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I am pleased to introduce this National Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy 2017–2021 of the Ministry of Public Health, which is the combination of revised Reproductive Health, and Child and Adolescent Health strategies. It gives detailed direction for the area of RMNCAH for the next five years.

The strategy has been developed within the framework of the National Health Strategy 2016–2020. It has seven strategic areas: Maternal Health, Newborn Care in Health Facilities, Birth Spacing and Family Planning, Child Health, Adolescent Health, Reproductive Morbidity, and Cross-Cutting and Enabling Strategic Approaches. Implementation Factors and Monitoring the Strategy’s Progress are complementary areas.

The role of the RMNCAH Directorate is accurately defined in this national strategy as one of stewardship. The principal activities of the Directorate should be motivating, advocating, guiding, linking, setting standards, monitoring, and collaborating with its partners. The Ministry considers this to be the most effective and efficient and least costly way for Afghanistan to achieve its goals with regard to reproductive, maternal, newborn, child, and adolescent health.

This strategy will guide the Ministry of Public Health in developing a costed implementation plan to address the RMNCAH needs of the country. It will also guide the implementing agencies, the private sector, and other partners in aligning their activities with the interventions of this strategy and their implementation.

Finally, I greatly appreciate and thank everyone involved for their active participation, collaboration, and valuable inputs. I would like to particularly acknowledge the strong leadership of the RMNCAH Director in directing the strategy development team, including the RMNCAH team, national and international technical partners, the Provincial Health Officers, and nongovernmental implementing agencies.

Sincerely,

Ferozuddin Feroz, MD, MSc (Health Systems Management)
Minister of Public Health, Afghanistan
March 2017
ACKNOWLEDGEMENTS

This National Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy 2017–2021 was developed through a participatory and collaborative process that involved RMNCAH Directorate staff and national and international stakeholders. I would like to express our sincere appreciation and gratitude to each of them.

At the heart of the development were the strategy sub-groups led by Dr. Zohra Shamszai (Maternal Health), Dr. Rizwan Ullah (Newborn Care in Health Facilities), Dr. Ghutai Sadiq Yaqubi (Birth Spacing and Family Planning), Dr. Sayed Alisha Alawi (Child Health), Dr. Naqeebullah Ziar and Dr. Danish (Adolescent Health), Dr. Rangina Aziz (Reproductive Morbidity), Dr. Abdul Zahir Seddiqi (Reproductive Health Commodity Security), and Dr. Nezamuddin Jalil and Dr. Mohammad Samim Soroush (Cross-Cutting Issues and Monitoring).

In addition, I would like to thank the strategy core group members, who provided valuable inputs during the reviews of strategic areas in regular meetings of the core group. The core group consisted of members from the MoPH and its key national and international partners and stakeholders (listed alphabetically):

- Afghan Family Guidance Association (AFGA)
- Afghan Midwifery Association (AMA)
- Afghan Social Marketing Organization (ASMO)
- Afghan Society of Obstetricians and Gynecologists (AFSOG)
- Aga Khan Development Network (AKDN)
- CARE
- HEMAYAT Project
- Marie Stopes International-Afghanistan (MSI)
- Swedish Committee for Afghanistan (SCA)
- United Nations Population Fund (UNFPA)
- United Nations Children’s Fund (UNICEF)
- US Agency for International Development (USAID)
- World Health Organization (WHO).

Our special thanks go to all development partners for their direct and indirect support and participation in the development of this document. I would like to acknowledge USAID’s support for the contributions of two international technical advisors from Management Sciences for Health (MSH): Dr. Iain Aitken and Dr. William Newbrander. We would like to extend our sincere appreciation to Dr. Aitken and Dr. Newbrander for their valuable inputs in compiling the Reproductive Health, and Child and Adolescent strategies, and refining and enriching the strategy.

I must also acknowledge the contributions of our other international partners in providing valuable comments and inputs on the draft strategy, including Global Affairs Canada, the Family Planning 2020 Global Initiative, and WHO’s regional and headquarters offices.
Finally, it is important to acknowledge the National Technical Advisor for RMNCAH Strategy Development, Dr. Ahmad Shakir Hadad, who led the day-to-day management and coordination of the process.

With best regards,

Zelaikha Anwari, MD, MPH
RMNCAH Director
March 2017
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<th>Full Form</th>
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<td>Afghanistan Demographic and Health Survey</td>
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<td>AFGA</td>
<td>Afghan Family Guidance Association</td>
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<tr>
<td>AFSGO</td>
<td>Afghan Society of Obstetricians and Gynecologists</td>
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<td>AHS</td>
<td>Afghanistan Health Survey</td>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>AKDN</td>
<td>Aga Khan Development Network</td>
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<td>ALCS</td>
<td>Afghanistan Living Conditions Survey</td>
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<td>AMICS</td>
<td>Afghanistan Multiple Indicator Cluster Survey</td>
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<tr>
<td>AMS</td>
<td>Afghanistan Mortality Survey</td>
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<tr>
<td>AMTSL</td>
<td>Active management of the third stage of labor</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ANPHA</td>
<td>Afghan National Public Health Association</td>
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<td>ANPHI</td>
<td>Afghan National Public Health Institute, MoPH</td>
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<tr>
<td>APA</td>
<td>Afghan Pediatric Association</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ASMO</td>
<td>Afghan Social Marketing Organization</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
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<tr>
<td>BCG</td>
<td>Bacillus Calmette Guérin (anti-TB vaccine)</td>
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<tr>
<td>BEmOC</td>
<td>Basic emergency obstetric care</td>
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<tr>
<td>BEmONC</td>
<td>Basic emergency obstetric and newborn care</td>
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<tr>
<td>BHC</td>
<td>Basic health center</td>
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<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
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<td>BS</td>
<td>Birth spacing</td>
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<td>BS/FP</td>
<td>Birth spacing/family planning</td>
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<td>CAH</td>
<td>Child and adolescent health</td>
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<tr>
<td>CBHC</td>
<td>Community-based health care</td>
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<tr>
<td>CEmOC</td>
<td>Comprehensive emergency obstetric care</td>
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<tr>
<td>CEmONC</td>
<td>Comprehensive emergency obstetric and newborn care</td>
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<tr>
<td>CGMP</td>
<td>Community-based growth monitoring and promotion</td>
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<tr>
<td>CHC</td>
<td>Comprehensive health center</td>
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<td>CHNEP</td>
<td>Community Health Nurse Education Program</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>C-IMNCI</td>
<td>Community-based Integrated Management of Childhood Illnesses</td>
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<tr>
<td>DH</td>
<td>District hospital</td>
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<tr>
<td>DMPA</td>
<td>Depo-medroxy-progesterone acetate</td>
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<tr>
<td>EmOC</td>
<td>Emergency obstetric care</td>
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<tr>
<td>EmONC</td>
<td>Emergency obstetric and newborn care</td>
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<tr>
<td>ENC</td>
<td>Emergency newborn care</td>
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<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<tr>
<td>ETAT</td>
<td>Emergency triage, assessment, and treatment</td>
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<td>FHAG</td>
<td>Family Health Action Group</td>
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<td>FHH</td>
<td>Family Health House</td>
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<td>FP</td>
<td>Family planning</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GCMU</td>
<td>Grants and Contracts Management Unit, MoPH</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>GDHR</td>
<td>General Directorate of Human Resources, MoPH</td>
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<td>HEFD</td>
<td>Health Economics and Financing Directorate, MoPH</td>
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<td>HF</td>
<td>Health facility</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HMIS</td>
<td>Health management information system</td>
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<td>HPD</td>
<td>Health Promotion Department, MoPH</td>
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<tr>
<td>HPV</td>
<td>Human papilloma virus</td>
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<tr>
<td>IEC/BCC</td>
<td>Information, education, and communication/behavior change communication</td>
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<td>IHS</td>
<td>Institute of Health Sciences</td>
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<tr>
<td>IMNCI</td>
<td>Integrated Management of Neonatal and Childhood Illnesses</td>
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<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
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<tr>
<td>IPCC</td>
<td>Interpersonal communication and counseling</td>
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<td>IUD</td>
<td>Intra-uterine device</td>
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<td>IYCF</td>
<td>Infant and young child feeding</td>
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<td>LAM</td>
<td>Lactational amenorrhea method</td>
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<td>LARC</td>
<td>Long-acting reversible contraceptive</td>
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<td>LRP</td>
<td>Learning resource package</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>MCH</td>
<td>Maternal and child health</td>
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<td>mCPR</td>
<td>Modern contraceptive prevalence rate</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MMR</td>
<td>Maternal mortality ratio</td>
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<tr>
<td>MMR</td>
<td>Measles, mumps and rubella vaccine</td>
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<tr>
<td>MNDSR</td>
<td>Maternal and Newborn Death Surveillance and Response</td>
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<td>MNH</td>
<td>Maternal and neonatal health</td>
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<tr>
<td>MoEd</td>
<td>Ministry of Education</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
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<td>MoWA</td>
<td>Ministry of Women’s Affairs</td>
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<td>MSF</td>
<td>Médecins sans Frontières</td>
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<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>NHP</td>
<td>National Health Plan 2015 to 2020</td>
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<tr>
<td>NHS</td>
<td>National Health Strategy 2016–2020</td>
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<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<tr>
<td>NMNEAB</td>
<td>National Midwifery &amp; Nursing Education Accreditation Board</td>
</tr>
<tr>
<td>NMR</td>
<td>Neonatal mortality rate</td>
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<tr>
<td>NRVA</td>
<td>National Risk and Vulnerability Assessment</td>
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<tr>
<td>ORS</td>
<td>Oral rehydration solution</td>
</tr>
<tr>
<td>PHI</td>
<td>Pediatric Hospital Improvement Initiative</td>
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<tr>
<td>PLIS</td>
<td>Pharmaceutical Logistics Information System</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<tr>
<td>PNC</td>
<td>Postnatal care</td>
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<td>PPH</td>
<td>Postpartum hemorrhage</td>
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<td>PPHCC</td>
<td>Provincial Public Health Coordinating Committee</td>
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<td>PPHO</td>
<td>Provincial Public Health Office</td>
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<tr>
<td>QI</td>
<td>Quality improvement</td>
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<td>RAMOS</td>
<td>Reproductive Age Mortality Study</td>
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<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>RHCS</td>
<td>Reproductive health commodity security</td>
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<tr>
<td>RMNCAH</td>
<td>Reproductive, maternal, newborn, child, and adolescent health</td>
</tr>
<tr>
<td>SBA</td>
<td>Skilled birth attendant; skilled birth attendance</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SEHAT</td>
<td>System Enhancement for Health Action in Transition Program</td>
</tr>
<tr>
<td>SHC</td>
<td>Sub-health center</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VIA</td>
<td>visual inspection with acetic acid</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

Afghanistan has been internationally recognized for the significant health gains made over the past 15 years, especially in maternal and child health outcomes, with the rebuilding of the health system. Yet much remains to be done, especially for the health and well-being of women, mothers, newborns, children, and adolescents. This Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy 2017–2021 seeks to lay out a clear plan for the Ministry of Public Health (MoPH) to make further gains to improve the health of Afghanistan’s most vulnerable citizens in the coming years.

THE NEED FOR AN RMNCAH STRATEGY

Afghanistan has made great progress in reducing maternal, infant, and child mortality since 2002 through implementation of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). As a result, 60% of the population is within one hour of a health facility, and 88% within two hours’ travelling time. Fifteen thousand rural communities have community health workers (CHWs) who are trained to treat childhood illnesses and provide condoms and contraceptive pills and injectables. By about 2010, 60% of pregnant women were using antenatal care (ANC), 50% were using a skilled birth attendant, and 20% of couples were using a modern contraceptive. However, since that time there has been no further progress in the use of these services.

There are considerable variations in the use of services among different regions and provinces, but distance, access to transport, and cost remain the major barriers to use of services at health facilities. Security has become a significant additional barrier in recent years. Some people still consider these services “not necessary” or “not customary,” and a woman’s level of education makes some difference in the use of most services. The contribution of community-based services has declined over the past five years. The overall proportion of sick children being treated by CHWs and the contribution of CHWs to the overall contraceptive prevalence rate are less than they were. Reasons are not clear, but it seems that the supplies, support, and motivation of the volunteer CHWs are problematic.

THE GOAL OF THIS STRATEGY

This strategy aims to improve the health, nutritional status, and well-being of women, mothers, newborns, children, and adolescents throughout Afghanistan. The strategy seeks to avert preventable deaths and morbidity and treat patients’ conditions by ensuring that appropriate preventive and curative information and services are universally available to every family and community.

THE GUIDING PRINCIPLES OF THIS STRATEGY

- Effectiveness
- Acceptability to families and communities
- Affordability and sustainability
- Scale-up
- Quality of care
- Integration
- Continuum of care
- Equity of access
**The Targets and Impact of This Strategy**

Within five years—by 2021:

- Neonatal mortality will be reduced by 25%.
- Post-neonatal mortality will be reduced by 30%.
- Child mortality will be reduced by 35%.
- Maternal mortality will be reduced by 30%.

**The Scale of This Strategy**

The main emphasis of this strategy is not to propose new technical interventions but to:

- improve the quality of, access to, and utilization of existing evidence-based essential maternal, child, and adolescent health services;
- promote the extension of preventive and curative maternal, infant, and child health services and behaviors of known effectiveness in the communities where people live.

The MoPH will also advocate, coordinate, and collaborate with other sectors to ensure adequate responses to multisectoral issues such as literacy and education of women, food security, water and sanitation, security, gender equity, roads, and communications, all of which significantly influence the survival and health of women, newborns, children, and adolescents.

