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PROGRAM EVALUATION OF THE PRE-SERVICE MIDWIFERY EDUCATION PROGRAM IN AFGHANISTAN

Final Phase One Report

September 16, 2009

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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INTRODUCTION

Maternal mortality has been recognized as a public health priority in Afghanistan since 2002 when the Ministry of Public Health was revitalized.ⁱ 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.ⁱⁱ 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.ⁱⁱⁱ

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 I 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 I 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.

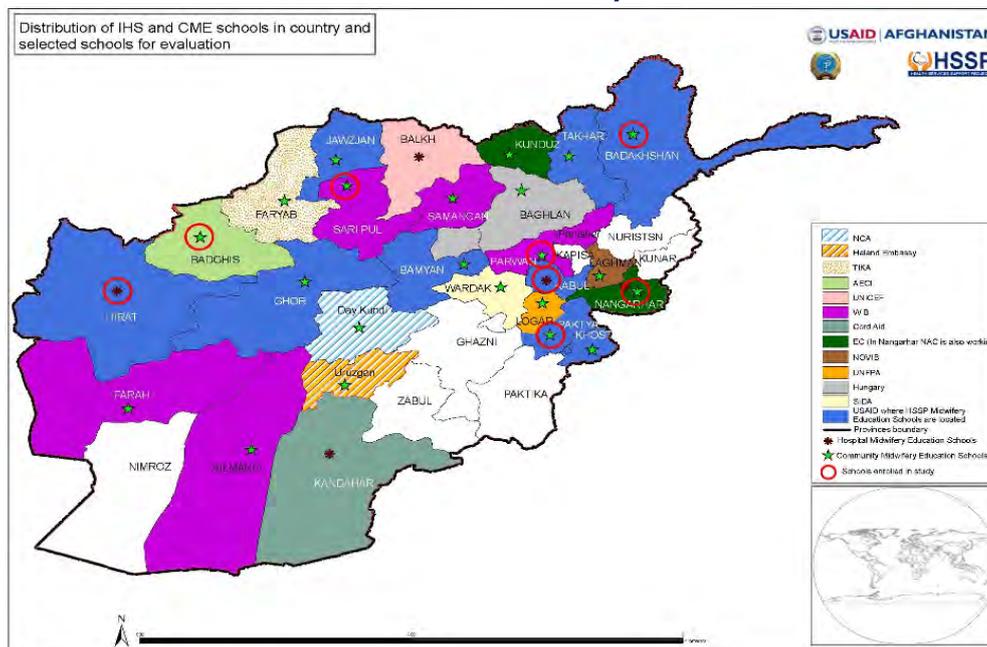
SAMPLING PLAN

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



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

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. iv v 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 vi

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.

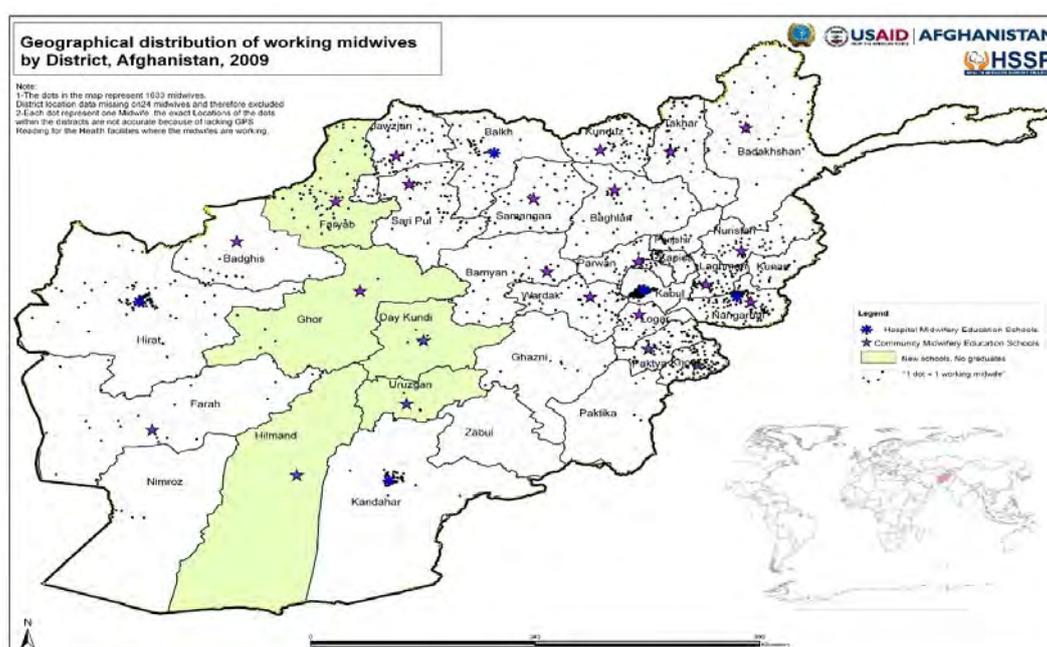
The numbers and proportions of students currently studying, previously enrolled in the programs, graduated, who found employment or was assigned (deployed) to a government or private health facility after graduation, and who continued to work as of the end of May, 2009 (currently working) are shown in Table I. See Appendix A for the complete table of midwives graduates and deployment by province.

Table 1: Students Enrolled, Graduated, Deployed and Currently Working, May, 2009

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 level¹. 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.²

Type of Program	Currently studying	Enrolled	Graduated	Drop-outs	% Graduated	Deployed/Employed	% Deployed/Employment of graduated	Currently working (as of May, 2009)	% currently working of graduated	Currently working of deployed/employed
IHS	167	1232	1103	129	90%	890	81%	754	68%	85%
CME	509	886	858	28	97%	785	91%	694	81%	88%
Total	676	2118	1961	157	93%	1675	85%	1448	74%	86%

Map 2: Geographical distribution of Working Midwives by District, Afghanistan, May, 2009.



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,

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

Type of School	% Graduated	% Deployed	% currently working
CME	97	91	81
IHS	90	81	68
Absolute difference	7	10	13
Proportional difference			16%

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

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

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

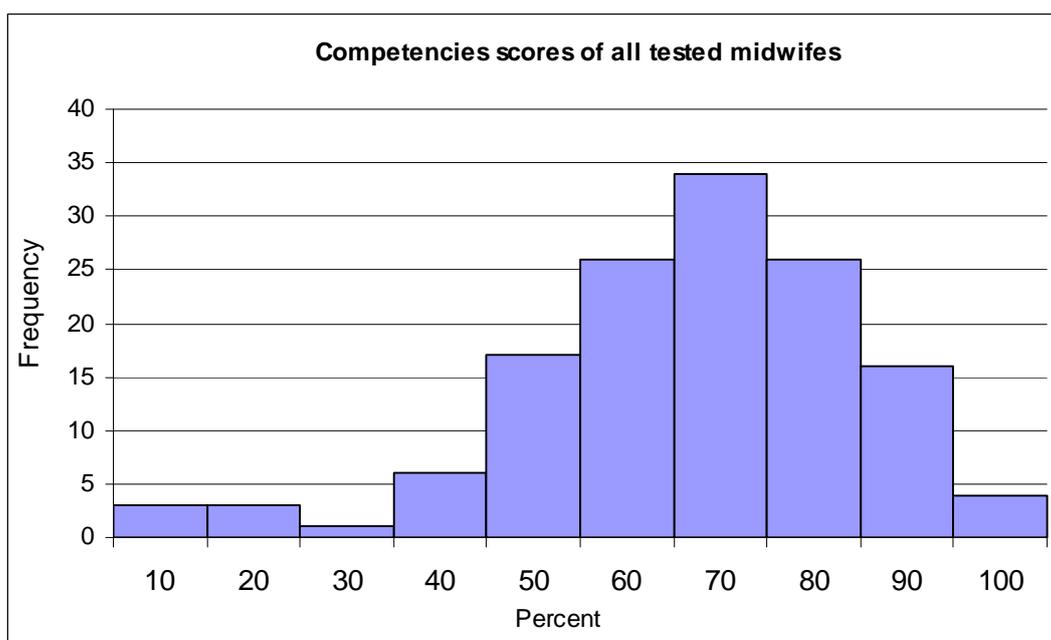
	Time 1 – 2006 (pre – before graduating a class)	Time 2 – 2008 (first half) (post – after graduating a class)	Difference (Pre- post difference between Treatment and Control group, respectively)
Provinces w/ midwifery school with at least one graduating cohort by 2007 (treatment)	64%	111%	47%
Provinces w/ No midwifery school with at least one graduating cohort by 2007 (control)	69%	108%	39%
Absolute difference (between treatment and control at time 1 and time 2)	-5%	3%	8%
Proportional difference			17%

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



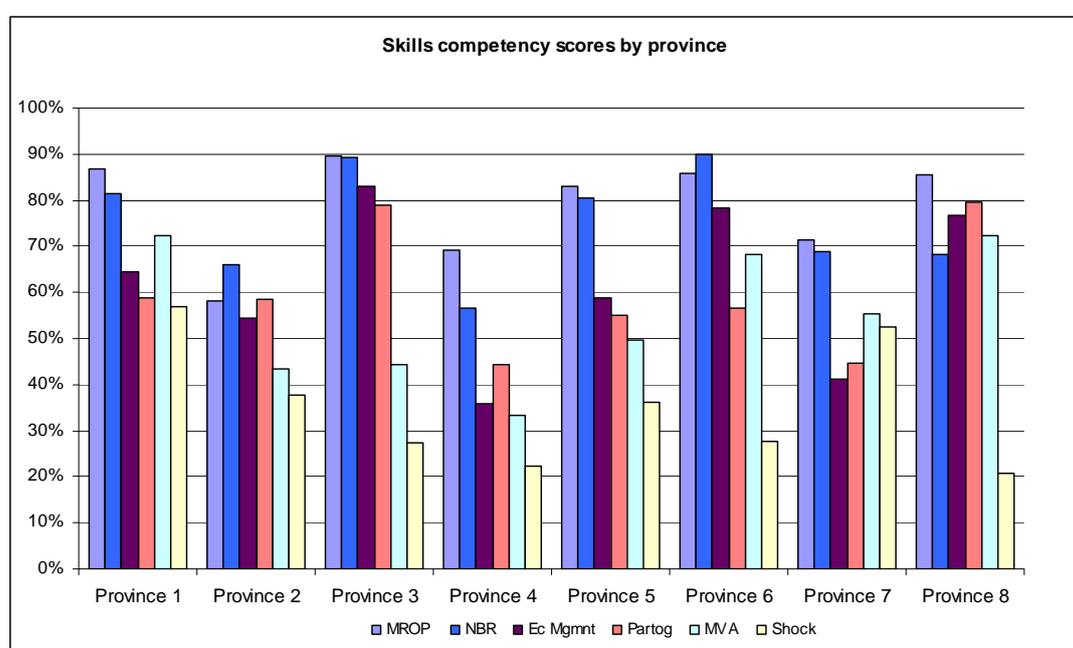
When broken down by type of competency, we see that the competency scores ranged from a low of 35% for shock management to 81% for MROP. Shock management was the lowest score by a substantial amount, with MVA, NBR, and Partograph use with moderate scores and MROP and NBR strongest.

