، سالونیه) بود.

کلیه پروگرام گزارشی های اجتماعی، امیر معین برای میانگین BPHS ارائه داده شده، رمز صحت پایبو و رسم قواعد شریعت صحت عاشورا، نمایندگی بود.

اعدادی مکاتب قابلیتی واجد بنیادهای ایفا از نگست صحت اجتماعی تا یا این درباره تجارب شاک به ارتب مکاتب قابلیتی و کمیته کار قابلیتی می‌تواند شده از این مکاتب بررسی می‌گردد.

هدف کلی از ارزیابی شامل این است که بهره‌برداری قابلیت ها در وظایف و کیفیت خدمات صحت برای مادران و نوزادان جه تأکید داشته و میکوایی و به‌کارگیری که این پروگرام چونه به‌طور میانگین تا شاگردان آننه برای خدمات بهتر به جامعه ایجاد گردید.

از شاهمخونه خواهش گردد که اجماع دهد:
از شما را دعوت می‌کنیم تا در این ارزیابی اشتراک گیرید. از شما جنگ سوال در رابطه به این از موارد تعلیمات قابلیتی گونه‌ مثل: مورتیب پروگرام قابلیتی و ثباتات از روی دسترسی و کیفیت خدمات صحت مطلوب و مادرخواهی بررسی. در اینجا از شما تفاوت ضروری و شدک تقارن و پیشنهادات خوشه یا در رابطه به بهره‌برداری از مکاتب قابلیتی با ما شرکتی سازیت.

خطرات، نرخی و قوانین این قانونگام
ببینیم چگونه خطر و یا قانونی در این ارزیابی‌های جشنی روی ارزیابی واقع و کارآفرینی بانکی از جواب‌دادن امتت و رژیم. امسال حاضر کردنی شما می‌تواند مشاهده را در زمانی که خواسته میرود. مکاتب که در این ارزیابی جمع‌آوری می‌گردد به منظور به‌کارگیری تعلیمات قابلیتی و خدمات که توسط قابلیتی می‌تواند فارغ شده عرضه می‌گردد استفاده شده خواهد.

محرمت
امکانات این ارزیابی‌ها شامل اختیاری و محرمت ماتان می‌شود. در این ارزیابی چشم‌انداز نهایی خواهش بود. آگر کدام سوالی شما در نظر می‌گیرید و یا از سوالی بودید، درباره‌تل و پرسیده‌تل نهایی خواهش داشت. با این حال، واهمیت گرفتن نهایی خواهشد. درباره‌تل و پرسیده‌تل نهایی خواهش داشت.

ما از ارائه‌کنندگان این ارزیابی قدردانی می‌کنیم. اهدا می‌کنیم که بسیار مهم است. مصادر حدودی یک سیاست دیگر می‌باشد. اگر احتمال زمانی مستند درباره‌تل و پرسیده‌تل چنین می‌باشد، این ارزیابی درباره‌تل و پرسیده‌تل می‌باشد. می‌باشد کدام سوالی درباره‌تل و پرسیده‌تل از این به‌کارگیری چه جایگاهی شود؟

اگر موقوف‌های سه‌گانه دارای ارزیابی، حاصل این اختیار باشد، منظور از این می‌باشد، رضایت شاکی نیاز به این فرمه بایسته می‌باشد که شما آن را امضا کنید.
تصمیم مینامایم که متن فرم رضایت به من در شروع مصا حبه خوانده شد ومطالب آن به من واضح گردید، بناءً می‌باشد اختیاری در این مصاحبه است. مینامایم.

امضا/شمار مصاحبه شونده 

اراده/شمار

امضا/شمار مصاحبه عضویت

اراده/شمار

تصمیم مینامایم که متن فرم رضایت اکثریت اعضای کننده را در حضور اشتراک کننده خوانده و افضل یاد و دیده که اشتراک نمایید

امضا/شمار (سوال کننده)

تاریخ

صرف بعد از امضا و مهر (IRB) قابل اعتبار می‌باشد.