**Key Strategic Approaches**

Six approaches distinguish this new strategy:

1. **Quality improvement of existing services in health facilities**
   
   The new emphasis will be on needs assessments followed by quality improvement. These will include expanding use of the Maternal and Newborn Death Surveillance and Response program and the Pediatric Hospital Improvement program, and regular use of the integrated monitoring checklist visits to health facilities. The provincial RMNCAH Scorecard will be regularly used to assess the progress of RMNCAH programs.

   New efforts will be made to improve interpersonal communication, respectful maternity care, and the levels of privacy and confidentiality in health facilities.

2. **Rejuvenation of community-based RMNCAH care**

   To improve the participation and motivation of the CHWs, the RMNCAH Directorate will work with the Community-Based Health Care (CBHC) Department, Grants and Contracts Management Unit (GCMU), and Provincial Public Health Offices (PPHOs) to make sure that the intended levels of support, supervision, and supplies are available to the CHWs. Community RMNCAH services will be rejuvenated by redesigning the job description of the CHWs so that they play a more proactive and integrated role in the continuum of care for mothers and children through the first 1,000 days of a child’s life. Midwives at the supervising facility will provide more technical support for and supervision of female CHWs.

3. **Improved and innovative approaches to referral systems**

   As well as promoting expansion of both traditional and innovative transport systems, including ambulances, between communities and different levels of facilities, RMMCAH will promote scaling up of innovative uses of telephone communications from communities and between different health facilities to facilitate management decision-making, access to transport, and preparation to receive referrals at the receiving hospital.
4. A fresh approach to health communication
Much of the success of the health services so far has been the results of an effective information, education, and communication and behavior change communication (IEC/BCC) program. However, fresh messages, methods, and materials are needed to catch people’s attention once more. IEC/BCC programs in the past have focused on women/mothers. To impact social values and norms, the new communication strategy will expand attention to the men and older women (mothers-in-law) of the community, emphasizing the honor in making use of RMNCAH services for family members. This will be achieved through the shura and religious leaders, as well as by empowering the female CHWs and Family Health Action Group (FHAG) members. While mass media do reach many people in the cities, the media are less effective in rural areas.

5. Collaboration with the private sector
The private sector is assuming an increasingly important role in providing care to women and children, especially in urban areas. The RMNCAH Directorate will continue to expand its links with the private sector through memoranda of understanding (MOUs) with individual private facilities and by collaborating with professional associations to encourage different approaches to maintaining quality of care in private facilities.

6. Expanded school health programs for children and adolescents
The growing cohorts of young women and men who have been going through both primary and secondary schools will provide an increased number of change agents for healthier living in their communities. The MoPH is expanding its school health program and working with the Ministry of Education to incorporate health content into the curricula for grades 1-12.
INTRODUCTION AND CONTEXT

The Policy Context
This National Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy 2017–2021 derives its authority from the National Health Policy 2015 to 2020 of the MoPH:

The Mission
The mission of the Ministry of Public Health of the Government of the Islamic Republic of Afghanistan is “to prevent ill health and achieve significant reductions in mortality in line with national targets and sustainable development goals and to reduce impoverishment due to catastrophic health expenditure. Also to be responsive to the rights of all citizens through improving access and utilization of quality, equitable, affordable health and nutrition services among all communities especially mothers and children in rural areas. And through changing attitudes and practices, promoting healthy life-styles and effectively implementing other public health interventions. All in coordination and collaboration with other stakeholders within the frame work of strong leadership, sustained political will and commitment, good governance, and effective and efficient management in its continuous pursuit to become a ministerial institution of excellence.”

Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy Statement
“The Ministry of Public Heath through its leadership and effective governance is committed to reduce the high levels of reproductive, maternal, neonatal, child and adolescent (RMNC&A) morbidity and mortality. These are the major causes of concern in the national public health agenda. It is the policy of the Ministry to have close oversight of the many different aspects of work that comprise RMNC&A health. These include, but are not limited to: maternal and newborn death surveillance and response, collaboration and coordination with stakeholders, strengthening human resources, improvement of the quality of health services, medical records and reporting for health information systems, program monitoring and research, innovation, and new technology.

The Ministry of Public Health gives high priority to the provision of rights-based services for women, children and adolescents. It also highly regards the harmonization of the considerable technical and financial partner support for RMNC&A health in line with the aid effectiveness principles of the Paris Declaration. The Ministry places high importance on qualitative as well as quantitative results. For example, progress on delivering quality RMNC&A services, including respectful health care.

During this policy period, 2015–2020, the Ministry is especially committed to work on the following: reducing the unmet need for family planning, increasing utilization of quality skilled birth attendance including access to comprehensive obstetric care, essential and emergency care of sick newborns, national vaccination coverage, coverage of interventions for the prevention and management of child pneumonia and diarrhea, and the treatment of severe acute malnutrition.”¹

¹ National Health Policy 2015 to 2020.
The health sector is committed to adopting and implementing Sustainable Development Goal (SDG) 3. This includes targets for maternal and child health and family planning which are relevant for this RMNCAH Strategy. In addition, the MoPH is committed to align with other initiatives such as the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030, and Family Planning 2020.

**Social Determinants of Reproductive, Maternal, Newborn, Child, and Adolescent Health**

Several features of Afghan society have important effects on health, health-related behaviors, and the levels of use of health services. These include families’ living environments, age at marriage, fertility patterns, the distribution of wealth, and levels of education and literacy.

- **Marriage, fertility, and population**
  Women’s age at marriage is an important social and demographic indicator. On average, women who marry earlier are more exposed to high-risk teenage pregnancies and give birth to more children overall. The median age at first marriage has been increasing; among current 20–24-year-old women it was 19.5 years, and the proportion married before 18 years was 35% (Afghanistan Demographic and Health Survey [ADHS] 2015).

  Fertility rates have also declined, and the total fertility rate of 6.3 reported by the National Risk and Vulnerability Assessment (NRVA) 2007–2008 survey has fallen to 5.3 (ADHS 2015). Nevertheless, the population growth rate is increasing by about one million people each year. This will produce significant growth in demand for health and other services.

- **Housing characteristics**
  Access to improved water and sanitation facilities has steadily increased. In 2007, only 27% of households had access to an improved water supply, and 5% to an improved toilet. By 2015, those indicators had increased to 65% and 25%, respectively (ADHS 2015). Improved water supplies were found in 86% of urban households and in 58% of rural households. Fifty-two percent of urban households had improved latrines, but only 16% of rural households did.

- **Household wealth**
  The distribution of household wealth is very different in urban and rural areas, which makes a very significant impact on the use of services. In rural areas, distance from a health facility and lack of resources, combined, pose a major obstacle to use of services in health facilities.

  In rural populations, 52% of households are in the bottom two wealth quintiles—those below the national poverty level—and only 3% are in the wealthiest quintile. In urban populations by contrast, 91% of the households are in the upper two quintiles of wealth, and only 5% are below the national poverty line (Figure 1).
Education and literacy
In all parts of the world, one of the most important determinants of family health is the education of the wife and mother. This is equally true in Afghanistan, and the increasing numbers of girls and young women who are receiving education at all levels can be expected to have an increasing impact on health in the coming decade.

Out of all women of reproductive age, 84% have had no education. In rural areas that proportion is 89% and in urban areas, it is 67% (Figure 2). However, when we look at young women 15 to 24 years of age, it is 71%, and 12% were in primary school or had completed primary school. Another 14% were in secondary school or had completed it.

Figure 1: Distribution of the population by wealth quintiles

Source: ADHS 2015

Figure 2: Education levels of women of reproductive age by residence and of women aged 15–24 years

Source: ADHS 2015
• **Provincial diversity**
It is very clear from the ADHS that health status and the use of health services vary greatly among provinces. These reflect the diversity in geography and climate, and the cultures, patterns of human habitation, economies, and food security situations that have developed in those different settings.

Changes in the political and the security situations in recent years have also had a significant effect. In some provinces, growing numbers of families have left for settlements and camps for internally displaced persons in other parts of the country, especially around the margins of the larger regional cities. Insecurity has also resulted in the closing of some health facilities, a lack of female health care providers, and increasing limitations on travel to facilities, especially by women and children.

• **The national economy**
Economic growth has been declining in the past four to five years but is expected to stabilize if the security and political situation are steady. In addition, the contribution of overseas development assistance to government income has declined, from 38% in 2011 to 23% in 2014. This means that there will need to be greater prioritization of interventions as well as an increase in efficiency (NHS 2016–2020).

**The Need for This Strategy**
Afghanistan has been internationally recognized for the significant health gains made over the past 15 years. The rebuilding of the health system has especially improved maternal, newborn, and child health outcomes, with the rebuilding of the health system. Many of these gains have been the result of the focus on primary care as manifested in the BPHS, composed of evidence-based essential maternal and child health interventions. This has been supported by the EPHS. Gains in RMNCAH have included:

- Increased access to health services, including maternal and child health services:
  - Sixty percent of the population live within one hour’s travelling time of a health facility, and 88% are within two hours’ travelling time.
  - All secondary and tertiary health facilities have midwives, and 90% of primary care facilities have midwives.
  - Health posts with a male and a female CHW have been established in more than 15,000 communities of 1,000–1,500 people. They are providing family planning services and community case management of childhood illnesses. In 6,500 of these communities, the health promotion activities of the community health workers are supported by a FHAG.
  - There are Family Health Houses with a Community Midwife in 125 remote communities in four provinces.

- Increased use of key health care services:
  - Antenatal care
  - Births attended by skilled provider, most in health facilities
  - Use of modern birth spacing/family planning methods

- Declines in maternal, neonatal, post-neonatal, and child mortality.

Current health indicators in reproductive, maternal, newborn and child health are shown in Table 1.
Table 1: Reproductive, maternal, newborn, and child health indicators, 2010–2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010–2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (MMR)</td>
<td>695/100,000</td>
</tr>
<tr>
<td>Infant mortality rate (IMR)</td>
<td>45/1,000</td>
</tr>
<tr>
<td>Neonatal mortality rate (NMR)</td>
<td>22/1,000</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>55/1,000</td>
</tr>
<tr>
<td>Pregnant women with at least one skilled ANC visit</td>
<td>59%</td>
</tr>
<tr>
<td>Births with a skilled attendant present</td>
<td>51%</td>
</tr>
<tr>
<td>Breastfeeding at age 2</td>
<td>54%</td>
</tr>
<tr>
<td>Couples using modern family planning method</td>
<td>20%</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Source: ADHS 2015

Note: 1 See introduction and notes to Strategic Area 1: Maternal Health.

While the accomplishments in health are remarkable, much remains to be done. National surveys suggest that there has been very little progress in several key indicators between 2010 and 2015. The proportions of pregnant women using ANC and skilled birth attendance at health facilities have not increased since about 2010. This may be due, in part, to a lack of understanding of the benefits of these services. What is clear is that distances from health facilities and the costs of reaching and using the services are the major barriers. At the same time, the use of services like family planning and the management of childhood illnesses that are available at health posts in the community as well as at health facilities has also not increased in the last five years. This raises concerns about the support to and motivation of the volunteer CHWs.

This strategy attempts to identify and address the barriers to health of women, children, and adolescents and take advantage of new opportunities to promote health. It establishes the priorities for the refocusing and aligning of the MoPH and its partners’ efforts on the specific tasks for reducing mortality and morbidity among women, infants, children and adolescents for the period 2017–2021, while ensuring that the relevant elements outlined in the recently approved National Health Strategy (NHS) 2016–2020 are carried out.

Hence, it is crucial at this juncture of the Afghanistan’s health system development to have a new RMNCAH Strategy. It will build upon recent achievements and lessons to accelerate the momentum in RMNCAH. It will mobilize intersectoral support and coordinate resources to the central priority of improving the health and nutritional status of Afghan women, newborns, children and adolescents during the next five years. It is significant that for the first time MoPH reproductive, maternal, and newborn strategies are being combined with child and adolescent health strategies in this National RMNCAH Strategy 2017–2021. The goal is to provide a holistic and harmonized approach for improving the health status of women and children.

The Goals of This Strategy

This strategy seeks to minimize preventable deaths and morbidity among women and children and adolescents throughout Afghanistan:

- To improve their health, nutritional status, and well-being through promotion and provision of preventive services and the promotion of healthy lifestyles;
- To treat patient conditions by ensuring that evidence-based essential preventive and curative information and services are available to every family and community;
- To improve service quality and extend access to more of the population—in all parts of the country down to each community and household.
The impact of this strategy will be the reduction of mortality of women, mothers, newborns, children, and adolescents through:

- **Birth spacing and family planning**
  - Promotion of the lactational amenorrhea method (LAM), postpartum family planning, and postabortion care to minimize the numbers of children born less than 24 months after the previous child, especially among teenagers and other young couples;
  - Greater awareness of the risks of early pregnancy during adolescence and of high-parity pregnancies.

- **Antenatal care for mothers**
  - Promotion of the benefits of ANC and of the appropriate times for seeking it;
  - Delivery planning and preparation, nutrition advice, and distribution of iron, folic acid and calcium supplements to all pregnant mothers by health facility midwives and CHWs;
  - High-risk mothers (young, primigravidas, grand multiparas) identified for special promotion of ANC and skilled birth attendance at the health facility.