Table 3: Results for Each of the 6 Competency Scores for All Tested Midwives, All Provinces Combined, May, 2009

All Provinces (means)	
Manual removal of placenta (MROP)	81%
Newborn Resuscitation (NBR)	76%
Eclampsia Management (Ec Mgmt)	63%
Partograph Use (Partog)	60%
Manual Vacuum Aspiration (MVA)	55%
Shock Management (Shock)	35%

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



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

Competency	Type of School	
	CME % achieved (# respondents)	IHS % achieved (# respondents)
MROP	81% (101)	80% (37)
NBR	77% (101)	74% (37)
Eclampsia	64% (101)	61% (36)
Use of partograph	59% (101)	63% (37)
MVA	61% (101)	39% (36)
Shock	38% (100)	25% (37)

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 team work. (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.³ 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.

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 I); 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.”

x. **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, Paktia, 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 program 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 I 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. ⁴Practicing 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

⁴ Benner, Patricia. From Novice to Expert – Excellence and Power in Clinical Nursing.

- 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 I: Data collection tools

Interview Questionnaire for Graduated Midwives working in health facilities

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

- ورق معلومات را برای هر یک جواب دهنده گان خانه پُری نماید
- جوابات را بالای یک طرف ورق سفید بنوسید
- کود مخصوص ورق جوابات را بالای هر صفحه ورق جوابات بنوسید
- ورق جوابات را شماره گذاری نماید
- در ابتدا بگذارد تا جواب دهنده گان به تمایل خود جواب دهنده و بعداً برای تشریحات بیشتر فراخوانید، هیچگاه سوالات تلقینی (رهنمای کننده) را مطرح نسازید
- در صورتیکه جواب دهنده نظر دیگر نداشت، مشاهدات خود را بنوسید.
- مشاهدات خود را از جوابات جواب دهنده با یک خط مستقیم جدا سازید
- جوابات متعاقب را با دو خط موازی جدا سازید

تفصیل پروگرام تربیوی Education Program description

۱. موضوعات در جریان پروگرام تعلیمی قابله گی خواندید کدام ها بودند در مورد هر یک معلومات مختصر دهید؟
۲. زمانیکه شما محصل بودید آیا در پروگرام شما کدام تغییرات عمده صورت گرفت؟

موثریت پروگرام تربیوی در آماده سازی محصلین برای فعالیت عملی Effectiveness of education program to prepare students for practice

۳. درباره کیفیت تعلیم و ترینگ که حاصل کردید چه نظر دارید؟
۴. در کدام بخش کلینیکی خود را بشتر راحت احساس میکردید؟
۵. در کدام بخش کلینیکی خود را کمتر راحت احساس میکردید؟
۶. برای اینکه محصلین آینده از موارد مذکور مطمئن باشند برای بهبود پروگرام چه مشوره میدهید؟
۷. نقاط قوی تعلیم که حاصل کردید به نظر شما کدامها است؟
۸. نقاط ضعیف تعلیم که حاصل کردید به نظر شما کدامها است؟
۹. هنگام که فارغ شدید، آیا خود را برای عرضه خدمات صحتی به خانم ها آماده حس کردید؟
۱۰. چه فکر میکنید که چگونه میتوانیم پروگرام را بهبود بخشیم تا فارغان آینده خود را بهتر آماده کار حس کنند؟

موانع در برابر عرضه خدمات با کیفیت برای مادران و نوزادان Barriers to ability to deliver quality MNH care

۱۱. به نظر شما کدام عوامل مانع عرضه خدمات بهتر به مریضان شما و فامیل های شان میگردد. (در ابتدا بگذارد تا جواب دهنده به تمایل خود جواب دهد بعداً مسایل مختلف را بپرسید چون: مواد و سامان آلات، تجربه، همکاری تیم طبی چون داکتر، جراح، قابله مشکلات در رجعت دادن ترانسپورت وسایل مکالمه و غیره).
۱۲. آیا میتوانید راه های را پیشنهاد کنید که این موانع را کمتر سازد.

تأثیرات دراز مدت Impact

۱۳. آیا پروگرام تر بیوی قابله گی برای خانم های محل تان تغییرات را بار آورده است؟
۱۴. آیا این پروگرام تاثیری مهمی بر دیگران هم داشته است؟
۱۵. آیا این پروگرام نتایج حیرت آوری و یا نتایج که توقع آن نمیرفت داشته است؟
۱۶. آیا این پروگرام جوابگوی و متناسب به ضرورت های مردم محل شما میباشد؟
۱۷. آیا این پروگرام جوابگوی نیازمندی های کسانی که بیشترین ضرورت دارند میباشد؟
۱۸. آیا از جمله ضرورتمند ترین مردم، کسانی بوده اند که بعضی شان از این خدمات محروم مانده اند؟

درس ها Lessons learned

۱۹. از کدام دستاورد تان احساس افتخار میکنید؟
۲۰. کدام خدمات بهتر انجام داده شده میتواندست و چگونه؟ برای کم کردن اشتباهات به چه چیزی نیاز دارید؟
۲۱. آیا شما کارهای کرده اید که دیگران ممکن نکرده باشند؟
۲۲. درس های مهمی که از این تجربه تان حاصل کرده اید چه است؟
۲۳. آیا کدام ابتکاری یا طرز العمل خوب را مشاهده کرده اید؟
۲۴. اگر دیگران پروگرام تعلیمی مشابه را در جا های دیگر آغاز کنند به نظر شما کدام عوامل و شرایط باید موجود باشد تا موفقتر باشند؟
۲۵. کدام شرایط و عوامل ممکن پروگرام های جدید را مشکل ساخته یا به ناکامی مواجه میکنند؟
۲۶. پروگرام های مشابه دیگر باید روی کدام مسایل بیشتر تمرکز کنند؟
۲۷. به کسانی که راپور این ارزیابی را خواهند خواند چه پیامی دارید؟

بخش B: مطالعه واقعات

<p>۲۸. واقعه فرضی پارتوگراف را به جواب دهنده بدهید اجازه دهید تا پارتوگراف را تکمیل نماید شماره سوال (۲۷) را در بالای پارتوگراف که جواب دهنده می کشد بنویسد کود مخصوص را در بالای پارتوگراف تکمیل شده بنویسد</p>
<p>۲۹. واقعه فرضی شک ب سبب خونریزی مهیلی را ب جواب دهنده بدهد اجازه دهید جواب دهنده را جوابات خود را در ورق جوابات بنویسد شماره سوال (۲۸) را در بالای ورق جوابات بنویسد در هر صفحه یک کود مخصوص را بنویسد شماره صفحات از شماره ۱ آغاز میشود</p>

بخش C: مشاهدات مهارتها

<p>۳۰. جواب دهنده را حین تمرین احیای مجدد طفل نوزاد روی مودل مشاهده کنید در موقع که جواب دهنده کاری عملی مینماید چک لست را خانه پری نماید کود مخصوص را در چک لست بنویسد</p>
<p>۳۱. جواب دهنده را حین تمرین خروج پلاستنا با دست روی مودل مشاهده کنید در موقع که جواب دهنده کاری عملی مینماید چک لست را خانه پری نماید کود مخصوص را در چک لست بنویسد</p>
<p>۳۲. جواب دهنده را حین تمرین (Manual Vacuum Aspiration) روی مودل مشاهده کنید در موقع که جواب دهنده کاری عملی مینماید چک لست را خانه پری نماید کود مخصوص را در چک لست بنویسد</p>
<p>۳۳. جواب دهنده را حین تمرین مواظبت از پری کلمپسیا روی یک شخص داوطلب که رول مریض را بازی میکنند مشاهده کنید در صورتیکه کدام داوطلب حاضر نمی باشد، یکی از ارزیابی کنندگان رول مریض را اجرا نماید در موقع که جواب دهنده کاری عملی مینماید چک لست را خانه پری نماید کود مخصوص را در چک لست بنویسد</p>

مراحل نهایی

از تکمیل شدن مراحل ذیل اطمینان حاصل کنید:

۱. ورق معلومات
۲. جوابات سوالات ۱ الی ۲۷
۳. پارتوگراف (سوال ۲۸)
۴. تمام اوراق جوابات سوال ۲۹
۵. چک لست خانه پری شده احیا مجدد طفل نوزاد
۶. چک لست خانه پری شده خروج پلاستنا با دست

۷. چک لست خانه پری شده (Manual Vacuum Aspiration) □

۸. چک لست خانه پری شده تداوی پری اکلپسیا □

پیش از آغاز مصاحبه بعدی و یا خارج شدن از کلینک، لطفاً خود را مطمئن سازید که مراحل ذیل را تکمیل نموده اید

۹. تمام اوراق ذکر شده فوق را در یک پاکت گذاشته

۱۰. اسم خود را و کود مخصوص را در بالای پاکت بنویسید

۱۱. پاکت را ببندید

۱۲. هر دوازیابی کننده بالای سیل پاکت امضا نماید

Partograph Case Study

سوال ۲۸ پارتوگراف

- خانم عاصمه به تاریخ 12.9.2000 به ساعت 05.00 داخل بستر شد.
- تمزق جیب مایع امینوتیک به ساعت 04.00 صورت گرفته است.
- گراویدا 3، پارا (Gr) 2+0 عاصمه، P، 3 عاصمه، 2+0 عاصمه (Gr) 2+0)
نمبر شفاخانه 7886
- در زمان دخول سر جنین به اندازه ۴/۵ بالای ارتفاع عانه قابل جس بوده و عنق رحم به اندازه 2 cm (۲ سانتی متر) توسعه داشت.
- 09.00
- راس جنین به اندازه 3/5 بالای ارتفاع عانه جس می شود.
- عنق رحم به اندازه 5cm توسعه نموده است.
- سه تقلص در 10 دقیقه هر یک 20-40 ثانیه دوام میکند.
- حرکت قلب جنین (FHR) 120/min فی دقیقه است.
- تمزق جیب و مایع امینوتیک شفاف است.
- درز های استخوان های جمجمه مقابل همدیگر قرار دارند.
- فشار خون 120/70mm Hg
- حرارت 36.8c
- نبض ۸۰ دقیقه
- مقدار ادرار 200ML ؛ پروتین و استون منفی