یک‌ماه بعد از تاریخ فوق از اعتبار ساقط است

نوت: اگر کدام سوال در رابطه با حقوق مشترکان این ارزیابی داشته باشد با شکایتی در رابطه با این تحقیق داشته باشید لطفاً با دکتر نصرت الله (اتساری) به نمبر تلفن (0799878691) در تماس شوید.
Key informant interview guide (English version used only)
Name of Interviewer: _____________________________

Name of Interviewee

Designation

Date interview conducted

Time interview started

Time interview completed

Method used for recording the answers

a) audio recording  b) video recording  c) note taking

Consent obtained and consent form signed

Please ask the following questions and note the answers on one side of blank sheets provided
Please number the blank sheets before you start
Please write down the question numbers at the beginning of answers to each question

I am (interviewer’s name) from MOPH/HSSP. We are working on this project to improve quality of midwifery program and the quality of care provided by graduates. An important first step in this process is getting an understanding of key stakeholders’ perception of the program.

Before we start, I would like to remind you that there is no right or wrong answers in this discussion. We are interested in knowing what you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to outside people outside. Please be assured that the information provided during the interview will be strictly confidential. If we plan to disseminate findings from the interview we will not attribute your name to those findings.

Program Description:

1. There are two types of midwifery programs in the country; can you describe them and their differences?
2. What are the objectives of midwifery programs in Afghanistan?
3. Is the program aligned with MOPH policies and guidelines?

Program Effectiveness:

4. How well the program was implemented? Are you satisfied? Would others agree?
5. What support were you able to provide to midwifery programs, please describe? How often this support was offered? How do you assess the effectiveness of this support on the quality of education provided at schools?
6. Do you believe the midwifery programs are producing high quality graduates who meet national accreditation board standards?
7. What percentages of midwifery schools have been accredited?

Program Impact:

8. How do you assess the impact of program on the health needs of women and children?
9. What impact did the program have on utilization of maternal and child health services?
10. Do you believe students graduated from midwifery program are currently practicing in the target areas? If not why not? What would you propose to improve their appropriate deployment?
Lessons Learned:

11. Can you briefly describe the strengths and weaknesses of the midwifery program in the country?
12. What strategies would you propose to improve provision of support to midwifery programs?
13. How can accreditation board work closely with AMA in improving the quality of education in midwifery schools?
14. What can Accreditation Board do to advocate for recognition of midwifery profession in Afghanistan?
15. Anything else you would like to add
نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمت قابلی ها - و پروپز تقویه خدمات صحتی (HSSP)

فورم موافقت‌نامه

توظیحات در مورد ارزیابی:

سلام. نام، پیام‌دی‌گی از وزارت صحت عمومی افغانستان، پروپز تقویه خدمات صحتی و موادوی درگیریکه پروگرام تربیه قابلیت‌های افغانستان را در اسفار مسئولیت می‌کند. این مسئولیت به‌طور مداوم می‌تواند با یکدهد در یک آزمون تجاربی مختلف مصاحبه داشته باشد تا ای نشان در این مکان بررسی.

در این تجربه شان به ارتباط مکاتب قابلیت گی و کیفیت کار قابلیت های فارغ شده از ان مکاتب برسی.

هدف کلی این ارزیابی نشان این است که به‌طور تربیه قابلیت‌های قبل از خدمات روی دسترسی و کیفیت خدمات صحتی برای مادران و نوزادان جه تایید داشته و می‌خواهیم بیان کنیم که این پروگرام چگونه بهبود یافته متوناد با شاگردان آینده برای خدمات بهتری به جامعه آماده گردد.

از شما که خواسته‌خواهند که انجام دهید:

من شما را دعوت می‌نماییم تا در این ارزیابی شرکت کنید. از شما چند سوال در رابطه به اعداد مختلف تحلیلات قابلیت گی مانند مثال: موتوریت پروپرام قابلیکی و تاثیر آن روی دسترسی و کیفیت خدمات صحتی طرف و مادرخوای اپسید. در آخر از شما تفاهم داشته‌ایم.

شما نظرات و پیشنهادات خود را در رابطه به بهبود بخشیدن تعلیمات قابلیت گی با شریک سازی.”