- **Birth practices**
  - Safe delivery in an adequately equipped institution and assisted by trained personnel;
  - Labor monitored with the partograph, and delivery completed with active management of the third stage of labor (AMTSL);
  - All health facilities prepared to provide appropriate basic or comprehensive emergency obstetric care as quickly and effectively as possible;
  - If facility delivery is not possible, the family prepared for a clean delivery at home and to use misoprostol to prevent postpartum hemorrhage;
  - The family prepared to recognize danger signs and be prepared for referral to a facility.

- **Newborn and postpartum care**
  - In both home and facility deliveries, immediate onset of breathing ensured, clean cord care and the use of chlorhexidine 7.1% to prevent infections;
  - Good thermal care through skin-to-skin contact with the mother and early exclusive breastfeeding;
  - Kangaroo mother care for low-birth-weight babies;
  - Home visits by the CHW in the first week after birth to provide postpartum support and care for the mother, including provision of vitamin A and iron supplements, and care for the newborn, including recognition of danger signs and referral advice;
  - Counseling on exclusive breastfeeding, LAM, and postpartum birth spacing/family planning.

- **Child health**
  - Exclusive breastfeeding for the first six months of life, with timely introduction of appropriate supplementary foods;
  - Timely and correct immunizations;
  - Early diagnosis and correct treatment of diarrhea, acute respiratory infection (ARI) and fever, and referral of severe cases;
− A healthy home environment with regular handwashing, home hygiene, and the reduction of tobacco and solid fuel smoke.
− Early childhood development, including using the nursery period as a platform for cost-effective service delivery for preschool children. Adapt, test, evaluate, and incorporate an early childhood development program;
− Reduced risk of childhood emotional and behavioral problems by decreasing exposure to toxic stress, promoting protective factors, and systematically screening for risk factors and emerging clinical problems. Conduct advocacy and awareness rising; reduce the barriers to evidence-based treatments by orienting pediatricians; and provide parent management training, cognitive behavioral therapy, and child-parent psychotherapy.

• Adolescents
  − Integration of health information and promotion in all school curricula;
  − Provision of basic first aid and a screening program for problems with eyes, ears, and dental health;
  − Provision of iron and folic acid supplements to adolescent girls in school;
  − Introduction of a youth-friendly health service program in all health facilities;
  − Support for an intersectoral strategy to create increased awareness of the risks of early marriage and need for healthy lifestyles for adolescents.

These RMNCAH strategies will be supported by:
• Special attention to the needs of marginalized groups, especially nomads and communities of refugees and internally displaced persons;
• Monitoring of quality of care and strategies to improve it;
• A renewed and more relevant communication strategy;
• Innovative approaches to improving referral systems;
• Continued emphasis on security and distribution of medical commodities;
• Mainstreaming of gender-sensitive approaches and actions;
• Strengthening of mental health support for women, adolescents, and victims of gender-based violence (GBV);
• Increased collaboration with the private sector to maintain comprehensive and quality RMNCAH services.

Guiding Principles
The eight guiding principles below ensure that the strategic interventions put forth in this document are consistent with the core values of the MoPH and the National Health Strategy 2016–2020. The guiding principles for RMNCAH strategies are:
• Effectiveness: To use interventions of proven effectiveness for each of the major causes contributing to maternal, newborn, child, and adolescent mortality and morbidity in Afghanistan.
• Acceptability to families and communities: To provide services and counseling that people understand, with respect, and under appropriate conditions of privacy and confidentiality.
• Affordability and sustainability: To use limited resources efficiently so that RMNCAH services are cost-effective and ultimately sustainable with available resources.
• Scale-up: To ensure that approved, effective interventions are applied in all parts of the country.
• **Quality of care:** To maintain and improve the quality of all lifesaving and health-promoting RMNCAH interventions.

• **Integration:** To link separate services to improve efficiency, increase client convenience, and reduce missed opportunities for promoting and providing services.

• **Continuum of care:** To promote awareness of and the practice of a continuity of care from preconception through pregnancy, childbirth, and the postpartum period, and then through the first two years of a child’s life. Also, to strengthen the community and health facility institutions of care and their management to maintain an effective continuity of care from the home, CBHC, and the different levels of facility care through an effective and reliable referral system.

• **Equity of access:** To ensure equity by having full coverage of lifesaving, evidence-based interventions, especially for remote rural communities, the poor, and other marginalized groups.
STRATEGIC AREA I: MATERNAL HEALTH

Maternal Mortality
Maternal mortality in Afghanistan has declined overall during the past 15 years but may have increased slightly since about 2010 because of increasing insecurity. The 2000–2002 MMR of 1,600 per 100,000 found in the Reproductive Age Mortality Study I (RAMOS I) is well attested. It is agreed that the MMR of 327 in the 2010 Afghanistan Mortality Survey (AMS) was too low and that the ADHS 2015 MMR of 1,291 is too high, in both cases because of data problems. However, the lack of overlap of their confidence limits suggests that there was some increase in the MMR between the two studies.

An MMR of 695 per 100,000 is suggested instead of the 1,291 reported in the ADHS. It is more compatible with the findings of two other studies done at about the same time. It is also more compatible with the rates of service use for ANC, skilled birth attendance, and family planning found by the ADHS.

Determinants of Maternal Health
Maternal and perinatal health are the results of many different factors, but the proximal determinants are set out in Box 1. Of these, the most important are fertility rates, the rate of skilled birth attendance, and the availability of emergency obstetric care for those with complications of pregnancy or delivery.

Box 1: Determinants of maternal and perinatal health
- Family planning, the general fertility rate, and the total fertility rate
- Antenatal care
- Skilled (facility) birth attendance
  - Delay type 1: Decision to refer from home or health facility
  - Delay type 2: Transportation to referral center
- Emergency obstetric and newborn care
  - Delay type 3: Time between arrival and emergency care
- Postnatal and newborn care

Fertility Rates and Family Planning
Family planning contributes to maternal health in two main ways. First, fewer births in the overall population (the general fertility rate) mean fewer maternal deaths. Second, because use of family planning reduces the total fertility rate of individual women, the number and proportion of high-risk pregnancies, especially high-parity pregnancies, is also reduced. The

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4 The estimated MMR of 1,291 in ADHS 2015 is based on the finding that 65% of the deaths of women of reproductive age were the result of maternal causes. This maternal proportion is considered much too high. The other contemporary studies suggest that a maternal proportion of 35% is a more realistic national average. That would results in an estimated MMR of 695 per 100,000.
current modern contraceptive prevalence rate (mCPR) of 20% is probably preventing 20% to 34% of potential maternal deaths.  

*Antenatal Care*

ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labor and delivery, thus ensuring referral to an appropriate level of care (WHO ANC guideline, 2016).

Attendance at one or more ANC visits in clinics has slowly increased since 2002 to its recent level of 59% (urban 72% and rural 55%) (Figure 3). There are differences according to educational level completed, but since the number of pregnant women with education at that time was small, education has little overall impact. There has also been a gradient with wealth quintile, but in the latest survey, there was no significant difference between the lowest three quintiles (ADHS 2015).

*Figure 3: Antenatal care attendance rates by residence*

![Antenatal care attendance rates by residence](source)


In the ADHS 2015, the proportion of pregnant women completing four antenatal visits changed from 15% to 18% between 2008 and 2013. The rate in urban areas (32%) was twice that (14%) in the rural areas. The effect of completed education was significant: 15% with no education, 27% with completed primary, and 35% with completed secondary education. Again, there was little difference among the lower three wealth quintiles.

The AMS 2010 asked for reasons why ANC was not used (see Figure 4). Forty-one percent of women said that it was “not necessary.” Interestingly, this reason was given more often in urban areas (54%) than rural areas (40%). It was also more common among better educated women and those from wealthier families. “Not customary” was the reason given by 22% (rural 23%, urban 11%). This reason was cited less frequently by educated women but more often by wealthier women. Among rural women not attending an ANC clinic, 52% gave the

reasons “lack of money,” “too far,” and/or “transportation problems.” However, only 27% of urban women complained of “lack of money,” and only 11% complained of “transportation problems.” “Security reasons” were important for only 13% of women and then only notably in the South, East, and South East regions.

Figure 4: Reasons for not attending antenatal care

![Figure 4: Reasons for not attending antenatal care](image)

Source: AMS 2010

Problems of distance and cost affect both urban and rural women. Promotion of ANC through FHAGs and IEC/BCC remains important, but more easily understood and tangible benefits from each ANC visit are probably needed. Meanwhile, simple but important activities like the distribution of prophylactic iron, folic acid, and calcium tablets at community level should also be considered.6

Skilled Birth Attendance

The main cause of the overall decline in mortality ratios has been the increased access to and use of skilled birth attendants (SBAs) for childbirth. The increase in health facilities means that 60% of the population are now within one hour’s travelling time of a facility and 88% within two hours. In addition, the training and deployment of midwives now means that only 63 (9%) of basic health centers (BHCs) and 67 (12%) of sub-health centers (SHCs) are without a midwife. The average number of deliveries per month is 10 for BHCs and 6.5 for SHCs.

Rates of skilled birth attendance grew steadily in both urban and rural areas until about 2010 but have not increased significantly since then. Rates of SBA use by the Kuchi remain very low.

Women with a primary school education are now 60% more likely to use a SBA than women with no education. That gap has become smaller as the SBA rate for women with no education has slowly risen from 18% (2005) to 45% (2013). Since about 90% of women of reproductive age have no education, this suggests that IEC/BCC strategies have been

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6 The National Nutrition Survey 2013 found that 40% of women of reproductive age were anemic, and 24% were iron deficient. Vitamin D deficiency was found in 96%.
effective during this time. In the next 5–10 years, as cohorts of young women with more education\(^7\) enter the childbearing stages of their lives, we should expect to see the use of SBAs increase.

**Figure 5: Skilled birth attendance by residence**

![Figure 5: Skilled birth attendance by residence](image)


The greatest differences in use of SBAs are based on household wealth. While the SBA rate for the poorest quintile has increased from 7% to 24% since 2002, the ADHS 2015 shows that the SBA rate for the wealthiest quintile (85%) is almost four times that of the poorest. The ADHS 2015 also reported the effect of distance on the use of a SBA according to remoteness quintiles. Of the most remote women, 22% used a SBA, while 60% of the least remote women used a SBA.

We can conclude that the main practical reasons for not using a SBA at childbirth are the costs of care in urban areas and the combination of distance and the costs of care and travel in rural areas. Cultural gender-based reasons for not using health services are still important. Women have limited decision-making power and mobility and even less control over household resources.

**Emergency Obstetric and Newborn Care**

The Emergency Obstetric and Newborn Care (EmONC) Needs Assessment survey that was done in 2010 showed a high level of EmONC practice and competence in facilities that were supposed to be providing comprehensive EmONC (CEmONC). Some needs for improvement were identified. The recently completed quality of care study in maternal health has looked at quality at all levels of care and in a selection of private facilities. This includes the monitoring of routine delivery care and basic emergency obstetric and newborn care (BEmONC) capacity in BHCs and SHCs. These facilities supervise almost 40% of institutional deliveries and will often be the first to review complicated home deliveries that may need referral to CEmONC facilities.

\(^7\) The Afghanistan Living Conditions Survey (ALCS) 2013–2014 reported that 25% of females aged 20–24 and 38% of females aged 15–19 years had completed primary education or more (p. 152).
Cesarean section rates up to 10% are associated with a decline in maternal and neonatal mortality. However, increases in caesarean section rates beyond 10% are not associated with reductions in maternal and newborn mortality rates. In Afghanistan, caesarean deliveries accounted for 3% of all births in the five years prior to the ADHS 2015 survey.

**Postnatal Care**

The pattern of rates of postnatal care reflects SBA rates, but in only about half to two-thirds of deliveries with SBAs (ADHS 2015: total 33%, urban 48%, rural 28%). This lower coverage probably depends on timing of discharge and whether a postnatal check is completed before then.

The customary seclusion at home of women after childbirth is now becoming much shorter than the traditional 40 days. However, it still includes the early postpartum period, during which most problems occur for both the mother and the newborn. The program of postnatal home visits by CHWs developed as part of the Integrated Child Survival Programme needs to be further developed to include postnatal care of the mother and scaled up nationally.

**Strategic Approach 1.1: Improve Equitable Access to Maternal Health Care Services**

Maintain and improve equitable access to respectful professional maternal health care services, including ANC, SBA, EmONC, and postnatal care at health facilities and by community midwives.

1.1.1 *Maintain levels of midwifery and female obstetric staff according to national standards at all levels of public health facilities.*

Specific actions will include:

- Restore the full number of community midwifery schools (31) by 2018 to maintain the supply of community midwives.

In 2010, there were 32 midwifery schools around the country; however, in 2013 the number of schools dropped to 22 due to lack of funding. Through the new System Enhancement for Health Action in Transition (SEHAT) Programme, the number of midwifery schools is planned to increase to 31 by 2018.

- Advocate for and follow up on deployment and retention of skilled service providers at all levels.
- Integrate high-impact RMNCAH interventions into all pre-service training curricula.
- Advocate for appropriate remuneration to attract and motivate health care providers to work in rural and underserved areas.

To address the issues of employment and deployment, the RMNCAH Directorate will advocate for deployment of female health care providers according to the Citizen Charter and geographical and national needs, as well as appropriate remuneration to attract and motivate health care providers to work in rural and underserved areas. This will be done in coordination with the General Directorate of Human Resources (GDHR), the Institute of Health Sciences (IHS), the Ministry of Higher Education, the Afghanistan Midwifery & Nursing Education Accreditation Board, other professional regulatory bodies, and public and private universities and institutes.