معلومات ذیل را در پارتوگراف ترسیم نماید:

09:30	حرکات قلب جنین	FHR ۱۲۰	تقلصات 3/10 هر 30 ثانیه	نبض 80/min
10:00	حرکات قلب جنین	136 FHR	تقلصات 3/10 هر 30 ثانیه	نبض 80/min
10:30	حرکات قلب جنین	140 FHR	تقلصات 3/10 هر 35 ثانیه	نبض 88/min
11:00	حرکات قلب جنین	130 FHR	تقلصات 3/10 هر 40 ثانیه	نبض 88/min
حرارت 37C				
11:30	حرکات قلب جنین	136 FH	تقلصات 4/10 هر 40 ثانیه	نبض 84/min
جس راس 2/5				
12:00	حرکات قلب جنین	140 FHR	تقلصات 4/10 هر 40 ثانیه	نبض 88/min
12:30	حرکات قلب جنین	130 FHR	تقلصات 4/10 هر 45 ثانیه	نبض 88/min
13:00	حرکات قلب جنین	140 FHR	تقلصات 4/10 هر 45 ثانیه	
نبض 90/min حرارت 37C				

• 13:00

- سر جنین به اندازه 0/5 بالای ارتفاع عانه قابل حبس است.
- عنق رحم کاملاً توسعه نموده.
- مایع امینوتیک شفاف.
- درز استخوان های جمجمه مقابل همدیگر قرار گرفته
- فشار خون 100/70 mmHg
- مقدار ادرار 150 ml، پروتئین و استون ادرار منفی

معلومات ذیل در پارتوگراف ثبت گردد:

• 13:20: تولد بنفسهی کودک به جنسیت دختر بوزن ۲.۸۵۰ g

مجموعه: () از ۱۰

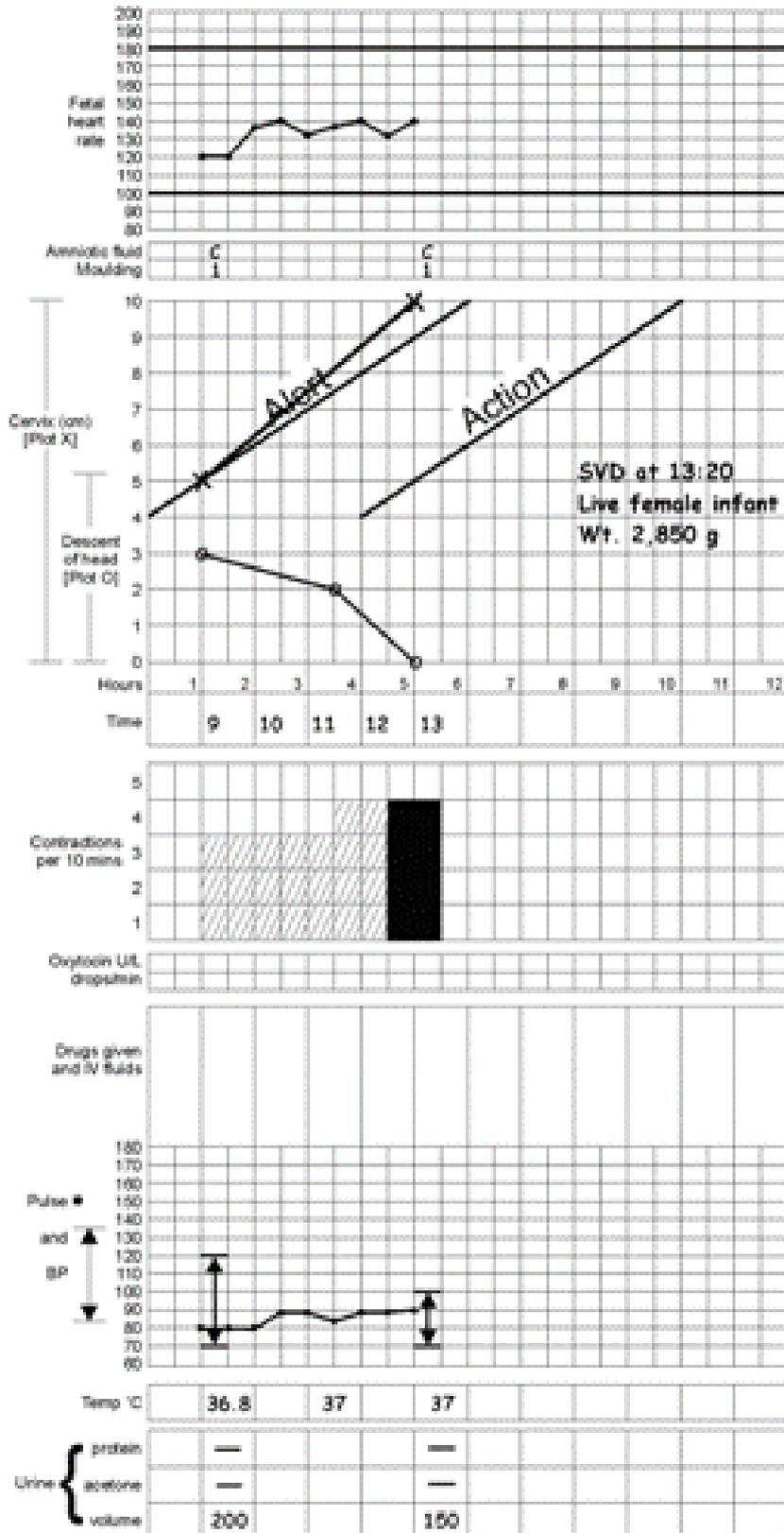
سوال ۲۸ پارتوگراف (درست ۱، نادرست ۰)

<input type="checkbox"/>	Name	Gravida	Para	Hospital number
<input type="checkbox"/>	Date of admission	Time of admission	Ruptured membranes	hours

<input type="checkbox"/>	Fetal heart rate	
<input type="checkbox"/>	Amniotic fluid Moulding	
<input type="checkbox"/>	Cervix (cm) [Plot X]	
<input type="checkbox"/>	Descent of head [Plot O]	
<input type="checkbox"/>	Contractions per 10 mins	
<input type="checkbox"/>	Oxytocin U/L drops/min	
<input type="checkbox"/>	Drugs given and IV fluids	
<input type="checkbox"/>	Pulse ● and BP ▲▼	
<input type="checkbox"/>	Temp °C	
<input type="checkbox"/>	Urine { protein, acetone, volume	

استفاده از پارتوگراف، کلید جواب

Name Mrs. A Gravida 3 Para 2+0 Hospital number 7885
 Date of admission 12.9.2003 Time of admission 5:00 A.M. Ruptured membranes 04:00 hours



Case Study Shock Due to Hemorrhage

۲۹. مطالعه واقعه: شاک بنابر خونریزی مهبلی بعد از ولادت

خانم عاصمه دو ساعت قبل یک نوزاد کاملاً به ترم را در خانه به دنیا آورده است و دایه محل او را ولادت داده است. که او فعلاً وی را به شفاخانه آورده است زیرا او بعد از ولادت خونریزی شدید مهبلی دارد. مدت درد های زایمان ۱۲ ساعت بوده است، ولادت نورمال و پلاسنتا ۲۰ دقیقه بعد از ولادت نوزاد خارج شده است. خانم "عاصمه" در عقب یک اسپ قرار داشته و توسط شوهر و خواهرش همراهی میشود. در جریان مراقبت قبل از ولادت دایه محل مفکوره پلان ولادت را توضیح کرده بود، و خانم عاصمه ترتیبات کراچی اسپ دارا زمانیکه به مرحله زایمان داخل میشود به خانه او گرفته بود. او همچنان از خواهرش تقاضای همراهی خویش را نموده و در صورت ضرورت به خون خواهرش را متقاعد به دادن خون کرده بود.

ارزیابی (تاریخچه، معاینه فیزیکی، طرز العمل های تلویزیونی/معاینات لابراتواری)

۱. کدام مسایل را در ارزیابی تان از خانم عاصمه شامل خواهید نمود و چرا؟
۲. کدام قسمت خاص معاینات فیزیکی خانم عاصمه شما را کمک خواهد نمود تا تشخیص را عاجلاً نموده و یا مشکلات و ضروریات او را مشخص نماید و چرا؟
۳. کدام پروسیجر های تشخیصیه/ معاینات لابراتواری (در صورت موجودیت) را شما در ارزیابی خانم عاصمه شامل می سازید و چرا؟

تشخیص (مشخص ساختن پرابلم ها/نیازها)

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

- سرعت نبض 120/minute، فشار خون 80/60 mm Hg، تعداد حرکات تنفسی 24/minute، و درجه حرارت خانم عاصمه 36.8°C است.
 - او خاسف است و عرق دارد.
 - رحم وی نرم است و با مساز غور رحم، تقلص نمی کند. او خونریزی شدید مهبلی که داری رنگ سرخ و روسن است دارد.
 - دایه محل وی میگوید که او فکر مینماید که پلاسنتا و آغشیه مکمل بوده است.
۴. به اساس این دریافت ها تشخیص خانم عاصمه چه است و چرا؟

تهیه مراقبت (پلانگزارى و مداخلات)

۵. به اساس تشخیص پلان مراقبت و تداوی شما برای خانم عاصمه چه است و چرا؟

ارزیابی:

- پانزده دقیقه بعد از شروع تداوی رحم اوسخت شده و مقدار خونریزی کاهش یافته است، سرعت نبض 110/minute فشار خون 80/60 mmHg است. مریض خاسف، عرق آلود و متهیج به نظر میرسد. مقدار هموگلوبین دریافت شد و شاید در حدود ۳ باشد. گروپ خون خانم با گروپ خون خواهرش یکسان میباشد.