خطرات ناراحتی و فواید این گفتوگو

هیچگونه خطر و یا فاقد مستقیم در اشتراک این ارزیابی متوجه نخواهد بود. اگر کدام‌یکی از شما ارائه می‌کند و یا هر سوالی دیگری که باشد شما می‌توانید از جواب دادن انتخاب و آزاد اگر احساس ناراحتی کردید شما می‌توانید مشاهده را هر زمانی که خواسته باشد توقف دهید.

معلومات که در این ارزیابی جمع آوری می‌گردید به منظور بهبود بخشیدن تعلیمات قابلیت گی و خدمات که توسط قابلیت‌های فارغ شده عرضه می‌گردد استفاده خواهد شد.

محدودیت

اشتراک در این ارزیابی کامل اختیاری و ملزم است معلوم مانیده شما عرضه یا نمی‌شود. اگر کدام‌یکی از شما به این افتخار نمی‌شود، باید آنها را از اشتراک خودن باشم.

ما از اشتراک‌تان در این ارزیابی قدردانی می‌کنیم زیرا معلوم می‌کنیم که می‌توانید بهم‌همه مهم است. مصاحبه حدود یک ساعت دوم خواهد کرد. اگر هر زمانی سوالی داشتیدیست هراس بپرسید. هر زمانیبخواهی اشتراکات ناشی از این مصاحبه داده می‌توانید. می‌خواهیم یکدوم سوالی درآمده به این ارزیابی از من بگوئید؟

اگر موافق هستید که در این ارزیابی حضور یک‌گردید ظرف ده روز ممکن است. اگر لاشه نمایید، ضمن نشان داده تا در این فرم به‌دست می‌آید که شما از نم‌تا امضا خواهید کرد.

تصمیم مسئولیت که متن فرم رضایت به من در شروع مصایح خواندن شد و مطالعه آن به من واحده گردد، نیاز به مصرف اختیاری در این مصاحبه اشترک مسئولیت.
طرح می‌باشد: اگر کدام سوال در رابطه با حقوق مشترک‌ها، ارزیابی، نظرات و مواردی را در رابطه با آن تحقیق داشته باشید، تلفن (0799878691) به نام تیلیفون در همدان، تلفن برای تماس به ثبت رسیده می‌شود.

نتیجه‌گیری: از این نظر، اگر این سوال در رابطه با مشترک‌ها، ارزیابی و نکاتی در رابطه با آن تحقیق داشته باشید، تلفن (0799878691) به نام تیلیفون در همدان، تلفن برای تماس به ثبت رسیده می‌شود.
Interview guide to be used by the assessors (English version used by the assessors)

Interview Guide for Group of Clients

I am (interviewer’s name) from MOPH/HSSP. We are working on this project to (purpose of the project). An important step in this process is getting an understanding of community’s perception of the program. Before we start, I would like to remind you that there is no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today. Let’s start by going around the circle and having each person introduce herself. (Members of the research team should also introduce themselves and describe each of their roles.)

1. What problems did you have in your last pregnancy? Please describe?
2. What did you do for these problems?
3. Please describe if you have you ever experienced any problems getting health care when you needed it?
4. What do women and men in your community think about the midwives at this clinic?
5. Would you allow your daughters/women from your family to be trained as a midwife?
6. Are there ways that obtaining care from a midwife could be made easier for you and your family?
7. What could be done more to improve the quality of care provided by midwife in your community?
Interview Guide for Group of female community member (not clients of the midwife)

I am (interviewer’s name) from MOPH/HSSP. We are working on this project (purpose of project). An important first step in this process is getting an understanding of community’s perception of the program. Before we start, I would like to remind you that there is no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated or shared with people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today. Let’s start by going around the circle and having each person introduce herself. (Members of the research team should also introduce themselves and describe each of their roles.)

16. What major health issues you see in your community?
17. What problems do you see mostly among women and children?
18. To whom do people go to seek health care?
19. What do the women and men in your community think about the midwife?
20. Would you allow your daughters/women from your family to be trained as a midwife?
21. Please describe if you have ever experienced any problems getting health care when you or women in your family needed it?
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Codes for Types of Complications:
- Forceps
- Vacuum
- Dystocia
- Retention of Placenta
- Fetal distress
فعلاییت‌های را که به ولادت مربوط نیست اندازه‌گیری (نامی) نمایید.

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مجموع این صفحه
## Annex 2: Detailed Midwifery Deployment data

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