1.1.2 *Review staffing norms to advise the General Directorate of Human Resources.*
Specific actions will include:

- Review and update respective RMNCAH staffing norms and skill mixes at different levels of the health system.
- Develop national guidelines for adjusting facility staffing levels according to their workload. (Apply the WHO Workload Indicators of Staffing Need methodology.)

1.1.3 Increase the number of Family Health Houses serving remote communities.
At present, there are 125 Family Health Houses (FHHs) serving remote communities in four provinces (Bamyan: 24; Dykundi: 62; Faryab: 30; Herat: 9).

1.1.4 Scale up implementation of new evidence-based interventions.
Specific actions will include:

- Introduce calcium tablets during pregnancy for primary prevention of pre-eclampsia/eclampsia.
- Implement the use of antenatal corticosteroids to women in preterm labor to prevent respiratory distress syndrome in the newborn.

Strategic Approach 1.2: Maintain and Improve the Quality of Midwifery and Obstetric Care in All Public Health Facilities
See also Section 7.1: Quality Improvement under Cross-cutting Issues and Enabling Strategic Approaches.

1.2.1 Assess and maintain the availability of quality routine maternity care, basic or comprehensive emergency obstetric and newborn care as appropriate in different levels of facility.
Specific actions will include:

- Maintain the regular use of the National Health Facility Integrated Monitoring Checklist to monitor facilities at the provincial level.
- Conduct periodic in-depth national EmONC assessment of facilities at all three levels of obstetric care.

Routine maternity care should always include cleanliness of the facility and midwifery technique, use of the partograph to monitor progress of labor, and AMTSL. The provision of BEmOC services includes, but is not limited to, intravenous and intramuscular administration of drugs such as antibiotics, uterotonics, antihypertensives, and anticonvulsants; assisted vaginal delivery; manual removal of the placenta; manual vacuum aspiration for management of abortions; and stabilization and referral of obstetric emergencies not managed at the basic level. The provision of CEmONC services for mothers includes all the above services plus caesarean sections and blood transfusion services.

1.2.2 Strengthen the Maternal and Newborn Death Surveillance and Response (MNDSR) program to improve the quality of maternal and perinatal care.
- Implement MNDSR in the five regional and national specialist hospitals, and then expand it to all provincial hospitals.

Implementation of an effective maternal and newborn death surveillance and response program is a key strategy for improvement of the quality of maternal and neonatal health services. MNDSR permits timely qualitative in-depth investigation of the causes and circumstances surrounding maternal deaths. This then assists the formulation and promotion of improved protocols and standards of clinical care.
The key activities of the MNDSR program include:

- Notify maternal and neonatal deaths through Civil Registration and Vital Statistics, in accordance with Afghan legislation.
- Expand implementation of MNDSR to regional and provincial hospitals.
- Disseminate results of mortality reviews, while ensuring confidentiality and data safety.
- Monitor implementation of mortality review recommendations.
- Record lessons learned and provide feedback to health facilities and communities.
- Pilot the use of a verbal autopsy tool, with the collection of maternal deaths as a notifiable event by sentinel sites of the National Disease Surveillance system.

1.2.3 Reduce delays in starting effective treatment of complications at the referral hospital.

Specific actions will include:

- Use communication systems to enable the receiving hospital to be prepared for the arrival of the woman or child with complications.
- Develop appropriate “fast-track” systems for admission of referrals and emergencies in hospitals.
- Ensure that delays and their reasons are investigated and documented as part of MNDSR processes.
- Strengthen the documentation, monitoring, and evaluation of referrals and outcomes.

1.2.4 Advocate and promote respectful maternity care for all women and their families.

Specific actions will include:

- Provide equal protection for women and men in health facilities’ organizational policies regarding clients’ rights to privacy, informed consent, confidentiality, and the delivery of high-quality services.
- Train health providers (pre-service and in-service) in interpersonal communication and counseling (IPCC) skills and respectful maternity care, focusing on client-centered maternity and newborn services.
- Implement the recently developed Respectful Maternity Care Training Program nationwide through BPHS and EPHS NGO trainers.

Advancing respectful care is a priority to increase facility birth and ensure effective implementation of women’s rights in health services. Respectful maternity care refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, the birth, and the postnatal period. It respects her rights and choices through supportive communication, actions, and attitudes. It emphasizes confidentiality and privacy. It eliminates eligibility barriers (such as marital status, spousal or mother-in-law’s consent, age, ethnicity/tribe, or number of children) in access to health services. It ensures that every woman is offered the option to experience labor and childbirth with a companion of her choice. Disrespect, abuse, and mistreatment during birth are known to be significant barriers to increasing facility-based births.
1.2.5 Maintain the skills and support capacity development of health service providers.
The RMNCAH Directorate advocates appropriate pre-service and in-service training of all cadres of health care providers in normal obstetric care, BEmONC, CEmONC, and respectful maternity care.

Specific actions will include:
- Strengthen pre-service and in-service training and follow-up after training through regular review and revision of learning packages, protocols, and guidelines.
- Provide regular in-service and refresher training according to needs assessments and national policy.
- Provide job aids (checklists and wall charts) for essential EmOC procedures, especially in facilities where they are not frequently performed.
- Develop referral protocols and make checklists available at referring and receiving facilities.
- Support national professional associations and regulatory bodies in implementation of accreditation and certification programs.

1.2.6 Maintain and support essential levels of supplies and equipment.
Specific actions will include:
- Coordinate with the Pharmaceutical Department of the MoPH to find an appropriate storage facility for climate-sensitive drugs, especially oxytocin.
- Coordinate with the Blood Bank Department to ensure that all CEmONC facilities have and maintain a quality blood bank or walking blood bank service.

Strategic Approach 1.3: Promote Increased Use of Maternal Health Services
An integrated approach is required to overcome those obstacles, not related to distance and cost, to greater use of ANC and SBA.
See also Section 7.3: The RMNCAH Communication Strategy in Cross-cutting Issues and Enabling Strategic Approaches.

Specific actions will include:
- Promote and maintain the quality of clinical care.
- Improve IPCC and respectful maternity care.
- Increase the specificity of client guidance about the purpose, importance, and timing of antenatal, delivery and postnatal care.
- Promote the use of the Maternal and Child Health (MCH) Handbook in communities.

Strategic Approach 1.4: Expand Community-Based Maternal and Newborn Health
The role of CHWs in maternal and newborn health care has gradually expanded since 2003. Originally, their role was to identify pregnant women and encourage them to use ANC and SBA services at the health facility, discuss birth preparedness with the family and the use of a clean delivery kit in home deliveries, and teach the recognition of danger signs requiring referral to the facility. Since then there has been (1) pilot testing and the initial scale-up of the use of misoprostol for prevention of postpartum hemorrhage in home deliveries and (2) partial scale-up of a program of postpartum home visits (days 1, 3, 7, and 28) for newborn care and the initial treatment and referral of newborns with pneumonia or sepsis. CHWs are
not trained to assist at home deliveries, only to provide advice on a safe delivery to the family.

It is becoming clear that a significant proportion of rural families will continue to be unable to attend regular ANC clinics and a facility for SBA because of a combination of cost and distance. The RMNCAH Directorate, in collaboration with the CBHC Department, will therefore develop an integrated protocol of ANC, delivery care, and postnatal/newborn care at home for CHWs that will emphasize continuity of care for all pregnant and lactating mothers in the community. It will emphasize activities for the CHW that are within her level of skill and actively promote referral to the health facility for essential activities that can only be done by trained staff.

The CHW’s maternal and neonatal health (MNH) protocol will need to be designed in the most efficient way to keep the number of home visits within the scope of a volunteer’s workload. In a population of 1,000 to 1,500 people, 37–55 pregnancies can be expected in a year (the crude birth rate is 37/1000). Female CHWs also have a significant role in providing contraceptive methods to women in their communities. Senior members of the women’s FHAGs will be able to help in some ways, and male CHWs can also provide some assistance to family members. A successful program will require a greater involvement of the facility midwife in support and supervision of the female CHWs.

**Strategic Approach 1.5: Integrate Maternal-Newborn Care in the Community with Care in the Facility**

1.5.1 *In collaboration with the CBHC Department, design and pilot-test a protocol for MNH care by CHWs that is integrated with MNH care at the facility and ensures continuity of care.*

1.5.1.1 *CHWs will provide simple ANC through 2-3 home visits at specified times.*
- CHWs identify pregnant women, with help of FHAG members.
- CHWs promote attendance at the facility or FHH for ANC, especially to teenage mothers.
- CHWs provide guidance on healthy pregnancy and explain danger signs requiring referral.
- CHW provides supplies of iron and folic acid tablets for anemia prophylaxis, and calcium tablets for women at risk for pre-eclampsia or eclampsia.

1.5.1.2 *CHWs will promote and assist in preparations for a safe delivery.*
- CHWs discuss birth preparedness and the importance of a SBA with the family, especially for higher-risk pregnancies.
- CHWs discuss the importance of a clean home delivery and assist in obtaining a clean delivery kit as needed.
- CHWs explain the use of misoprostol and provide the tablets according to the approved protocol.

1.5.1.3 *CHWs will do regular home visits (days 1, 3, and 7) after delivery, even if the woman has delivered at the facility, to provide postpartum and newborn care.*
- CHWs provide postpartum advice and warn about any danger signs.
- CHWs provide the postpartum mother with vitamin A capsules and iron and folic acid tablets.
• CHWs ensure immediate newborn care, including delayed washing and thermal control, early and exclusive breastfeeding, and clean cord care, including the application of chlorhexidine 7.1% gel.
• CHWs warn about danger signs in the newborn and refer if there are signs of pneumonia or sepsis.

1.5.1.4 Define and develop protocols and guides for the roles of the male CHWs and FHAG members in this program.

**Strategic Approach 1.6: Develop Training and Management Packages**
Together with the CHW MNH care protocol, the MoPH will develop training and management packages. Specific actions will include:

- Develop revised and integrated sets of IEC/BCC materials for use by CHWs and FHAG members.
- Develop guidelines for managing and supporting CHWs for midwives at health facilities. The guidelines should cover both pregnancy care and BS/FP activities by the female CHWs. (See also 3.3.)
- Develop job aids and a training program for both in-service training and pre-service training of midwives.
- In collaboration with the Health Management Information System Department, develop a modified reporting system for CHWs to include the minimum number of indicators necessary to monitor the program.

**Strategic Approach 1.7: Continue the Scale-Up of the Use of Misoprostol for Prevention of Postpartum Hemorrhage in Home Deliveries**

- Continue implementation of this priority intervention while the integrated community-based MNH approach is being developed.
STRATEGIC AREA 2: NEWBORN CARE IN HEALTH FACILITIES

The newborn mortality rate for the period 2011–2015 was 22 per 1,000 live births. This means that 40% of all under-five deaths occur in the first month of life. Newborn mortality has continued to decline as access to and use of both SBA and child health services have improved, but this decline has been slower than the declines in post-neonatal and child deaths. Most newborn deaths are at home, and four causes account for more than 85% of these deaths: complications of delivery (including asphyxia), hypothermia, prematurity and low birth weight, and infections.

Strategic Approach 2.1: Expand Access to Evidence-Based, High-Impact Interventions for Newborn Care in All Health Facilities

2.1.1 Appropriate levels of care will be available in all health facilities.

- A newborn care corner in each delivery room
- A newborn stabilization unit in each district hospital
- A special newborn care unit in each provincial hospital
- A newborn intensive care unit (NICU) in regional and tertiary hospitals.

The RMNCAH Directorate advocates provision of essential evidence-based neonatal services in all health facilities from BHCs and SHCs to tertiary hospitals. This will include immediate resuscitation, clean cord care and use of chlorhexidine 7.1%, thermal control, and early breastfeeding. It will further include weighing newborns, conducting physical examination of the baby, supporting breastfeeding, and immunizing the infant. Antibiotic treatment of mild neonatal infections should be available at all facilities.

Provincial, regional, and tertiary hospitals will manage severe neonatal infections, including meningitis; very low-birth-weight infants; complications of asphyxia; severe neonatal jaundice; convulsions; and life-threatening congenital anomalies.

2.1.2 Promote early breastfeeding and skin-to-skin contact of the mother and baby. The establishment of exclusive breastfeeding is essential. While 90% of newborns delivered in health facilities start to breastfeed within the first day, only 43% started within the first hour, and 39% had already received a prelacteal feed (ADHS 2015). Midwives are encouraged to monitor three sessions of breastfeeding for at least five minutes and help the mother to improve attachment and position, in order to prevent breastfeeding problems.

2.1.3 The RMNCAH Directorate will pilot the feasibility and expansion of kangaroo mother care.

2.1.3.1 Implement first in the regional hospitals and then expand to provincial hospitals.

Strategic Approach 2.2: Improve the Quality of Newborn Care Services

2.2.1 Improve the quality of essential and advanced newborn care services for the leading causes of death (prematurity, birth asphyxia, and neonatal sepsis) at existing health facilities.

Specific actions will include:

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8 This ADHS 2015 estimate is considered low, probably because of underreporting. A more likely figure is 40 per 1,000 live births.
• Ensure the availability of needed supplies and medical equipment in the health facilities.
• Initiate and enhance regular clinical audits through the MNDSR in tertiary, regional, and then provincial hospitals, reporting and taking actions to reduce neonatal deaths.
• Advocate mentorship programs in newborn care.