۶. به اساس این دریافت ها ادامه پلان تداوی شما برای خانم عاصمه چه است و چرا؟

ورقه ثبت جوابات

۲۹. شک بنابر خونریزی مهبلی بعد از ولادت

ارزیابی (تاریخچه، معاینه فیزیکی، طرز العمل های تلویزیونی/معاینات لابراتواری)

نمره مجموعه: () بر ۱۲		۱. کدام مسایل را در ارزیابی تان از خانم عاصمه شامل خواهید نمود و چرا؟					
احوال پرسی				مهربانی و احترام		توضیح در باره کار های را که می خواهید انجام دهید	
به مریض به دقت گوش میدهد (طرز آرام، اطمینان بخش)							
ارزیابی سریع							
نبض سریع و ضعیف		فشار خون >90mmHg		خسافت		جلد عرق دار و سرد	
جلد چسپ ناک				تنفس سریع		اختلال حواس	
دیدن خروج پلاستناو تقلص و سختی رحم			کامل بودن پلاستنا و آغشیه آن				

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

دیدن تقلص و سختی رحم						
اگر رحم تقلص نکرده باشد مساز رحمی هر چه عاجل تر شروع گردد						
معاینه بخاطر پاره گی ها:		عججان		مهبل		عنق رحم

۳. کدام پروسیجر های تشخیصیه/ معاینات لابراتواری (در صورت موجودیت) را شما در ارزیابی خانم عاصمه شامل می سازید و چرا؟

هیچ کدام معاینه لابراتواری						
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تشخیص (مشخص ساختن پرابلم ها/نیازها)

نمره مجموعه: () بر ۲

۴. به اساس این دریافت ها تشخیص خانم عاصمه چه است و چرا؟

مشکوک به رحم اتونیک		شک از سبب خونریزی بعد از ولادت
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تهیه مراقبت (پلانگزارى و مداخلات)

نمرهٔ مجموعه: () بر ۱۸

۵. به اساس تشخیص پلان مراقبت و تداوى شما برای خانم عاصمه چه است و چرا؟

مساژ رحمى باید ادامه یابد	مریض باید تنها گذاشته نشود	تقاضای کمک و همکاری شود
مطمین شدن از باز بودن طرق تنفسی	مریض به یک پهلو قرار داده شده	اکسی توسین به مقدار ۱۰ یونیت از طریق عضله
پاهای مریض بالا نگهداری میشود	مریض گرم نگهداری میشود	تطبيق اکسیجن به مقدار 6-8 L/minute از طریق ماسک یا کنولا
نبض، فشار خون، وضایعات خون را در هر ۱۵ دقیقه تحت نظارت قرار دهید		
محلولات وریدی با استفاده از سوزن سوراخ کلان: یک لیتر محلول سودیم کلوراید و یا محلول رنگر لکتات در ظرف 20-15 دقیقه (تطبيق نماید)		
تعیین مقدار مایعات گرفتگی و مقدار ادرار با تطبيق کتر		
تهیه خون برای مریض	تعیین گروپ خون و کراسمچ	تعیین هموگلوبین
تشویق مریض جهت اظهار نگرانی های خویش	توضیح تمام مراحل که برای تداوی یا منجمت اختلالات گرفته می شود	
گوش دادن به نریض با دقت، حمایت عاطفی و اطمینان دادن		

نمرهٔ مجموعه: () بر ۱۱

ارزیابی:

۶. به اساس این دریافت ها ادامه پلان تداوی شما برای خانم عاصمه چه است و چرا؟

ادامه محلول سودیم کلوراید و یا رنگر لکتات داده شود	تطبيق جریان وریدی دومى جهت عاجل نقل الدم
به سرعت ۶۰ قطره درفی دقیقه	ضافه ۲۰ یونت اکسی توسین IV در لیتر دومى مایعات
فشار سیستولیک خون بیشتر از ۱۰۰	نبض کمتر از ۱۰۰
آدامهٔ انفوژن به سرعت یک لیتر در ظرف ۶-۸ ساعت	
سختی رحم	ضایعات خون
علایم حیاتی	هر ۱۵ دقیقه بعد کنترل شود:
تشویق مریض جهت اظهار نگرانی های خویش	توضیح تمام مراحل که برای تداوی یا منجمت اختلالات گرفته می شود
گوش دادن به نریض با دقت، حمایت عاطفی و اطمینان دادن	

Newborn Resuscitation

۳۰. احیای مجدد نوزاد

نمره	مرحله /وظیفه
	آماده گی
	۱. لباس های تر را کشیده نوزاد را خوب خشک نموده و با لباس های گرم و خشک بپوشانید.
	۲. نوزاد را بالای یک سطح پاک و گرم گذاشته و تمام نواحی آنرا به استثنای وجه و صدر بپوشانید.
	استفاده از ماسک و bag بخاطر احیای مجدد
	۱. راس نوزاد را اندکی بحالت بسط قرار دهید تا طرق تنفسی باز گردد.
	۲. طرق تنفسی را با سکشن پاک نماید طوری که اول دهن و بعدا بینی را: <ul style="list-style-type: none"> • کتتر را داخل دهن نوزاد نموده و در اثنای خروج آنرا سکشن نماید. • کتتر را داخل هر سوراخ بینی نوزاد نموده و در اثنای خروج آنرا سکشن نماید. • در اثنای سکشن کردن باید خوب دقت شود تا خون و موکونیم اگر در افرازات بینی و دهن موجود میباشد دیده شود. • اگر بعد از سکشن کردن طرق تنفسی هنوز هم نوزاد تنفس کرده نمی تواند به عملیه تنفس مصنوعی (ventilation) شروع نماید.
	۳. فوراً وضعیت راس نوزاد دوباره چک گردد تا مطمئن شوید که گردن در وضعیت اندکی بسط قرار دارد.
	۴. ماسک را بالای وجه نوزاد طور قرار دهید که زنج، دهن و بینی وی را کاملاً بپوشاند. (از ماسک سایز ۱ برای نوزادان که وزن نورمال دارند و از ماسک سایز ۰ برای نوزادان که وزن کمتر دارند استفاده گردد).
	۵. نظر به سایز خریطه یا bag آنرا فقط با دو انگشت و یا با همه دست فشار میدهیم.
	۶. بعد از هر دو الی سه تنفس مصنوعی دورادور ماسک را و بالا آمدن صدر را چک نماید
	۷. اگر صدر نوزاد با هر تنفس مصنوعی بالا بیاید: <ul style="list-style-type: none"> • تنفس مصنوعی ۴۰ بار در یک دقیقه داده شود.
	۸. اگر صدر نوزاد در اثنای تنفس بالا نیاید: <ul style="list-style-type: none"> • وضعیت راس نوزاد دوباره چک گردد تا مطمئن شوید که گردن در وضعیت اندکی بسط قرار دارد. • ماسک را بالای وجه نوزاد دوباره وضعیت داده تا کاملاً ماسک بالای وجه قرار گرفته و کدام سوراخ یا درز باقی نماند. • خریطه یا bag را با همه دست فشار میدهیم تا فشار تنفس مصنوعی زیاد گردد. • سکشن دهن و بینی تکرار شود تا مخاط، خون، و موکونیم از طرق تنفسی خارج گردد.
	۹. به مدت یک دقیقه برای نوزاد تنفس مصنوعی داده شود و در صورت موجودیت اکسیجن از آن استفاده گردد و عملیه را توقف داده فوراً نوزاد را بخاطر تنفس بنفسهی و رنگ جلد ارزیابی نماید: <ul style="list-style-type: none"> • اگر تنفس نورمال گردد (۳۰-۶۰ تنفس فی دقیقه) تنفس مصنوعی را توقف داده و نوزاد را پهلوی مادر بگزارید تا تماس جلد به جلد تامین گردد. • اگر نزد نوزاد سیانوز مرکزی (central cyanosis) لبها و زبان کبود، فرورفتگی قفس صدری (chest in drawing)، زجرت تنفسی زفیری (grunting)، و تعداد حرکات تنفسی کمتر از ۳۰ فی دقیقه تاسس نماید

نمره	مرحله /وظیفه
	وی را برای مشکلات تنفسی تداوی نماید. <ul style="list-style-type: none"> • اگر نوزاد gaspng دارد، یا تنفس ندارد و یا تعداد حرکات تنفسی کمتر از ۲۰ فی دقیقه دارد باید تنفس مصنوعی را برایش ادامه دهیم.
	۱۰. اگر نوزاد شروع به گریه نماید، تنفس مصنوعی را توقف دهید و بعد از ختم گریه تعداد حرکات تنفسی وی را برای مدت پنج دقیقه بشمارید: <ul style="list-style-type: none"> • اگر تنفس نورمال گردد (۳۰-۶۰ تنفس فی دقیقه) تنفس مصنوعی را توقف دهید. • اگر نزد نوزاد سیانوز مرکزی (central cyanosis) لبها و زبان کبود، فرورفتگی قفس صدری (chest in drawing)، زجرت تنفسی زفیری (grunting)، و تعداد حرکات تنفسی کمتر از ۲۰ الی ۳۰ فی دقیقه تاسس نماید وی را برای مشکلات تنفسی تداوی نماید. • اگر نوزاد gaspng دارد، یا تنفس ندارد و یا تعداد حرکات تنفسی کمتر از ۲۰ فی دقیقه دارد باید تنفس مصنوعی را برایش ادامه دهیم.
	۱۱. اگر نوزاد بعد از گرفتن ۲۰ دقیقه تنفس مصنوعی بطور منظم تنفس کرده نمی تواند: <ul style="list-style-type: none"> • تنفس مصنوعی را همراه با اکسیجن ادامه دهید. • در صورت امکان انتقال نوزاد را تنظیم نموده و وی را به یک مرکز که خدمات بهتر را ارائه میدارد رجعت دهید. (tertiary center)
	۱۲. اگر نزد نوزاد بعد از گرفتن ۲۰ دقیقه تنفس مصنوعی gaspng و تنفس موجود نباشد باید تنفس مصنوعی را برایش توقف داد. مادر و فامیلش از نظر عاطفی تقویه گردد.
	وظایف بعد از عملیه یا Procedure
	۱. کتتر سکشن را برای ۱۰ دقیقه در محلول کلورین ۰.۵% decontamination میگزاییم.
	۲. سطوح ما سک و خریطه تنفس مصنوعی را همراه پنبه الکول دار ۹۰-۶۰% یا کلورین ۰.۵% پاک نموده وفورا" شسته شود.
	۳. دست ها را همراهی آب و صابون کاملا" بشوید و همراه یک پارچه تمیز و پاک خشک نماید و یا بگزارید تا در هوا خشک گردد.
	مجموعه از (۱۷)