2.2.2 Reduce delays in starting effective treatment of complications at the referral hospital.
Specific actions will include:
• Improve and strengthen coordination between obstetricians and pediatricians for neonatal resuscitation in the delivery room and operating room.
• Promote awareness of and early response to the need for cesarean sections for fetal causes.
• Promote development of hospital-specific protocols for rapid and safe transfer of newborns from the labor room to the neonatal nursery.

2.2.3 Improve monitoring and supportive clinical supervision for newborn care services through appropriate use of tools and data.
Specific actions will include:
• Work with the HMIS Department to add new newborn indicators and include them in the expanded RMNCAH Scorecard.
• Include newborn care in joint monitoring visits to facilities. These will include newborn clinical drills.

2.2.4 Strengthen the newborn in-service training program.
Specific actions will include:
• Support provincial in-service training programs to include essential newborn care, IMCI, advanced newborn care, and Helping Babies Survive training packages.
STRATEGIC AREA 3: BIRTH SPACING AND FAMILY PLANNING

Birth spacing and family planning are two of the most effective and cost-effective public health interventions for reducing maternal and infant mortality. A gap of less than two years between successive births is associated with higher maternal and infant mortality rates and higher rates of undernutrition and morbidity among children. Each additional pregnancy multiplies a woman’s risk of dying from complications of pregnancy and childbirth. As the modern contraceptive prevalence rate (mCPR) increases, maternal mortality decreases, both because there are fewer pregnancies and because there are fewer high-parity, high-risk pregnancies. The current mCPR of 20% is preventing between 20% and 34% of potential maternal deaths.9

According to the ADHS 2015, the median birth interval in Afghanistan is 28.4 months, and 32% of children are born less than 24 months after the previous one. The population group at highest risk of short birth intervals is teenage mothers. Among women aged 15-19 years, 68% of second or subsequent births are within 24 months of the previous one. Eight percent of women in that age group have already had their first child and are at risk of another pregnancy.

A series of national surveys since 2003 have shown an increase in the mCPR from 10% in 2003 to 20% in 2010. Since then, the overall mCPR has remained unchanged (Figure 6). The urban mCPR is 70% higher than the rural mCPR, and the mCPR of the wealthiest quintile is double that of the poorest quintile. Of the current mCPR of 20%, the main contributions by method are: pills 6.8%, injectables 4.8%, condoms 3.3%, female sterilization 1.8%, IUDs 1.4%, and implants 0.2%. Contraceptives are obtained about equally from public and private health institutions, including 31% from pharmacies (pills and condoms) (ADHS 2015).

Figure 6: Modern contraceptive prevalence rate by residence


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According to the NRVA 2007–2008, distance from a facility makes little difference to the mCPR. This is because pills and condoms have been available at health posts since the beginning of the BPHS, and CHWs have been able to initiate injectables with clients since 2009. In 2010, about 70% of BS/FP consultations were at health posts. In 2016, HMIS data showed that that proportion had declined to about 50%, suggesting that community-based provision of contraception is weakening.

Discontinuation rates of contraceptives can provide valuable clues about where FP counseling needs to be improved. The overall contraceptive discontinuation rate in the first 12 months is 26%. In 54% of clients, this is because the couple wanted to get pregnant, and in 8% it was because of method failure. Of the remainder, 4% wanted a better method, 4% said the husband disapproved (IUD 15% and condom 10%), and 13% complained of side effects or health concerns (pills 14%, IUDs 24%, and injectables 28%).

Questions about what MoPH providers told them during FP consultations indicated that 60% of women said that they had been told about side effects, 50% had been told what to do about them, and 70% had been told about alternative methods. This indicates a serious shortfall in counseling. However, the results for the private sector were worse, perhaps reflecting the widespread use of pharmacies for contraceptive supplies.

The unmet need for FP is 25% in both urban and rural populations, and neither education level nor family wealth makes any difference. This unmet need is equally divided between women who want another child after two years and those who want no more children. Regarding future use of contraceptives, 22% say they intend to use a contraceptive, 42% say they will not, and 34% are unsure.

**Strategic Approach 3.1: Promote Family Planning through Advocacy and Policy Dialogue**

Advocacy is critical to gaining both institutional and public support for legal and policy changes, including national laws, policies, and regulations affecting standards of practice, and community customs and practices. The main objectives of advocacy and continued policy dialogue are to encourage active involvement of elected representatives, community and religious leaders, and concerned groups and individuals, especially at the grassroots level. In 2016, a national intersectoral coordinating committee was formed and a national plan drafted.

Specific actions will include:

- Review and update policies and regulatory mechanisms to ensure universal and equitable access to modern FP information, products, and services.
- Strengthen integration of FP into other RMNCAH program activities.
- Build public-private partnerships to support the financing of FP commodities and services.
- Promote the distribution and use of existing booklets on FP and Islam, approved by the Ministry of Haj and Awqaf and Islamic Affairs.
- Promote the use of existing training packages for religious leaders on FP in close collaboration the Ministry of Haj and Awqaf and Islamic Affairs.
- Support the engagement of communities, civil society organizations, the private sector, parliamentary members, and the media in providing information and promoting FP programs.
- Establish healthy mothers’ associations at the health facility level to encourage other mothers to use contraceptives as a BS or FP method.
Strategic Approach 3.2: Increase Information, Education, and Communication and Social and Behavior Change Communication for Wider Use of Birth Spacing/Family Planning

Women (94%) and men (91%) in both urban and rural areas are aware of modern contraceptive methods. Eighty-nine percent know about pills, 87% about injectables, and 62% about IUDs. However, exposure to messages about BS/FP is not universal. In the 12 months before the ADHS survey, 40% of women had heard no FP message at all. Forty percent of women had heard a FP message on either radio or TV. Twenty-five percent of women heard a message about BS/FP from community leaders, but only 21% from a health worker. Of women not using a modern method, who had met with a health worker or CHW in the previous 12 months, only 18% had had a conversation about FP.

Specific actions will include:

• Use the distribution system for standard IEC materials. Ensure that existing FP/BS IEC materials are up-to-date and fresh. Coordinate with HPD to develop, print, and disseminate IEC/BCC material such as fact sheets, brochures, flip charts, and posters.
• As appropriate, use mass media, social media, SMS, and TV or radio spots and round-tables to promote FP and to dispel myths and misconceptions about contraception. Consider using information and communications technologies for promotion of FP.
• Increase the involvement of men and religious and community leaders to achieve higher demand for and use of modern FP services.
• Increase participation of family decision-makers in FP/BS activities. CHWs and Community Midwives will be trained to mobilize mothers-in-law and other family and community decision-makers to involve them in promoting culturally acceptable modern FP in the community.
• CHWs and FHAGs should focus on reaching out to poorer families, young married couples, and first-time parents with BS/FP information.
• Use innovative social and behavioral change communication interventions such as mixed-media activities, IPCC, and community sensitization through entertainment activities in mass gathering places under the social marketing program.
• Promote the implementation of BS/FP programs and campaigns at the provincial level.
• Integrate IEC/BCC for BS/FP into other RMNCAH activities.

See also the RMNCAH communication strategy under Cross-cutting Issues and Enabling Strategic Approaches.

Strategic Approach 3.3: Strengthen Community-Based Birth Spacing/Family Planning Approaches

Working with communities is a priority for bringing FP information and contraceptive methods to women and men in the communities where they live. The Community-Based Health Care Strategy (CBHCS) 2015–2020 outlines the roles of community health workers, community health supervisors, health shuras (shura-e-sehie), and FHAGs. When designed and implemented appropriately, community-based FP services can increase use of contraception, particularly where unmet need is high, access is low, and geographic or social barriers to use of services exist.

Specific actions will include:
• Strengthen linkages between the community health supervisor and community midwives at health facilities and the CHWs, shuras, and FHAGs in the community for promotion of BS/FP provision in the community.

• Design and promote an integrated program of home visits for postpartum birth spacing, breastfeeding, infant and young child nutrition, and immunization for community health workers, together with appropriate job aids and a training program. This is to increase the numbers of women who are counseled about BS/FP and to ensure follow-up. The program will particularly target younger women with their first child, who are at higher risk of short birth intervals, and women in poorer families who are least often reached by BS/FP messages and services.

• Improve counseling skills of CHWs on BS/FP, especially on LAM and postpartum FP options for exclusively breastfeeding and non-breastfeeding postpartum women.

• Strengthen community-based distribution of BS/FP methods by improving follow-up.

• Strengthen the links between CHWs and the community midwives at the facility to facilitate referrals for long-acting reversible contraceptives (LARCs) and supportive supervision.

• Ensure regular supply system by BPHS-implementing NGOs to health posts.

Strategic Approach 3.4: Improve Provision of Expanded Choice of Contraceptives

3.4.1 Expand the choice of contraceptives.

The RMNCAH Directorate will work to increase the range of effective FP methods to meet the varying needs of both current and future users. At present, oral contraceptives (progesterone only pills and combined oral contraceptives), injectables (Depo Provera), and condoms are the most commonly used contraceptives (15% of mCPR). IUDs and implants contribute only 1.6% to the mCPR.

The RMNCAH Directorate will promote LARC implants as a cost-effective, high-impact modern FP intervention in Afghanistan. FP implants are effective and safe to use in the postpartum and postabortion period. Recently, MoPH received approval to include implants in the essential medicines list (EML). In addition, initial trials are beginning for Sayana Press, a low-dose Depo Provera injectable contraceptive that can be self-administered. This could be an addition to, or as a replacement of, the currently available injectable.

Specific actions will include:

For contraceptive implants

• Develop a scale-up plan for contraceptive implants as part of a broader plan for the promotion of LARCs (IUDs, implants, and injectables), with a special focus on postpartum and postabortion couples. In view of husbands’ objections to the side-effects of LARCs, their inclusion in counseling and decision-making about a method should be emphasized. The program will also include appropriate counseling, referral training, and job aids for CHWs.

• Include contraceptive implants in the BPHS and EPHS drug lists.

• Promote and support provision of LARC methods at facility and community levels by community midwives.

For Sayana Press

• Continue the feasibility, acceptability, and cost-effectiveness studies to establish:

  − The relative advantages of Sayana Press and the existing injectable Depo Provera program
– Its feasibility of distribution at health facilities and by CHWs at health posts
  • When appropriate, promote its acceptance for the EML and the BPHS.
  • Develop an implementation plan.

For emergency contraception
  • Implement pilot feasibility and acceptability studies.

3.4.2 Promote use of postpartum and postabortion care family planning services.
  • Develop postnatal protocols for antenatal and postabortion counseling and facility postnatal care to expand provision of IUD and implant services for postpartum and postabortion care.

Strategic Approach 3.5: Strengthen the Capacity of Health Service Providers to Provide a Full Range of Modern Family Planning Methods
Capacity building of health care providers in BS/FP at all levels of the health system is important for quality FP service provision. Improved attitudes to and skills in BS/FP counseling are a priority.

Specific actions to be undertaken include:

3.5.1 \textit{Expand the number of training centers.}
  • Establish two new FP national training centers at two highly utilized national maternity hospitals.
  • Decentralize the FP competency-based training through establishment of provincial FP training centers.
  • Ensure all existing FP national and regional training centers are fully equipped with necessary commodities, supplies, and job aids for provision of quality BS/FP training.
  • Establish FP centers of excellence at health facilities to be used for replication of FP training, FP services provision, and mentorship to nearby facility health providers.
  • Map out the available capacity and resources of health facilities (both public and private) as potential training locations.

3.5.2 \textit{Strengthen in-service training approaches for service providers in birth spacing/family planning.}
  • Ensure that all national BS/FP Learning Resource Package (LRPs) and guidelines are up-to-date and aligned with international standards.
  • Coordinate implementation of BS/FP counseling training for health care providers at all levels (including CHWs). Make full use of the following tools: RMNCH counseling package and Decision Making Tool, and Balance Counselling Strategy Plus (BCS+).
  • Initiate and sustain a post-training follow-up and supervision system for all BS/FP trainees, in collaboration with GDHR.
  • Establish close coordination between the MoPH, the NGO implementers of the BPHS and EPHS, and international NGOs to ensure that there is no duplication of trainings and only nationally adopted training resource packages are used.
  • Develop training materials that are appropriate in content and scope for other health care providers at health facilities, especially male nurses and outpatient physicians, in order to enable greater integration of BS/FP into other RMNCAH activities.
• Coordinate development of e-learning modules (computer and mobile applications) for BS/FP services and counseling to improve both public and private health providers’ FP knowledge and skills.
• Promote the inclusion of BS/FP subjects, including LAM and postpartum FP counseling, into the pre-service curricula of physicians, Community Health Nurses, and other nurses in public and private institutions

Strategic Approach 3.6: Integrate BS/FP Services into All Levels of the Private Sector
By the end of 2016, 19 private hospitals had MOUs with the MoPH to deliver FP services. In future, it will be necessary to:
• Expand the numbers of private facilities with which the MoPH has MOUs for FP services.
• Strengthen coordination and collaboration with private-sector health providers to ensure that the private sector follows the MoPH’s national RMNCAH intervention package for the private sector.
• Develop a strategy for capacity building and refresher training of private-sector health providers.
• Support expansion of the availability of FP methods in private pharmacies through the social marketing program. Encourage strengthening of the counseling skills of pharmacy staff.
STRAIGHTEN AREA 4: CHILD HEALTH

Studies of child mortality in Afghanistan have provided uncertain estimates because of data problems. Nevertheless, the data do support the general conclusion that post-neonatal (1-11 months) and child (1-4 years) mortality rates have declined significantly. As is typically the case, however, neonatal mortality has declined to some extent, but more slowly. The most frequent causes of death remain pneumonia, diarrhea, and immunizable diseases, aggravated by underlying malnutrition. Newborn deaths occur typically in the first 24 hours of life and most of the rest within the first week. The causes are asphyxia, hypothermia, neonatal infections, and the complications of prematurity and low birth weight.