Manual Removal of Placenta

۳۱. خروج پلاسنتا با دست

نمره	مرحله/وظایف
	آماده گی
	۱. سامان آلات مورد ضرورت را تهیه نماید.
	۲. کار را که میخواهید انجام دهید به خانم بگویید، به وی گوش داده به سوالات و نگرانی هایش با دلچسپی پاسخ دهید.
	۳. تا حد امکان تقویه عاطفی دوامدار و اطمینان بخشی برای خانم فراهم نماید.
	۴. از خانم تقاضا شود تا مثانه خودرا تخلیه نماید و در صورت ضرورت کتتر مثانه تطبیق گردد.
	۵. انسستیزی داده شود (پتیدین و دیازپام، یا کیتامین از طریق ورید).
	۶. یک دوز واحد انتی بیوتیک داده شود: <ul style="list-style-type: none"> • امپی سیلین ۲ گرم از طریق ورید جمع میترونیازول ۵۰۰ ملی گرام وریدی، یا • سیفازولین ۱ گرم وریدی جمع میترونیازول ۵۰۰ ملی گرام وریدی
	۷. مانعه های محافظوی شخصی را بپوشید.
	کشیدن پلاسنتا توسط دست
	۱. دست ها و ساعد ها را کاملاً با آب و صابون بشوید و با یک پارچه پاک خشک نماید و یا بگذارید تا در هوا خشک گردد.
	۲. دستکش های معقم سطح عالی یا ستریل جراحی را در هر دو دست بپوشید. (یادداشت: در صورت موجودیت، دستکش های که تا آرنج دراز است استفاده شود)
	۳. حبل سروی را با یک پنس بگیرید.
	۴. حبل سروی را با ملایمت تا موازی بسطح کف اطاق کش نماید.
	۵. انگشتان یک دست را داخل مهبل و جوف رحم نموده و حبل سروی را تعقیب نماید تا به جایکه پلاسنتا قرار دارد برسد.
	۶. موقع که موقعیت پلاسنتا در جوف رحم تثبیت گردید حبل سروی را گذاشته و دست خود را بالای بطن قرار دهید تا غور رحم از بالای بطن حمایت شود و از uterine inversion یا رحم وارونه یا تغلف رحم جلوگیری شده باشد.
	۷. انگشتان دست را که داخل جوف رحم قرار دارد بطرف جنبی تا جایکه کنار ه های پلاسنتا قرار دارد حرکت دهید.
	۸. انگشتان دست داخل شده در جوف رحم را بسیار نزدیک بهم گرفته و با ملایمت در بین پلاسنتا و جدار رحم قرار دهید و کف دست بطرف پلاسنتا باشد.
	۹. تدریجاً دست را بطرف قدام و خلف با حرکات جنبی ملایم حرکت دهید تا تمام پلاسنتا از جدار رحم جدا شود: <ul style="list-style-type: none"> • در صورتکه پلاسنتا با حرکات جنبی ملایم انگشتان از جدار رحم جدا نشود به پلاسنتا اکریتا placenta accrete مشکوک شوید و ترتیبات مداخله جراحی را بگیرید.

	<p>۱۰. موقع که پلاستنا کاملاً جدا گردید:</p> <ul style="list-style-type: none"> • داخل جوف رحم را جس نماید تا مطمئن شوید که تمام پارچه های پلاستنا کشیده شده باشد. • دست را همراه پلاستنا به آهستگی از رحم بکشید. • کشش متقابل را در غور رحم بطور دوامدار با تیله نمودن غور رحم به جهت مخالف دست که خارج مینماید، فراهم نمایید.
	<p>۱۱. ۲۰ یونت اکسی توسین را در یک لیتر محلول وریدی مخلوط نموده بمقدار ۶۰ قطره فی دقیقه تطبیق نماید. (محلول سودیم کلوراید یا رنگر لکتات).</p>
	<p>۱۲. از یک اسپستانت تقاضا گردد که غور رحم را مساژ بدهد تا رحم اتونیک تحریک شده و تقلص نماید.</p>
	<p>۱۳. در صورت که خونریزی دوامدار باشد، بمقدار ۰.۲ ملی گرام ارگومترین یا پروستاگلاندین از طریق عضله تطبیق گردد.</p>
	<p>۱۴. سطح رحمی پلاستنا را معاینه نماید تا مطمئن شوید که مکمل است.</p>
	<p>۱۵. خانم را بطور دقیق معاینه نموده و هر نوع پاره گی های عنق رحم، و مهبل را ترمیم نماید ویا اپی زیوتومی را ترمیم نماید.</p>
وظایف بعد از عملیه	
	<p>۱. هر دو دست خودراکه که دستکش دارد در محلول ۰.۵٪ کلورین برای مدت زمان کم داخل نماید و بعداً دستکش ها را به حالت چپه بکشید:</p> <ul style="list-style-type: none"> • در صورتیکه دستکش ها را dispose می نمایم (دستکش های معاینه و دستکش های جراحی که دوباره استفاده نگردد) آنها را در یک خریطه پلاستیکی و یا قطی سرپوش دارد که سوراخ نباشد بگذارید. • در صورتیکه از دستکش های جراحی دوباره استفاده میشود آنها را برای مدت ۱۰ دقیقه برای decontamination در محلول ۰.۵٪ کلورین قرار دهید.
	<p>۲. دست ها را با آب و صابون کاملاً بشوید و با یک پارچه پاک نماید و یا بگذارید تا در هوا پاک گردد.</p>
	<p>۳. علایم خونریزی مهلی را تحت نظارت قرار دهید و علایم حیاتی خانم را بگیریید:</p> <ul style="list-style-type: none"> • هر ۱۵ دقیقه برای ۱ ساعت. • بعداً هر ۳۰ دقیقه برای ۲ ساعت
	<p>۴. مطمئن شوید که رحم خوب تقلص نموده است</p>
مجموعه از (۲۶)	

Manual Vacuum Aspiration [MVA]

۳۲. مراقبت بعد از سقط

نمره	مرحله/وظایف
	۱. با خانم با احترام و مهربانی احوال پرسی نماید.
	۲. مریض را بخاطر شاک و دیگر حالات که حیات را مورد تهدید قرار میدهد ارزیابی نماید.
	۳. در صورت تشخیص هر نوع اختلالات وضعیت مریض را پایدار ساخته و در صورت ضرورت به مراکز درمانی مجهز تر انتقال دهید.
ارزیابی طبی	
	۱. تاریخچه صحت باروری گرفته شود.
	۲. معاینات محدود فیزیکی (قلب، ریتان و بطن) و حوصلی را انجام دهید.
	۳. معاینات لابراتواری ضروری را انجام دهید.
	۴. به خانم در مورد وضعیت اش و توقع که می رود معلومات داده شود.
	۵. در صورت که مناسب باشد وظایف سیستم تناسلی وی را تشریح نماید.
	۶. اگر برای مریض IUD در نظر گرفته میشود: <ul style="list-style-type: none"> • در مورد تطبیق IUD باید با وی مشوره لازم شود. • تصمیم در مورد تطبیق IUD بعد از عملیه MVA ارتباط با وضعیت کلینیکی دارد.
آماده گی	
	۱. کار را که میخواهید انجام دهید به خانم (و پایبوازش) تشریح نماید و وی را تشویق نماید تا سوال نماید. به سخنان خانم با دلچسگی گوش دهید و به سوالات و نگرانی هایش پاسخ دهید.
	۲. در صورت امکان تقویه عاطفی دوامدار و اطمینان بخشی برای خانم فراهم نماید.
	۳. به مریض قبلاً یاد آوری گردد که ممکن وی در جریان بعضی از مراحل عملیه احساس نا راحتی نماید.
	۴. به خانم ۵۰۰ ملی گرام پاراسیتامول از طریق فمی ۳۰ دقیقه قبل از اجرا پروسیجر داده شود.
	۵. در مورد حساسیت با مواد انتی سبتیک ها و ادویه بیهوشی یا انیستتیک ها پرسان شود.
	۶. باید سامان آلات ستربل و معقم به سطح عالی که برای پروسیجر ضروری است آماده باشد.
	۷. مطمین شوید که کنولا سایزمناسب داشته و ادپتر مربوطه آماده باشد.
	۸. سرنج MVA را چک نموده و چارج نماید (وکیوم را آماده نماید)
	۹. چک نماید که خانم مثانه خود را تخلیه نموده است.
	۱۰. چک نماید که خانم کاملاً نواحی عجان خود را پاک شسته است.

	۱۱. مانعه های محافظوی شخصی را بپوشید.
	۱۲. دست ها را با آب و صابون کاملاً بشوید و با یک پارچه پاک نماید و یا بگذارید تا در هوا پاک گردد.
	۱۳. دستکش های جراحی استریل و یا معقم به سطح عالی را بپوشید.
	۱۴. سامان آلات استریل و یا معقم به سطح عالی را در یک تریو یا پطنوس استریل یا معقم آماده نماید.
وظایف قبل از عملیه	
	۱. بمقدار ۱۰ واحد اکسی توسین و یا ۰.۲ ملی گرام ارگومترین از طریق عضله تطبیق گردد.
	۲. معاینات حوصلی با یمینوال، چک نمودن جسامت رحم، موقعیت رحم و درجه اتساع عنق رحم را انجام دهید.
	۳. سپیکولوم را بداخل مهبل خانم نموده خون و انساج اضافی را با استفاده از اسفنج فورسپس و گاز خارج مینمایم.
	۴. عنق رحم و مهبل را دو مرتبه با محلول انتی سپتیک و گاز یا کتان استریل پاک نماید.
	۵. تمام محصولات حمل را از فوحه عنق رحم کشیده و عنق رحم را بخاطر پاره گی ها چک نماید.
اجرا بلاک پارا سرویکل (در صورت ضرورت)	
	۱. ۲۰ سی سی محلول لگنوکایین ۰.۵٪ بدو ن ادرینالین وا تهیه بدارید.
	۲. ۱۰ سی سی محلول ادرینالین ۰.۵٪ را داخل سرنج بکشید.
	۳. در صورتیکه از تیناکولوم یک دنداننه ای استفاده شود بمقدار ۱ سی سی محلول لگنو کایین را در لبه قدامی و خلفی عنق رحم زرق نماید (اکثراً موقعیت ۱۰ بجه یا ۱۲ بجه ساعت استفاده شود)
	۴. با ملایمت لبه قدامی عنق رحم با فورسپس تیناکولوم یا vulsellum گرفته شود. (در سقط نامکمل ترجیغاً فورسپس حلقوی یا اسپانچ استفاده میشود)
	۵. با تینا کولوم در عنق رحم اندکی کشش وارد نموده و تینیا کولوم را حرکت دهید تا ناحیه لشم بین اپیتلیوم عنق رحم و نسج مهبلگی را مشخص سازید.
	۶. سوزن سرنج را در تحت اپیتلیوم داخل نموده و پستون را با آهستگی به عقب بکشید تا مطمین شوید که سوزن داخل ورید نباشد.
	۷. در حدود ۲ ملی لیتر محلول لگنوکایین را در تحت اپیتلیوم، از ۳ ملی متر عمیق نروید، در ساعات ۳، ۵، ۷ و ۹ زرق نماید.
	۸. ۲ دقیقه انتظار بکشید و بعداً عنق رحم را با فورسپس بگیریید. (اگر خانم گرفتن با فورسپس را احساس نمود، دو دقیقه دیگر انتظار بکشید و دوباره تست نماید.)
پروسیجر MVA	
	۱. قبل از اجرا هر مرحله به خانم معلومات داده شود.
	۲. در عنق رحم یک کشش ملایم را ایجاد نماید تا عنق رحم و جوف رحم مستقیم گردد.
	۳. در صورت ضرورت عنق رحم را متوسع سازید و به این منظور از کنولا بزرگتر استفاده شود.
	۴. همزمان با گرفتن عنق رحم توسط فورسپس بطور دوامدار، کنولای انتخابی را با آهستگی و ملایمت داخل جوف رحم نماید تا که به غور رحم تماس نماید (اضافه تر از ۱۰ سانتی متر نباشد). بعداً کنولا را با آهستگی از غور رحم دور سازید.