<table>
<thead>
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<th>Period preceding survey (yrs)</th>
<th>Early childhood mortality rates (per 1,000) for 5-year periods before ADHS 2015</th>
<th>Approximate time periods</th>
<th>Neonatal mortality</th>
<th>Post-neonatal mortality</th>
<th>Infant mortality</th>
<th>Child mortality</th>
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Seeking to reduce child morbidity and mortality, the MoPH intends to ensure the provision of high quality, equitable health services for all Afghan newborns, children, and their mothers, with more focus on marginalized populations. Key child health strategies include the following.

**Strategic Approach 4.1: Ensure the Quality of Integrated Management of Pneumonia, Diarrhea, and Other Newborn and Childhood Illnesses (IMNCI)**

Access to case management of pneumonia and diarrhea is provided both at health facilities and by CHWs in about 15,000 health posts across the country. The proportion of children treated by CHWs has decreased from an earlier 40% to about 20%. Referral of serious cases continues in 20% of cases seen by CHWs.

This program is based on the Pneumonia and Diarrhea Action Plan 2016–2020. Rational use of drugs will need constant reinforcement. The ADHS 2015 reported that only 50% of children with diarrhea received ORS or recommended home fluids, and only 10% received zinc tablets. On the other hand, 20% of children with diarrhea were treated with antibiotics, and the proportion (54%) of children with symptoms of acute respiratory infection (ARI) who were given antibiotics was at least twice what it should have been.

Activities will include:

**4.1.1 Ensure the quality of IMNCI by health professionals in health facilities.**

- Support and monitor pre-service training in IMNCI in both public and private medical schools.
- Support and monitor pre-service training in IMNCI in the curricula of all nursing training schools.
- Promote and support supportive clinical supervision for facility health workers treating children through regular visits, clinical reviews, and mentoring by provincial health workers.

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10 The AHS 2006, AMS 2010, and ADHS 2015 suffered similar problems of missing data for births and deaths of girls and newborns and births and deaths in time periods progressively earlier than the survey.
MoPH Child and Adolescent Health (CAH) and NGO staff, emphasizing rational use of drugs and interpersonal communication.

- Promote and support maximum use of the three-day refresher training courses in IMNCI at the regional child health training centers.

4.1.2 **Ensure the quality of community IMNCI.**

- Ensure both basic and in-service training in community-based IMNCI of all CHWs and community health supervisors in community-based IMNCI. Work with provincial MoPH and NGO staff to ensure the training competence of CHW trainers, the availability of community-based IMNCI case management charts for all CHWs, and opportunities for supervised practical learning experiences.
- The CAH Department initiated an improved community IMNCI training program and pictorial job aid for CHWs and community health supervisors in 2008. This has been implemented in 25 provinces as an in-service training for CHWs already in place. The refresher training needs to be implemented in the remaining provinces. It has been incorporated into the basic training of new CHWs.
- Monitor and ensure the availability of essential medications at health posts.
- Establish supportive clinical supervision for CHWs through regular visits by community health supervisors, clinical reviews, mentoring, and provision of refresher training by health facility and provincial MoPH and NGO staff.

**Strategic Approach 4.2: Promote the Increased Use of IMNCI Services at Both Community and Health Facility Levels**

The ADHS 2015 reported that advice was sought for a sick child in the following cases: symptoms of ARI (62%), diarrhea (52%), and/or fever (54%). Only 65% of mothers of sick children knew about ORS packages or the recommended home fluids. This did not vary much between urban and rural populations or wealth levels, but education level was important. Among the 84% of women with no education, only 63% knew about ORS compared with 78% among women with a primary school education.

Activities will include:

- Support a renewed IEC/BCC program through communities, facilities, and media on awareness of childhood illnesses and obtaining appropriate treatments for them from trained staff at the community and facility levels.

**Strategic Approach 4.3: Expand and Strengthen the Pediatric Hospital Care Improvement Initiative**

Poor quality of care in hospitals results in an excess of preventable deaths of children. An estimated 10–20% of sick children seen at the primary level may require referral to hospitals. HMIS data show that children under five make up less than 30% of admissions of hospitals, but they account for more than 50% of hospital deaths. The main factors contributing to the poor quality of care and outcomes for children in hospitals are inadequate triage and assessment, delayed initiation of treatment, inadequate supplies of drugs, poor knowledge of standard treatment guidelines, and insufficient monitoring of sick children on wards.

The Pediatric Hospital Care Improvement Initiative (PHI) in Afghanistan has already proven to be a high-impact and cost-effective intervention. In the first year of PHI at Indira Gandhi Hospital (2009–2010), there was a decline from 9% to 4.6% of deaths from pneumonia in children within the first 24 hours after admission. The key interventions of PHI are:
Implement emergency triage, assessment, and treatment (ETAT) of severely sick children
Improve the quality of emergency care.
Promote hygiene, and prevent hospital infections.

ETAT has already been implemented in seven regional hospitals.

Key activities will include:
- Strengthen ETAT implementation in the existing six regional pediatric referral hospitals and include the other two components of PHI, improving emergency care and improving hygiene to reduce hospital infections.
- Extend the PHI program to provincial hospitals (two additional hospitals per year).

**Strategic Approach 4.4: Promote Healthy Behaviors in the Home to Prevent Diarrhea and Pneumonia**
The most important action for preventing diarrhea is handwashing. A place for handwashing was found in 86% of urban homes and 72% of rural homes. Soap and water were present in 65% of urban homes, but only 24% of rural homes. Another 28% had only water. In addition, only 12% of urban households and 4% of rural households use an appropriate treatment method for drinking water.

The incidence of pneumonia in children is higher in homes where people smoke or where solid fuel is used for cooking inside the building. Tobacco smoking occurs daily in 19% of both urban and rural homes. Cooking is done inside 63% of urban and 53% of rural homes rather than in a separate building or outside. However, solid fuel is used in 84% of rural homes but only 16% of urban homes.

Key activities will include:
- Advocate for and support home and personal health programs in the promotion of handwashing, treated drinking water, and the reduction of smoky home environments.
- Support the continued expansion of the combined ORS and zinc tablets packages at facility and community levels.

**Strategic Approach 4.5: Promote Exclusive Breastfeeding during the First Six Months after Birth**
The ADHS 2015 reports that exclusive breastfeeding under six months of age occurs in only 43% of children. At 4–5 months of age, only 33% of children are still exclusively breastfeeding, but 55% have been predominantly breastfeeding for the first six months. Nineteen percent of children under 6 months are using a bottle with a nipple.

Key activities will include:
- Strengthen IEC/BCC programs to promote breastfeeding among lactating mothers for child health as well as for LAM protection of the mother. This should be done by midwifery staff after delivery in facilities, health professionals seeing children at health facilities, and by CHWs and FHAGs at community level.

**Strategic Approach 4.6: Promote Growth Monitoring and Infant and Young Child Feeding**
The National Nutrition Surveys in 2004 and 2013 indicate that stunting in children has fallen from 61% to 41%. However, wasting has increased very slightly, from 9% to 10%. Seventy-
eight percent of children are still breastfeeding at one year. Appropriate semi-solid or soft foods were introduced at 6–8 months to 61% of children (ADHS 2015).

Key activities will include:

- Support the Departments of Public Nutrition and Community-based Health Care to scale-up the Community Nutrition Program, including the community growth monitoring component, from the present 25 provinces.
STRATEGIC AREA 5: ADOLESCENT HEALTH

Adolescents between the ages of 10 and 19 make up just over one-quarter of the population. This is a group that carries a high potential for health improvement of society as well as high risks for morbidity and mortality. A large proportion of these young people are attending school (see Table 3). Sixty percent of eligible children are attending primary school, and 38% are attending secondary school. These young people can be expected in the future to be more informed decision-makers, to use health services more and more effectively, and to become change agents in their communities.

Table 3: The proportion of eligible children attending primary or secondary school

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urban</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>78</td>
<td>71</td>
</tr>
<tr>
<td>Secondary school</td>
<td>59</td>
<td>42</td>
</tr>
<tr>
<td><strong>Rural</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>69</td>
<td>50</td>
</tr>
<tr>
<td>Secondary school</td>
<td>50</td>
<td>25</td>
</tr>
</tbody>
</table>

Age at first marriage has been slowly increasing. The ADHS found that 17% of women 15–19 years are currently married, versus only 3% of men. First sexual intercourse occurs within marriage. In urban areas, 8% of women have started childbearing, and in rural areas it is 12% (8% have had a child and 4% are pregnant with their first one). Levels of education also make a difference. Childbearing has started in 16% of women with no education, 9% of those with a primary education, and 7% in those who have attended secondary school.

Adolescents who become pregnant should be identified for special attention. Adolescent pregnancies carry a high risk of anemia, pre-eclampsia and eclampsia, prolonged labor and fistula, and prematurity and low birth weight. According to ADHS, if adolescents have a second child, the probability is that 68% of those children will be born less than 24 months after the first birth. Risks of neonatal mortality are higher with adolescent pregnancies, and the risks of both neonatal and post-neonatal mortality are higher when births are spaced less than 24 months apart.

The MoPH seeks to enable adolescents to become change agents for health in both their present and future families. It also seeks to reduce adolescent morbidity and mortality by providing and promoting the use of youth-friendly health services for primary, reproductive, nutritional, and mental health conditions. It will advocate for ongoing intersectoral efforts to reduce early marriage, delay the first pregnancy until at least 18 years of age, and reduce gender-based violence (GBV).

Strategic Approach 5.1: Expand Adolescent Sexual and Reproductive Health and General Health Services for Young People

Since 2015, the MoPH has established Youth Health Corners in secondary and tertiary health facilities in five provinces. These are rooms providing extra privacy, staffed by doctors and midwives, who are specially trained to provide counseling and care on adolescent nutrition and development, sexual and reproductive health (SRH), communicable diseases, and mental health. It is open three days each week for young men and three days for young women. In
addition, since 2012 the nationally available Youth Health Line has been available to provide counseling to young people. Based in Kabul, with both male and female staff, it receives between 70,000 and 80,000 calls annually.

Specific actions include:

- Expand the Youth Health Corners at the provincial level, as feasible.
- Advocate the expansion and strengthening of health care services to adolescents who inject drugs, or who suffer from mental disorders/problems, GBV, or social exclusion challenges.
- Improve data collection and the reporting system for adolescent morbidity and health-related issues (for example, inclusion of the age group 10–19 years in the HMIS).
- Maintain and expand Youth Health Line services.
- Involve religious leaders in adolescent health programs to increase community awareness at national and subnational levels about young people’s right to SRH information.
- Build youth leadership to advocate for promotion of SRH rights for young people.
- Strengthen national capacity to respond to adolescent SRH in emergency settings.
- Strengthen national health services delivery of services for sexually transmitted infections (STIs) and HIV for young populations.

**Strategic Approach 5.2: Promote Premarital Counseling Program at Health Facilities**

This program for newly engaged couples will be linked to the new marriage registration program and will provide health counseling and basic health screening, based on a program manual that has been developed.

Specific actions include:

- Introduce the pre-marriage counseling program gradually when the pilot phase has been successfully accomplished.
- Increase community awareness about prevention of early pregnancy.
- Establish a multisectoral Adolescent SRH Technical Working Group to coordinate and develop programs that address adolescent pregnancies.

**Strategic Approach 5.3: Improve School Health Services for Adolescents**

In collaboration with the Ministry of Education, a survey was carried out in 12 schools in Kabul Province. Based on its findings, School Health Service Guidelines have been developed and implemented in 180 schools in the province. This program includes training of two teachers in each school for the program; screening for vision, hearing, dental, and nutrition problems; a school health room with a kit of 29 items, including bandages, painkillers, and ORS; and a referral mechanism to the nearest health facility.

Specific actions include:

- Expand school health program to the provincial level.
- Expand distribution of micronutrients, including iron and folic acid, among adolescents.
- Integrate family life education into national school curricula and teacher training programs.
- Integrate GBV into the formal national school curriculum and teacher training program.
STRATEGIC AREA 6: REPRODUCTIVE MORBIDITY

The extent and nature of STIs in Afghanistan are largely unknown because no prevalence studies have been conducted. HIV is still predominantly a concentrated epidemic among injecting drug users (IDUs). Many of these IDUs have come from outside Afghanistan and are concentrated particularly in Herat, Kabul, and Mazar. HIV does not seem to be a problem among female sex workers or truckers, and the situation among men who have sex with men is undocumented. The National AIDS Control Program has initiated provision of STI services as a prevention strategy for HIV because the presence of an STI greatly increases the risk of acquiring or transmitting HIV infection. Since STIs and HIV/AIDS are so closely linked, the RMNCAH Directorate will coordinate closely with the AIDS Control Program.