	۵. سرنج آماده شده را طور به کنولا وصل نماید که کنولا را با یک دست و تینا کولوم و سرنج را در دست دیگر گرفته باشید. مطمئن شوید که کنولا بطرف جلو در اثنای وصل شدن با سرنج حرکت نکند.
	۶. pinch valve سرنج را آزاد نماید تا از طریق کنولا کشش در جوف رحم پیدا شود.
	۷. ا. بقایای محصولات حاملگی موجود در جوف رحم را با چرخاندن کنولا و سرنج از ساعات ۱۰ تا به ۲ و حرکت دادن کنولا به آهستگی بطرف عقب و جلو در داخل رحم تخلیه نماید. ب. اگر سرنج قبل از اتمام عملیه به اندازه نیم پر شود، سرنج را از کنولا جدا نموده و تنها سرنج را کشیده و کنولا را در جایش بگذارید. ج. پستون را فشار دهید و POC را در صافی تخلیه نماید. د. سرنج را دوباره چارچ نموده و به کنولا وصل نماید و پنچ والو را آزاد نماید.
	۸. علایم مکمل تخلیه را چک نماید (کف سرخ یا گلابی، عدم موجودیت انساج در کنولا، احساس ساییده شدن یا صدای کر کر و تقلص رحم در دورادور کنولا). کنولا و سرنج و کیوم (MVA) را با ملایمت خارج نماید.
	۹. کنولا را از سرنج و کیوم (MVA) جدا نموده و پستون را فشار دهید تا (POC) محتوی حمل در صافی تخلیه گردد.
	۱۰. قبل از کشیدن سپیکولوم، فورسپس یا تیناکولوم را از عنق رحم بکشید.
	۱۱. معاینه bimanual را بخاطر چک نمودن جسامت رحم و قوام رحم اجرا نماید.
	۱۲. در صورت ضرورت انساج کشیده شده را با آب و یا با محلول سودیم کلوراید بشوید.
	۱۳. انساج کشیده شده از جوف رحم را فوراً تفتیش نموده تا مطمئن شوید که جوف رحم کاملاً تخلیه گردیده است.
	۱۴. اگر محتوی حمل دیده نشود، وضعیت را دوباره ارزیابی نماید تا حمل خارج رحمی نباشد.
	۱۵. سپیکولوم را با آهستگی و ملایمت داخل نموده و بخاطر خونریزی چک نماید.
	۱۶. در صورت که رحم هنوز نرم باشد و خونریزی ادامه داشته باشد مراحل ۳ الی ۱۰ را تکرار نماید.
	وظایف بعد از پروسیجر
	۱. قبل از کشیدن دستکش ها، تمام مواد فاضله و باطله را در بین یک قطی یا خرطه که سوراخ نباشد بگذارید.
	۲. تمام سامان آلات را برای ۱۰ دقیقه در محلول ۰.۵٪ کلورین بخاطر decontamination قرار دهید.
	۳. سرنج ها و سوزن ها را Decontaminate و یا dispose نماید: • در صورت که از سرنج و سوزن دوباره استفاده گردد آنرا از محلول کلورین 0.5% مملو نموده (سوزن باید وصل باشد) و به مدت ده دقیقه در محلول مذکور قرار دهید تا decontamination گردد. • در صورتیکه سوزن ها و سرنج ها disposable باشند سوزن را داخل محلول کلورین 0.5% نموده و سه بار سرنج را از محلول مذکور مملو و خالی نموده و بعداً در یک قطی که در مقابل سوراخ شدن مقاوم باشد بگذرارید.
	۴. کنولا استفاده شده را با سرنج و کیوم وصل نموده و هر دو را با محلول کلورین ۰.۵٪ شستشو میدهیم.
	۵. کنولا را از سرنج جدا نموده و در محلول ۰.۵٪ کلورین برای ۱۰ دقیقه بخاطر decontamination بگذارید.

	۶. محتوی حمل را در جای مناسب، لاترین و یا یک قطی سرپوشدار محکم دور نماید.
	۷. هردو دست را که پوشیده با دستکش میباشد داخل محلول کلورین 0.5% نماید و دستکش ها را بطور سر چپه از دست ها بکشید. <ul style="list-style-type: none"> • در صورت که دستکش ها دسپوزبل باشند در یک قطی محفوظ و یا خریطه پلاستیکی انداخته شود. • در صورتیکه از دستکش ها دوباره استفاده گردد آنها را در محلول کلورین 0.5% برای ده دقیقه بگذارید.
	۸. دست ها را با آب و صابون کاملا" بشوید و با یک پارچه خشک پاک نماید و یا در هوا خشک نماید.
	۹. به مریض اجازه داده شود تا برای ۳۰ دقیقه بطور راحت استراحت نماید و بهبودی وی تحت نظارت قرار داده شود.
	۱۰. خونریزی وی چک گردد و قبل از رخصت شدن مطمئن شوید که درد های کرامپ مانند کاهش یافته باشد.
	۱۱. به مریض در مورد مراقبت بعد از سقط و علایم خطر آگاهی داده شود.
	۱۲. در صورت ضرورت به کنترل به مریض وقت مراجعه دوباره گفته شود و هم وی هر وقت که کدام نگرانی میداشته باشد مراجعه کرده می تواند.
	۱۳. اهداف باروری بحث شود و در صورت مناسب در مورد رهنمای خانواده معلومات ارایه گردد.
	مجموعه از (65)

Interview guide

رهنمای مصاحبه

- با قا بله احوال پرسى ميكنيم
- با استفاده از فورمه رضايـت هدف مصاحبه را برايش را تـشريح ميدهيم .
- اگر قابله موافق باشد مصاحبه دهد فورمه را امضا ميكنم .
- يك ورق معلو مات را گرفته آنرا خانه پري ميكنم.
- اگر ورق معلو مات غلط شد يا باطل شد و قابل اصلاح نبود يك ورق معلو مات ديگر استفاده کرده اولي را پاره ميكنم.
- با اجازه قابله سوال هارا شروع ميكنم .
- ازروي سوال نامه از سوال (۱) الي (۲۶) را ميخوانم و جوابات را در ورق هاي سفيد مينويسيـم.
- براي هر ورق سفيد شماره مخصوص ورق معلو مات را درج ميكنيم.
- ورق هارا حين نوشتن از اول شماره گزاري ميكنيم.
- حين عبور از يك سوال به سوال ديگر جملات انتفالي به كار مي بريم مثال : خوب تشكر حالا سوال ديگر دارم، از طرف ديگر، ضمناً، حالا بايد عرض دارم و غيره.
- در ختم سوال (۲۶) از قابله تشكر کرده يك تفریح کوتاه ميگيريم .
- بعد از تفریح ورق واقعه فرضی پار تو گراف را به قابله ميدهم و برايش يك پار تو گراف خالی ميدهم که پر کند اگر فکر کردید مناسب است اطاق را ترک کرده ميگذاريم قابله به تنهائي کار کند.
- وقني پا را گراف خلاص شد قابله را تفریح داده خود ما پارتو گراف را با پار تو گراف قبلا کار شده (کلید) مقایسه کرده نمره ميدهيم.
- ورق واقه فرضی را دو باره از قابله گرفته در دوسيه ميگزاريم (برای قابله بعدی)
- روی پارتو گراف شماره مخصوص ورق معلو مات را مينويسيـم
- پار تو گراف نمره داده شده را همراهی جوا بات قبلي ميگزاريم
- بعداً به قابله واقعه فرضی شان را ميدهم
- برای قابله ورقهای سفيد کافی (۵ يا بيشتـر) ميدهم که جوابهايش را بنويسد.
- در ختم قابله را تفریح داده خود ما از روی ورق نمره دهی شان جوابهای اورا نمره ميدهيم .
- ورقهای جوا بات را شماره گزاري ميكنيم.
- كود مخصوص را هم روی ورقهای جوابات قابله هم روی ورقهای نمره دهی مينويسيـم.
- ورقهای جوابات و ورق نمره دهی را همراهی جوا بات قبلي ميگزاريم.
- حالا از قابله خواهش ميكنيم که روی مودل طفل نوزاد احياي مجدد را تمثيل کند.
- در روی ورق نمره دهی از روی کارهای که قابله ميکند و اظهاراتي که ارايه مينمايد نمره ميدهيم.
- در ختم شماره كود خصوص ورق معلومات را روی ورق نمره داده شده نوشته آنرا به ورق هاي جوابات قبلي ميگذاريم.
- حالا روی مودل قابله MROP را کار ميکند.
- در روی ورق نمره دهی وی را نمره ميدهيم.
- در ورق نمره دهی شماره مخصوص ورق معلومات را نوشته آنرا همراه ديگر اوراق جوابات ميگذاريم.
- اگر قابله خسته باشد تفریح ميكنيم.
- اين بار قابله رول مودل MVA را کار ميکند.
- شماره مخصوص ورق معلومات را روی ورق نمره داده شده نوشته آنرا به اوراق جوابات قبلي اضافه ميكنيم.
- حالا يك شخص ثالث را دعوت ميكنيم که رول مريض را بازی ميکند اگر شخص ثالث نباشد يکي از شما اين رول را بازی ميکند.
- مريض در روی اکلمسيا ميباشد.
- قابله سوالهای معاينات و اهمتامات اکلمسيا را روی شخص ثالث تمرين ميکند و ما مشاهده ميکنيم.

- هنگامیکه قابله و شخص ثالث تمثیل میکنند ما در ورق نمره دهی او را نمره میدهیم.
- روی ورق نمره داده شده کد مخصوص ورق معلومات را میزنیم.
- جواب را همراه جوابات دیگر میگذاریم.
- از قابله و شخص ثالث تشکری میکنیم و ختم مصاحبه را اعلان میکنیم.