Strategic Approach 6.1: Increase Public Awareness of Sexually Transmitted Infections and Improve the Quality of HIV/AIDS Clinical Services

6.1.1 Strengthen programs for the prevention and management of STIs.
- Integrate STI syndromic management and primary prevention into the services of the BPHS.
- Build health workers’ capacity in STI syndromic management, including the provision of gender-sensitive and respectful counseling and care to identify risk behaviors of clients, perceptions of partners’ behavior, and indications of sexual or other practices between partners that may increase risk of transmission.
- Collaborate with BPHS-implementing partners to allocate resources for (1) the training of health workers in STI prevention, identification, and treatment, (2) the updating of the LRP for syndromic management of STIs, and (3) implementation of an STI training program for health workers in STI management.
- Monitor STI incidence and prevalence using the HMIS.
- Collaborate with the HPD and HIV/AIDS departments on the development of IEC/BCC materials for STI prevention.
- Promote male involvement and active participation in STI treatment by raising the awareness of health care providers and communities.
- Identify resources for further STI research.

6.1.2 Support surveillance of the entry of HIV into the general population.
- Collaborate with the AIDS Control Program in selecting the times and locations of HIV prevalence surveys among pregnant women in the general population.

Strategic Area 6.2: Improve Detection and Treatment for Breast, Cervical, and Prostate Cancers

Cancers of the breast and cervix kill more women than any other form of cancer. The causes of breast and cervical cancer are related to a woman’s sexual and reproductive choices and other exposures in early life, such as a history of infection with the human papillomavirus (HPV), age at first pregnancy and number of pregnancies, breastfeeding history, diet, and physical activity. According to the ADHS 2015, of family members who had been diagnosed with cancer, 21% were breast cancers and 5% were cervical cancers. Prostate cancer is the fourth most common cancer in Afghanistan, and it is the second most common cancer in men.
Cervical cancer is largely preventable with effective screening and treatment of precancerous lesions. Breast cancer survival rates are greatly increased through early detection and treatment. However, limited services are available in Afghanistan for the diagnosis and treatment of breast and cervical cancer. No radiotherapy or chemotherapy centers exist in the country. Hence, much of the disparity in disease burden is rooted in inequitable access to care.

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

6.2.1 Breast cancer approaches.
The following are the strategic approaches to breast cancer:
- Increase knowledge and awareness of communities and women about breast cancer and the importance of early detection and treatment.
- Support the promotion of breastfeeding to lower the risk of breast cancer.
- Develop IEC/BCC materials to increase awareness of the importance of early detection of breast cancer and breast self-examination.
- Develop an LRP to build the capacity of health providers in detection of the early signs of breast cancer through physical examination; counseling; and referral of breast cancer.
- Improve diagnostic services for breast cancer in the public and private sectors.
- Promote the development and initiation of a training program in chemotherapy, radiotherapy and breast cancer surgery techniques.
- Establish public-private partnerships to improve early screening, diagnosis, and management of breast cancer.

6.2.2 Cervical cancer approaches.
Detection approaches that can be implemented quickly and inexpensively to detect and treat cervical cancer are visual inspection with acetic acid (VIA) and cryotherapy. As these methods are simple and cost effective, they will play an important role in decreasing the mortality of women from cervical cancer and reduce the need for women to seek care in neighboring countries for these services.

The following are the strategic approaches to cervical cancer:
- Build health workers’ capacity to identify and treat cervical cancer in early stages.
- Review and finalize the LRP on detecting and treating cervical cancer.
- Collaborate with the Aga Khan University, IHS, the Nursing and Midwifery departments, and private institutions to ensure that the VIA and cryotherapy techniques are incorporated into nursing and midwifery curricula.
- Develop an IEC/BCC strategy and materials to increase awareness of the importance of early detection of cervical cancer and treatment.
- Promote incorporation of VIA and cryotherapy into the BPHS and EPHS as effective and efficient techniques to detect and treat cervical cancer in the early stages.
• Investigate the potential benefit of introducing the HPV vaccine to prevent cervical cancer.

6.2.3 Prostate cancer approaches.
The following are the strategic approaches to prostate cancer:
• Identify and pilot-test a cost-effective approach to screening for, diagnosing, and managing prostate cancer.
• Advocate inclusion of early detection and referral of prostate cancers in the BPHS.
• Increase communities’ and health professionals’ awareness about prostate cancer.

6.2.4 General approaches to cancer management.
• Advocate to the Directorate of Curative Medicine for the development of a training program on chemotherapy, radiotherapy, and modern techniques of treatment of breast and cervical cancer.
• Promote participation of all hospitals in the five regional cancer registries.

Strategic Area 6.3: Increase Awareness and Knowledge of the Risks of Obstetric Fistula and Its Prevention, and Improve Access to Treatment
A national obstetric fistula program has been established, through which a limited number of physicians have been trained in fistula repair, and funds have been made available to women for transport and medical expenses to make fistula repair accessible, regardless of economic status. In 2016, a second Obstetric Fistula Center was opened in Herat, and all staff trained.

The ADHS shows a 3% prevalence of obstetric fistula in Afghanistan (reported cases, not clinically confirmed). Of the cases of fistula, 72% occurred after delivery or a stillbirth, and 7% followed a sexual assault. Only 23% of women were aware of the symptoms of fistula. Forty-three percent of those with symptoms sought treatment (urban 63%, rural 35%). Seeking treatment varied greatly with levels of education and family wealth. Fifteen percent were treated with an operation (urban 4%, rural 24%). After treatment, the leakage stopped completely in 47% and was reduced in a further 33%.

The Obstetric Fistula National Committee will strengthen the fistula program using several strategic approaches, including the following.

6.3.1 Increase knowledge and awareness of fistula prevention, treatment, and rehabilitation among communities and health care providers.
• In collaboration with implementing partners, develop an LRP on fistula prevention, identification, treatment, and referral.
• Design and develop the IEC/BCC and IPCC materials to raise the awareness of obstetric fistula.
• Develop and implement a protocol for the confirmation and referral of suspected cases of fistula for assessment and management.
• Develop a manual for residency and in-service trainings program for the diagnosis, repair of obstetric fistula, and re-integration of patients in their families.

6.3.2 Improve access to fistula treatment.
• Collaborate with implementing partners to develop a costed action plan on fistula prevention, identification, and treatment.
- Operationalize the social re-integration and rehabilitation program at the existing centers for rehabilitation and treatment.

6.3.3 Improve documentation of obstetric fistulas and pelvic floor disorders.
- In collaboration with hospital specialist staff and the HMIS, conduct operational research on the identification and prevalence of obstetric fistula and pelvic floor disorders, together with local determinants.
- Integrate obstetric fistula indicators into the HMIS and data collection system.

Strategic Area 6.4: Raise Awareness about the Causes of Infertility and Its Prevention, Care, and Treatment

Information related to infertility in Afghanistan is not available, although worldwide it is estimated that 15% of couples of reproductive age experience infertility. There are various causes of infertility among women. For males, factors include sperm abnormalities and sexual dysfunction. Social challenges for the provision of effective infertility services are failure to seek timely health care on the part of affected couples, and negative attitudes toward infertility at both the service provider and community levels.

Very few service providers in Afghanistan possess the knowledge and skills needed to meet the needs of infertile couples. While basic counseling and treatment for infertility are possible, advanced and highly technical interventions are not feasible at present. As a first step in developing an infertility program, simple interventions for management of primary infertility and identification of opportunities for the prevention of secondary infertility can be initiated.

The following steps will begin to address the problem and lay the groundwork for a more complete program in the future:
- Build appropriate capacity at all levels for appropriate management of infertile individuals and couples, including referral to facilities with the capacity for early diagnosis and management.
- Develop appropriate IEC materials for increasing community awareness of infertility and what can be done both to prevent infertility and support affected couples.
- Promote active male participation in the prevention and management of infertility.
- Support infertility prevention measures, including improved postpartum and postabortion care, and early diagnosis and effective treatment of reproductive tract infections.

Strategic Area 6.5: Provide Services for Sexual and Reproductive Health and Aging

Aging in both women and men is associated with decline in all body functions, including sexual capacity, and a high incidence of noncommunicable diseases (NCDs), which negatively impact their SRH. Individuals may experience malignancies and sexual dysfunction, which may lead to relationship disharmony and psychological problems. Menopause in women may be associated with further bone demineralization, which can lead to fracture of long bones. Health services for the aging should include issues of fertility and sexual dysfunction, the management of menopause disorders, prevention of osteoporosis, and the promotion of physical activity, a healthy diet, stress management, and healthy behaviors.

Strategic approaches for managing aging disorders include:
• Promote an integrated approach to services for elderly women and men, which include the management of NCDs, post-menopausal problems, and screening tests for reproductive organ cancers.
• Plan and facilitate capacity building of health care providers for the care of women 50 years and above, especially for the management of menopause, such as hormonal replacement therapy and the prevention of osteoporosis.
• Develop an appropriate communication strategy to raise awareness of the health problems of aging and their potential family and medical management.

**Strategic Area 6.6: Implement Services for Sexual Dysfunction**
The most common forms of sexual dysfunction are erectile dysfunction in males and lack of desire in women. Sexual dysfunction can be caused by physical or psychological problems, medical or surgical interventions, or complications of disease. Sexual dysfunction disrupts the family and may lead to many social and health problems. Sexual dysfunction affects persons from adolescence upward.

Strategic approaches for dealing with sexual dysfunction include:
• Develop and implement an appropriately targeted capacity-building program of service providers for the diagnosis and treatment of sexual dysfunction.
• Develop an appropriate communication strategy to raise awareness of the problems of sexual dysfunction and their potential family and medical management.
7. CROSS-CUTTING ISSUES AND ENABLING STRATEGIC APPROACHES

7.1: RMNCAH Services for Marginalized Populations

In response to ongoing conflict, the numbers of internally displaced persons have increased, especially over the past three years. Surveys at the end of 2016 suggested the number of internally displaced people in Afghanistan was 1.2 million. The RMNCAH Directorate will play an advocacy role to ensure access to basic health services for women and children in these camps and settlements. In addition, there are significant nomadic and poor periurban populations that have poor access to services and do not make use of them.

7.1.1 Create a joint plan to guide the implementation of health programming in humanitarian settings.

To ensure that basic health services are available during emergencies, this strategic approach will include the following actions:

• Strengthen coordination and collaboration with the Emergency Preparedness and Response Office, humanitarian actors, the health cluster, the Afghanistan National Disaster Management Authority, and BPHS implementers.
• Support the development of national and provincial contingency plans to ensure adequate preparedness for environmental health and safety, personal security to prevent violence and GBV, and the provision of essential services in RMNCAH, including the preparation and stockpiling of emergency kits of equipment, supplies, and medications;
• Ensure that RMNCAH services are always included in the agenda points of emergency coordination meetings at national and provincial levels.
• Increase coordination with the Emergency Command Control Centre at the MoPH.
• Establish national and provincial guidelines for the assessment and monitoring of health conditions and access to and quality of health services in camps and settlements for refugees and internally displaced persons.

7.1.2 Support the CBHC Department in expanding and integrating community-based RMNCAH services for marginalized populations.

Use of RMNCAH services by nomadic communities and poor periurban populations is much below average. Supportive activities include:

• Support the CBHC Department in the development of specific job descriptions and LRPs for CHWs working in nomadic and poor urban communities.
• Promote and support efforts by NGO partners in extending services to these communities.

7.2: Quality Improvement

In order to achieve Afghanistan’s Sustainable Development Goals, the MoPH has made quality improvement a main priority. Some of the challenges faced in improving the quality of RMNCAH services include:

- Low motivation of health providers to participate in public health activities and in data collection;
- Lack of recognition of health workers who do quality work;

11 Amnesty International.
Inadequate staff at subnational level to supervise and monitor quality of service;
Lack of uniformity of quality improvement (QI) interventions in different health facilities;
Inadequate supportive supervision for quality improvement of services;
Inadequate use of data for decision-making at subnational level for assessing and improving quality of care;
Poor integration of a wide range of RMNCAH components in HMIS tools and lack of trained staff for data collection and reporting;
Poor adherence to reporting systems and feedback to service delivery levels;
Lack of model health facilities for demonstrating improved quality of care;
Inadequate commitment to QI at national and subnational levels;
Resistance to change within the health system;
Lack of support on the part of health services management;
Lack of adequate RMNCAH staff for follow-up.

Critical QI initiatives that the RMNCAH Directorate will prioritize and work on with other MoPH units and partners include:

7.2.1 **Integrate quality as an essential aspect of the national RMNCAH strategy.**
- Review and update, as necessary, national quality standards for RMNCAH care.
- Identify focal points for coordination of QI programs at the provincial, district, and facility levels.
- Advocate for improving leadership, management, and quality assurance skills for heads of health facilities.
- In close cooperation with national professional associations and medical councils, develop standards for accreditation and certification of RMNCAH service providers.

7.2.2 **Motivate health staff for quality assurance.**
- Ensure adequate working conditions through regular monitoring of facility quality standards and management accountability for improvements.
- Ensure regular availability of medicines and medical supplies.
- Manage staff workloads according to their job descriptions, and adjust staffing levels according to workload changes.
- Provide supportive supervision by addressing personal needs, promoting professional development, recognizing good work, encouraging initiative, and listening to ideas.
- Encourage a culture of achievement and performance-based promotion.
- Encourage systematic and regular use of data to challenge and motivate.
- Incorporate a coaching and mentoring program for new graduates and inexperienced staff where possible.

7.2.3 **Maintain ongoing quality improvement activities.**
- Maintain the annual monitoring of health facility quality standards, using the integrated monitoring checklists to ensure provider competence.
- Ensure regular monitoring and graphing of key RMNCAH program indicators at facility, district, and provincial levels; maintain and use provincial RMNCAH Scorecards.
- Institutionalize and expand the MNDSR program.
- Expand the PHI program, and coordinate it with the development of “fast-track” admission procedures for referred obstetric emergencies.
• Improve collaboration with facility and community shuras to monitor client and community satisfaction and help initiate improvements.
• Scale-up use of the Community Scorecard to provide constructive feedback on performance and community satisfaction to health facilities.