Consent form

ضمیمه د : فورمه موافقه الف: قابله

نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمت قابله ها - و پروژه تقویه خدمات صحتی (HSSP)

توضیحات در مورد ارزیابی:

سلام، نام من _____ است و من به نمایندگی از وزارت صحت عامه و پروژه تقویه خدمات صحتی افغانستان که پروگرام تربیه قابله ها را در افغانستان مساعدت مینمایند در خدمت شما میباشم. ما برای بهبود پروگرام تربیه قابله ها در سراسر کشور کار مینماییم. منحیت بخشی از کار خویش فعلا میخواهیم با یکعه از فارغین جدید مکاتب تربیه قابله ها ملاقات داشته باشیم تا از یشان درباره تجارب شان در مکاتب قابله گی و کارشان بپرسیم.

هدف کلی این ارزیابی دانستن این است که بهبود تربیه قابله ها قبل از خدمت روی دسترسی و کیفیت خدمات صحتی برای مادران و نوزادان چه تاثیر داشته و میخواهیم بدانیم که این پروگرام چگونه بهبود یافته میتواند تا شاگردان آینده برای خدمت بهتر به جامعه آماده گردند.

سوال تفریقی

آیا شما فعلا به حیث قابله ایفای وظیفه میکنید؟

بلی

نخیر

در صورتیکه جواب نه باشد توضیح نما ید چرا:

از شما چه خواسته خواهد شد که انجام دهید:

من شما را دعوت مینمایم تا در این مطالعه ارزیابی اشتراک کنید از شما چند سوال در رابطه تعلیم و کار فعلی تان خواهیم پرسید. میخواهم در یک بازی تمثیلی با یک مودل انا تومیک شما را مشاهده و یک فورم کو تاهی را خانه پری نما یم که این فورم در مورد استفاده از پارتو گراف، جلو گیری از خونریزی جریان حمل ویا بعد از ولادت میباشد.

خطرات، ناراحتی و فواید این گفتگو

هیچگونه خطر و یا فایده مستقیم در اشتراک این ارزیابی متوجه تان نخواهد بود. اگر کدام سوالی شما را ناراحت میکند و یا هر سوالی دیگری که باشد شما میتوانید از جواب دادن امتناع ورزید. اگر احساس ناراحتی کردید شما میتوانید مشاهده را هر زمانی که خواسته باشید توقف دهید.

در خاتمه این ملاقات من به شما در مورد کار تان مشوره خواهم داد. معلومات این ارزیابی برای بهبود تربیه قابله ها و کیفیت خدمات صحتی برای مادران و اطفال در افغانستان به کار خواهد رفت.

محرمیت

اشتراک در این ارزیابی کاملاً اختیاری و محرم است معلوماتی که شما عرضه مینمایید تنها به کارکنان این مطالعه قابل دسترسی خواهد بود نام، آدرس و دیگر معلومات شخصی تان روی هیچ فورم ، ورق و یا راپوری یادداشت نخواهد شد هیچ معلومات در رابطه به طرز کار شما با آمر تان و یا همکاران تان شریک نخواهد شد و بالای وظیفه تان هیچ اثری نخواهد داشت .

ما از اشتراکتان در این ارزیابی قدردانی مینمایم زیرا معلوماتی که میدهید بسیار مهم است . مصاحبه، مشاهده، فورمه سروی و یادداشت آن حدود دوساعت وقت شما را میگیرد. اگر هر زمانی سوالی داشتید بدون هراس بپرسید. هر زمانی بخواهید اشتراک تان را خاتمه داده میتوانید. میخواهید کدام سوالی در رابطه به این ارزیابی از من بکنید؟

اگر موافق هستید که در این ارزیابی حصه بگیریید لطفا اظهار نماید. من رضایت شفاهی تانرا در این فورمه یادداشت مینمایم که شما آنرا امضا خواهید کرد.

تصدیق مینمایم که من فورمه رضایت اشتراک کننده را در حضور اشتراک کننده خواندم و ایشان پذیرفتند 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 داشته باشید یا شکایتی در رابطه با این تحقیق داشته باشید لطفاً با دا کتر نصرت الله (انصاری) به نمبر تیلیفون (۰۷۹۹۸۷۸۶۹۱) در تماس شوید.

ضمیمه د : فورمه موافقه الف: قابله

نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمت قابله ها - و پروژه تقویه خدمات صحتی (HSSP)

توضیحات در مورد ارزیابی:

سلام. نام من _____ است و من به نمایندگی از وزارت صحت عامه و پروژه تقویه خدمات صحتی افغانستان که پروگرام تربیه قابله ها را در افغانستان مساعدت مینمایند در خدمت شما میباشم. ما برای بهبود پروگرام تربیه قابله ها در سراسر کشور کار مینماییم. منحصیث بخشی از کار خویش فعلا میخواهیم با یکده از فارغین جدید مکاتب تربیه قابله ها ملاقات داشته باشیم تا از یشان درباره تجارب شان در مکاتب قابله گی و کارشان بپرسیم. هدف کلی این ارزیابی دانستن این است که بهبود تربیه قابله ها قبل از خدمت روی دسترسی و کیفیت خدمات صحتی برای مادران و نوزادان چه تاثیر داشته و میخواهیم بدانیم که این پروگرام چگونه بهبود یافته میتواند تا شاگردان آینده برای خدمت بهتر به جامعه آماده گردند.

سوال تفریقی

آ یا شما فعلا به حیث قابله ایفای وظیفه میکنید؟

بلی

نخیر

در صورتیکه جواب نه باشد توضیح نما ید چرا:

از شما چه خواسته خواهد شد که انجام دهید:

من شما را دعوت مینمایم تا در این مطالعه ارزیابی اشتراک کنید از شما چند سوال در رابطه تعلیم و کار فعلی تان خواهیم پرسید. میخواهم در یک بازی تمثیلی با یک مودل انا تومیک شما را مشاهده و یک فورم کو تاهی را خانه پری نما یم که این فورم در مورد استفاده از پارتو گراف، جلو گیری از خونریزی جریان حمل ویا بعد از ولادت میباشد.

خطرات، ناراحتی و فواید این گفتگو

هیچگونه خطر و یا فایده مستقیم در اشتراک این ارزیابی متوجه تان نخواهد بود. اگر کدام سوالی شما را ناراحت میکند و یا هر سوالی دیگری که باشد شما میتوانید از جواب دادن امتناع ورزید. اگر احساس ناراحتی کردید شما میتوانید مشاهده را هر زمانی که خواسته باشید توقف دهید.

در خاتمه این ملاقات من به شما در مورد کار تان مشوره خواهم داد. معلومات این ارزیابی برای بهبود تربیه قابله ها و کیفیت خدمات صحتی برای مادران و اطفال در افغانستان به کار خواهد رفت.

محرمیت

اشتراک در این ارزیابی کاملاً اختیاری و محرم است معلوماتی که شما عرضه مینمایید تنها به کارکنان این مطالعه قابل دسترسی خواهد بود نام، آدرس و دیگر معلومات شخصی تان روی هیچ فورم ، ورق و یا راپوری یادداشت نخواهد شد هیچ معلومات در رابطه به طرز کار شما با آمر تان و یا همکاران تان شریک نخواهد شد و بالای وظیفه تان هیچ اثری نخواهد داشت .

ما از اشتراکتان در این ارزیابی قدردانی مینمایم زیرا معلوماتی که میدهید بسیار مهم است. مصاحبه، مشاهده، فورمه سروی و یادداشت آن حدود دوساعت وقت شما را میگیرد. اگر هر زمانی سوالی داشتید بدون هراس بپرسید. هر زمانی بخواهید اشتراک تان را خاتمه داده میتوانید. میخواهید کدام سوالی در رابطه به این ارزیابی از من بکنید؟

اگر موافق هستید که در این ارزیابی حصه بگیریید لطفا اظهار نماید. من رضایت شفاهی تانرا در این فورمه یادداشت مینمایم که شما آنرا امضا خواهید کرد.

تصدیق مینمایم که من فورمه رضایت اشتراک کننده را در حضور اشتراک کننده خواندم و ایشان پذیرفتند 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 داشته باشید یا شکایتی در رابطه با این تحقیق داشته باشید لطفاً با دا کتر نصرت الله (انصاری) به نمبر تیلیفون (۰۷۹۹۸۷۸۶۹۱) در تماس شوید.

Consent form Key stakeholders

فورمه موافقت نامه

نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمت قابله ها - و پروژه تقویه خدمات صحتی (HSSP)

توضیحات در مورد ارزیابی:

سلام، نام من _____ است و من به نمایندگی از وزارت صحت عامه افغانستان، پروژه تقویه خدمات صحتی و موسسات دیگریکه پروگرام تربیه قابله ها را در افغانستان مساعدت مینمایند در خدمت شما میباشم. ما برای بهبود پروگرام تربیه قابله ها در سراسر کشور کار مینماییم. منحصی بخشی از کار خویش فعلا میخواهیم با یکعده از دست اندرکاران مختلف (روسای صحت عامه، مسئولین پروگرام های قابلگی، آمرین پروژه های BPHS ازولایات مربوطه، ریس صحت باروری و ریس قوای بشری وزارت صحت عامه، نماینده بورد اعتباردهی مکاتب قابلگی وانجمن قابله های افغان) از بخش صحت مصاحبه داشته باشیم تا از ایشان درباره تجارب شان به ارتباط مکاتب قابله گی و کیفیت کار قابله های فارغ شده از این مکاتب بپرسیم.

هدف کلی این ارزیابی دانستن این است که بهبود تربیه قابله ها قبل از خدمت روی دسترسی و کیفیت خدمات صحتی برای مادران و نوزادان چه تاثیر داشته و میخواهیم بدانیم که این پروگرام چگونه بهبود یافته میتواند تا شاگردان آینده برای خدمت بهتر به جامعه آماده گردند.

از شما چه خواسته خواهد شد که انجام دهید:

من شما را دعوت مینمایم تا در این ارزیابی اشتراک کنید. از شما چند سوال در رابطه به ابعاد مختلف تعلیمات قابلگی بگونه مثال: موثریت پروگرام قابلگی و تاثیرات آن روی دسترسی و کیفیت خدمات صحتی طفل و مادرخواهم پرسید. در اخیر از شما تقاضا خواهند شد تا نظریات و پیشنهادات خویش را در رابطه به بهبود بخشیدن تعلیمات قابلگی با ما شریک سازید.

خطرات، ناراحتی و فواید این گفتگو

هیچگونه خطر و یا فایده مستقیم در اشتراک این ارزیابی متوجه تان نخواهد بود. اگر کدام سوالی شما را ناراحت میکند و یا هر سوالی دیگری که باشد شما میتوانید از جواب دادن امتناع ورزید. اگر احساس ناراحتی کردید شما میتوانید مشاهده را هر زمانی که خواسته باشید توقف دهید.

معلومات که در این ارزیابی جمع آوری میگردد به منظور بهبود بخشیدن تعلیمات قابلگی و خدمات که توسط قابله های فارغ شده عرضه میگردد استفاده خواهد شد.

محرمیت

اشتراک در این ارزیابی کاملا اختیاری و محرم است معلو ماتیکه شما عرضه مینمایید تنها به کارکنان این مطالعه قابل دسترسی خواهد بود نام، آدرس و دیگر معلومات شخصی تان روی هیچ فورم، ورق ویا راپوری یادداشت نخواهد شد هیچ معلومات در رابطه به طرز کار شما با آمر تان و یا همکاران تان شریک نخواهد شد و بالای وظیفه تان هیچ اثری نخواهد داشت.

ما از اشتراک تان در این ارزیابی قدردانی مینمایم زیرا معلوماتی که میدهید بسیار مهم است. مصاحبه حدود یک ساعت دوام خواهند کرد. اگر هر زمانی سوالی داشتید بدون هراس بپرسید. هر زمانی بخواهید اشتراک تان را خاتمه داده میتوانید. میخواهید کدام سوالی در رابطه به این ارزیابی از من بکنید؟

اگر موافق هستید که در این ارزیابی حصه بگیریید لطفا اظهار نماید. من رضایت شفاهی تانرا در این فورمه یادداشت مینمایم که شما آنرا امضا خواهید کرد.

تصدیق مینمایم که متن فورمه رضایت به من در شروع مصاحبه خوانده شد و مطالب آن به من واضح گردید، بناء من بصورت اختیاری در این مصاحبه اشتراک مینمایم.

امضا/شخصت مصاحبه شونده

تاریخ

تصدیق مینمایم که من فورمه رضایت اشتراک کننده را در حضور اشتراک کننده خواندم و ایشان پذیرفتند 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 داشته باشید یا شکایتی در رابطه با این تحقیق داشته باشید لطفا با دا کتر نصرت الله (انصاری) به نمبر تیلیفون (۰۷۹۹۸۷۸۶۹۱) 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

Consent form Community member women

فورمه موافقت نامه

نام پروژه: ارزیابی پروگرام تربیوی قبل از خدمت قابله ها - و پروژه تقویه خدمات صحتی (HSSP)

توضیحات در مورد ارزیابی:

سلام. نام من _____ است و من به نمایندگی از وزارت صحت عامه افغانستان، پروژه تقویه خدمات صحتی و موسسات دیگریکه پروگرام تربیه قابله ها را در افغانستان مساعدت مینمایند در خدمت شما میباشم. ما برای بهبود پروگرام تربیه قابله ها در سراسر کشور کار مینماییم. منحصبت بخشی از کار خویش فعلا میخواهیم با یکدهه از دست اندرکاران مختلف مصاحبه داشته باشیم تا از ایشان درباره تجارب شان به ارتباط مکاتب قابله گی و کیفیت کار قابله های فارغ شده از این مکاتب بپرسیم. هدف کلی این ارزیابی دانستن این است که بهبود تربیه قابله ها قبل از خدمت روی دسترسی و کیفیت خدمات صحتی برای مادران و نوزادان چه تاثیر داشته و میخواهیم بدانیم که این پروگرام چگونه بهبود یافته میتواند تا شاگردان آینده برای خدمت بهتر به جامعه آماده گردند.

از شما چه خواسته خواهد شد که انجام دهید:

من شما را دعوت مینمایم تا در این ارزیابی اشتراک کنید. از شما چند سوال در رابطه به ابعاد مختلف تعلیمات قابله گی بگونه مثال: موثریت پروگرام قابله گی و تاثیرات آن روی دسترسی و کیفیت خدمات صحتی طفل و مادرخواهم پرسید. در اخیر از شما تقاضا خواهند شد تا نظریات و پیشنهادات خویش را در رابطه به بهبود بخشیدن تعلیمات قابله گی با ما شریک سازید.

خطرات، ناراحتی و فواید این گفتگو

هیچگونه خطر و یا فایده مستقیم در اشتراک این ارزیابی متوجه تان نخواهد بود. اگر کدام سوالی شما را ناراحت میکند و یا هر سوالی دیگری که باشد شما میتوانید از جواب دادن امتناع ورزید. اگر احساس ناراحتی کردید شما میتوانید مشاهده را هر زمانی که خواسته باشید توقف دهید.

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

محرمیت

اشتراک در این ارزیابی کاملا اختیاری و محرم است معلوماتیکه شما عرضه مینمایید تنها به کارکنان این مطالعه قابل دسترسی خواهد بود نام، آدرس و دیگر معلومات شخصی تان روی هیچ فورم، ورق ویا راپوری یادداشت نخواهد شد. ما از اشتراک تان در این ارزیابی قدردانی مینمایم زیرا معلوماتی که میدهید بسیار مهم است. مصاحبه حدود یک ساعت دوام خواهند کرد. اگر هر زمانی سوالی داشتید بدون هراس بپرسید. هر زمانی بخواهید اشتراک تان را خاتمه داده میتوانید. میخواهید کدام سوالی در رابطه به این ارزیابی از من بکنید؟

اگر موافق هستید که در این ارزیابی حصه بگیریید لطفا اظهار نماید. من رضایت شفاهی تانرا در این فورمه یادداشت مینمایم که شما آنرا امضا خواهید کرد.

تصدیق مینمایم که متن فورمه رضایت به من در شروع مصاحبه خوانده شد و مطالب آن به من واضح گردید، بناء من بصورت اختیاری در این مصاحبه اشتراک مینمایم.

تاریخ

امضا/شخصت مصاحبه شونده

تصدیق مینمایم که من فورمه رضایت اشتراک کننده را در حضور اشتراک کننده خواندم و ایشان پذیرفتند که اشتراک نمایند

تاریخ

امضا شاهد (سوال کننده)

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 داشته باشید یا شکایتی در رابطه با این تحقیق داشته باشید لطفا با دا کتر نصرت الله (انصاری) به نمبر تیلیفون (۰۷۹۹۸۷۸۶۹۱) در تماس شوید.

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?

Prospective data collection Register

		نام قابله				ولایت										
		کود کلینیک				ونسواتی										
SNo	سن	Parity	تفصیل فعالیت‌ها (بلی ✓ نخیر ✗)							نتیجه ولایت (بلی ✓ نخیر ✗)						
			ولایت نورمال	ولایت کمک شده	نوع کمک		اختلاطات	نوع* اختلاطات	نمای شده	رجعت داده شده	وفاات مالم	ولایت مردم	ولایت زنده		وفاات نوزاد	وزن نوزاد (کیلو گرم)
			Forceps	Vaccum							Asyphexic	Normal				
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																
16																
17																
18																
19																
20																
*Codes for Types of complications							* Codes for Types of complications (continued)									
1	شکاف (به جدول شکاف به سبب خونریزی)						4	Dystocia								
2	(malpresentation, dispropotional Cephalopelvic large baby) ولادت انسدادی						5	Retention of Placenta احتباس پلاسنتا								
3	Preeclampsia/Eclampsia اکتلمسی / بری اکتلمسی						6	Fetal distress								

Annex 2: Detailed Midwifery Deployment data

School	Currently studying	Enrolled	Graduated	Drop-outs	Percent Graduated	Deployed	Percent deployed of graduated	Currently working	Percent currently working of graduated
IHS									
Herat	41	184	172	12	93%	136	79%	125	92%
Jalalabad	22	237	220	13	93%	220	100%	151	69%
Kabul	79	518	448	70	86%	320	71%	299	93%
Kandahar	25	75	54	21	72%	54	100%	50	93%
Mazar	0	218	209	9	96%	160	77%	129	81%
Total IHS	167	1232	1103	125	90%	890	81%	754	85%
CME									
Badakhshan	49	42	39	3	93%	39	100%	39	100%
Badghis	0	46	33	11	72%	14	42%	27	193%
Baghlan	0	34	34	0	100%	34	100%	30	88%
Bamyan	45	42	41	1	98%	36	88%	32	89%
Dikondy	16	0	0	0		0			
Farah	0	27	27	0	100%	22	81%	22	100%
Faryab	38	0	0	0		0		0	
Ghanekhel	18	96	93	3	97%	89	96%	66	74%
Ghor	25	0	0	0		0			
Helmand	22	0	0	0		0			
Jawzjan	53	50	46	4	92%	46	100%	43	93%
Kapisa	0	30	30	0	100%	30	100%	30	100%
Khost	61	60	60	0	100%	39	65%	39	100%
Kunduz	0	65	65	0	100%	60	92%	42	70%
Laghman	0	41	41	5	100%	36	88%	36	100%
Logar	20	20	20	0	100%	20	100%	18	90%
Noristan	0	19	19	0	100%	19	100%	19	100%
Paktya	50	45	44	1	98%	42	95%	39	93%
Parwan	29	84	84	0	100%	84	100%	53	63%
Samangan	0	38	37	1	97%	34	92%	34	100%
Saripul	0	40	39	1	98%	39	100%	36	92%
Takhar	48	44	43	1	98%	43	100%	41	95%
Uruzgan	12	0	0	0		0		0	
Wardak	23	63	63	0	100%	59	94%	48	81%
Total CME	509	886	858	31	97%	785	91%	694	88%
Grand Total IHS & CME	676	2118	1961	156	93%	1675	85%	1448	86%

ⁱ Bartlett L, Mawji S, Whitehead S, Crouse C, Dalil S, Ionete D, Salama P, and the Afghan Maternal Mortality Study Team. Where giving birth is a forecast for death: maternal mortality in four districts of Afghanistan, 1999-2002. *Lancet* 2005; 365:864-70.

ⁱⁱ Human Resource Department Policy, July 2003. MoPH, Kabul.

ⁱⁱⁱ Afghanistan multiple indicator cluster survey 2003: report to the Afghanistan MOPH, by the Johns Hopkins University Bloomberg School of Public Health & Indian Institute of Health Management Research, unpublished.

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^v MoPH. (2008). *National Human Resources Development Plan for Reproductive Health*.

^{vi} Smith JM, (2008 122). Establishment of an accreditation system for midwifery education in Afghanistan: Maintaining quality during national expansion. *Public Health*. , 558-567.