7.2.4 Initiate focused, time-limited quality improvement activities.
• Use the Harmonized Quality Improvement Program framework and the Challenge Model with learning collaboratives to monitor and support the implementation of new initiatives or to focus on selected, priority programs that needs strengthening.
• Coordinate the in-service training program and local communication strategy with these QI initiatives.
• Implement systematic gap analysis.

7.3: The RMNCAH Communication Strategy
Each of the strategic areas described in this strategy document includes some elements of IEC and BCC. The following serious challenges confront RMNCAH staff who are attempting to improve the situation:
➢ The health system lacks a standard package of IEC messages and materials on RMNCAH, and many of the materials have not been changed or refreshed for several years.
➢ Health providers have inadequate IPCC skills.
➢ IEC materials are often not properly used.
➢ There is inadequate coverage of active community health shuras, and FHAGs have been developed in only 6,500 (41%) of the 15,840 communities with health posts. The strategies and skills in working with them to achieve social change are still poorly developed and applied.
➢ The emphasis has usually been on the individual or family behavior rather than the changing of social norms and values.

Background for the Communication Strategy
“Honor” is a most important value in Afghan society. Traditionally, achieving family health and happiness with the family’s own resources was very honorable. Seeking help from health services was perceived as less than honorable.

Key decision-makers in choosing whether to seek help from health services are rarely the sick persons themselves. Those who decide if outside help is necessary are usually the mothers-in-law and traditional birth attendants. Those who decide if and when help will be sought are the male family members, who control resources, and religious or other community leaders. The DHS reported that only 5% of women were the main decision-makers in their own health care. Another 43% said that decisions were shared with the husband. Forty-eight percent said that the husband was the main decision-maker. The more education a woman had, the greater was the probability of her sharing in decision-making about her care. The communication strategy, therefore, recognizes the importance of targeting men, mothers-in-law, and religious leaders to gain informed and timely decision-making in the interests of women and children. At the same time, it will target women to continue to maximize their empowerment.

The mass media still have only a partial coverage of the national population. Table 4 shows that 47% of women have no access to a radio or a TV (urban 21% and rural 55%). Access of men is higher, especially to the radio. The main difference made by education is in watching TV.
Table 4: Penetration of mass media to men and women

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
<th>No Education</th>
<th>Primary school</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saw TV in last week</td>
<td>39</td>
<td>71</td>
<td>30</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>Heard radio in last week</td>
<td>24</td>
<td>26</td>
<td>23</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>No access to radio/TV</td>
<td>47</td>
<td>21</td>
<td>55</td>
<td>52</td>
<td>28</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saw TV in last week</td>
<td>46</td>
<td>80</td>
<td>36</td>
<td>32</td>
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<tr>
<td>Heard radio in last week</td>
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<td>57</td>
<td>40</td>
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<td>34</td>
<td>11</td>
<td>41</td>
<td>46</td>
<td>28</td>
</tr>
</tbody>
</table>

The communication objective is to create demand for key RMNCAH interventions and promote healthy RMNCAH behaviors at the individual, family, and community levels.

### 7.3.1 Comprehensive social mobilization and communication strategy.

The communication and behavior change objectives of the different RMNCAH strategic areas will be integrated within a comprehensive social mobilization and communication strategy. It will emphasize the honor and social value of using RMNCAH services and adopting the healthy behaviors promoted by them.

#### Audiences.

The main targets of communication will be:

- Women of reproductive age/mothers of small children
- Husbands: health providers and male CHWs
- The women of the community: female CHWs, mothers-in-law, and FHAGs
- The men of the community: the community health shuras
- Religious leaders: special programs
- First-time parents
- Youth.

#### The implementation framework.

- **Interpersonal/group communication**
  - CHWs to shuras, FHAGs, and husbands, using home visits and IEC materials
  - Reinforcement of the messages by health facility providers during visits
- **Community sensitization**
  - Engaging religious leaders
  - Key cultural events and special days
  - Celebrity endorsements
- **Mass/news media**
  - Entertainment education
  - TV and radio talk shows and public service announcements
  - SMS alerts.

### 7.3.2 Key activities in collaboration with the Health Promotion Department.

- Develop and compile a standard package of RH and CAH IEC materials. All IEC materials produced for RMNCAH will be standardized and made available to implementing partners and RH and CAH organizations within the private sector.
• Strengthen production, distribution, and use of IEC materials.
• List all RMNCAH IEC materials to be included on a national M&E checklist.
• Develop a distribution and monitoring mechanism for RMNCAH IEC materials in health facilities to track the availability, use, and replacement of RH and CAH IEC materials.
• Facilitate widespread distribution of the MCH Handbook.

7.3.3 Key activities in collaboration with the CBHC Department and GCMU.
• Continue the scale-up of FHAGs to all health posts, and maintain support and refresher training to existing CHWs and FHAGs.
• Revitalize community and facility health shuras using the new Health Shura Manual and training program.

7.4: Referral Systems
Access to quality MNH services requires an effective and efficient referral system to a higher level of care when that is necessary, particularly in case of life-threatening MNH complications. A functioning referral system will address the first two of the “three delays” that contribute to preventable maternal and newborn mortality. These are delays in the decision to seek care by the family at home or by a provider at a health facility, and delays caused by difficulties in traveling to the next level of care. This strategic approach applies both within and between the public and private health care systems. Implementation of the RMNCAH strategies described in previous sections will also ensure the availability and quality of appropriate care at all levels to reduce the need for referral due to gaps in service availability or quality.

7.4.1 Reduce delays in decision-making at community level.
Specific activities include:
• Increase the clarity and specificity of client guidance about danger signs in MNCH.
• Since traditional birth attendants and mothers-in-law are influential decision-makers about when extra help is needed, the CHWs and FHAG members will discuss with these women the recognition and significance of danger signs in pregnancy, childbirth, and the postpartum period.
• Since male household members make decisions about the transport and money required for referrals, the male CHWs and the shuras will discuss with the men the nature and significance of complications of pregnancy and the urgency of referral.

7.4.2 Reduce delays in transportation from home.
Specific activities include:
• Discuss with health facility shuras both traditional and innovative methods of transport (for example, mini-ambulances) that may be appropriate to the terrain and climate of that area. The facility shura can then discuss these possibilities with community health shuras.
• Discuss with shuras how emergency funding mechanisms can be arranged for poor families, if necessary.

7.4.3 Reduce delays in the detection and first aid management of complications of delivery at SHCs and BHCs before referral to a higher level of care.
• Ensure consistent use of the partograph to monitor delivery.
• Ensure presence of oxytocin and magnesium sulfate to at least initiate treatment of complications before referral. Provide job aids to assist in implementation of management in these facilities where the incidence of complications may be small.
• Increase health care providers’ capacity to promptly identify needed referrals of sick newborns to higher-level health facilities.
• Use m-health programs to make it easier for staff in peripheral facilities to seek advice or confirmation of their decisions from staff at the referral facility.

7.4.4 Reduce transportation delays between health facilities.
• Promote the establishment of district transportation systems of ambulances or hired vehicles, and appropriate telephone communication systems to reduce delays in using the system.

7.5: The RMNCAH Commodity Security System
RMNCAH commodity security is achieved when all individuals can obtain and use affordable, quality RH commodities of their choice whenever they need them. RMNCAH health commodities include all lifesaving essential medicines and the equipment, reagents, and consumables required for efficient delivery of RMNCAH services. This includes a special focus on the procurement of contraceptives and other RH commodities. The RMNCAH Directorate will act primarily to coordinate, advocate, and mobilize donor resources in collaboration with its partners.

7.5.1 Strengthen the flow of information, including quantification estimates for RMNCAH commodities, to ensure regular ordering and supply of needed commodities.
The aim is to strengthen the Pharmaceutical Logistics Information System (PLIS) to provide RH and CAH staff/managers and pharmacists with the information on stock status and consumption patterns required for making timely quantification forecast of commodities required.
Specific actions include:
• Coordinate the improvement and expansion of the PLIS;
• Conduct PLIS training at all levels to ensure the accuracy, completeness, and timeliness of data.
• Monitor and ensure the availability of functional information technology and other required equipment at all levels.

7.5.2 Strengthen the system for procurement and distribution of RMNCAH commodities and supplies.
To secure availability of funding for commodities and supplies, with particular attention to contraceptives and RH commodities and to strengthen a system of efficient and effective distribution and dispensing of RH commodities, the following are proposed:
• Strengthen the national procurement process for RH commodities.
  − Advocate with partners to contribute more resources for RH commodities.
  − Advocate the pooling of resources and unification of the procurement of quality RH commodities. This process should be led by MoPH according to an agreed-upon plan and budget for national and partners’ financial contributions.
• Improve the RH stock status at the national and provincial levels, through structured monitoring, planning, and delivery.
- Develop monitoring tools to gather and use information about the RH supply chain management system for use in supervisory visits.
- Monitor progress on addressing barriers and possible alternatives.
- Design and implement an initiative to increase public and private pharmacists and drug vendors’ awareness about RH commodities.
- Improve stock management of private-sector health institutions of RH commodities through professional health associations and organizations.

7.5.3 Strengthen in-service training on RH commodity security.
Training of pharmacists, provincial RH officers, and health workers at all levels of the health system is a key priority. The following activities will be implemented:

- Ensure that the RH commodity security training package and guideline are up-to-date.
- Develop a national plan for capacity building on RH commodity security (RHCS) and supply chain management, in collaboration with FP partners.
- Conduct the RHCS trainings in all provinces.
- Establish an effective mechanism for a RHCS post-training follow-up program and supervision.

7.6: Greater Collaboration between the Public and the Private Sectors
As the private sector has become a significant provider of health services, collaboration between the RMNCAH Directorate and the private sector becomes increasingly important to ensure that the quality of health services in the private sector is at least equal to that of the public sector. The RMNCAH Directorate will build on existing links with professional organizations and private hospital organizations to promote quality of care and services and their participation in priority national public health programs.

Activities will include:

- Invite representatives from the private sector to participate on the RMNCAH Coordinating Committee, taskforces, and working groups.
- Expend the scope of MOUs between the MoPH and private facilities for different kinds of services.
- Invite private-sector health practitioners to attend in-service training programs sponsored by the MoPH.
- Provide in-service training materials, quality assurance materials, and monitoring checklists to private providers and institutions.
- Develop strategic public-private partnerships to engage the non-health private sector enterprises in Afghanistan to play a more meaningful role in public health interventions such as EPI campaigns.

7.7: Gender Issues
The MoPH Gender Department plays a key role in addressing gender equality and equity in the national health policies and guidelines. The main aim of this unit is to focus on priority areas of RH, especially mothers and newborns, and women’s and children’s rights. Success in achieving these goals will be evaluated by the extent to which interventions have contributed to overall RH and CAH rights and to the attainment of the SDGs.

7.7.1 Increase gender sensitivity among health care providers.
- Support increased awareness of gender issues and RH rights among health workers in their training programs.
• Promote the improvement of providers’ counseling skills to ensure that women understand health situations, treatment and return instructions, and information needed for informed decision-making about use of services.
• Promote inclusion of husbands, male family members, and community leaders in informed decision-making about RMNCAH services.
• Promote sex-disaggregated data collection in HMIS and surveys.
• Integrate gender sensitivity where appropriate into RMNCAH training programs.

7.7.2 Promote the design of health services to empower women.
• Promote the priority of privacy and confidentiality as a quality assurance value in the structure of health facilities and in the provision of services.
• Advocate for the increased recruitment and deployment of female CHWs, as their presence facilitates increased access to health services by rural women.
• Advocate for increase in female health care providers, including community health supervisors.

7.7.3 Promote strategies and activities to prevent harm from gender-based violence and harassment in health facilities.
• Support the code against sexual harassment in all public and private organizations providing health services.
• Advocate for a support system for female health workers in health facilities.
• Provide opportunities to raise the awareness, knowledge, and competencies of health providers, service program supervisors, and receptionists in GBV. This should include GBV prevention, response, and referrals, confidentiality and other ethical considerations, and gender-sensitive, respectful approaches to counseling.

7.7.4 Promote gender equity in the workforce.
• Increase gender parity in managerial positions, and provide opportunities for equal participation of female staff in the planning and design of projects.
• Set/maintain comparable average salaries for males and females in comparable positions, and enjoin health facilities to adopt similar supervision procedures for male and female staff of equal rank.
• Provide opportunities for increasing gender equity and rights in membership in and leadership of health workers’ organizations and health boards.

7.8: Gender-based Violence
Gender-based violence (GBV) is a significant problem in Afghanistan. The DHS reported that of the women aged 15-49 who were interviewed, 53% had experiences GBV at some time, and 46% in the previous 12 months. The pattern of behavior starts early in marriages. Of current 15-19-year-olds, 33% had experiences GBV, and 31% of women had experienced GBV before the birth of their first child. Sixteen percent of women had been beaten while pregnant. In 94% of cases, it was the current husband who was responsible, but another 8% of beatings were by parents or parents-in-law.

In urban settings, the situation is a bit better, only 43% experienced GBV compared to 56% in rural areas. Likewise, education provides some advantage; only 44% women with a primary school education experienced GBV compared to 56% for those with no education.
In addition to physical violence, sexual violence had been experienced by 7% of women, and by 6% in the previous 12 months. Emotional abuse was experienced by 37%. Injuries had been sustained by 26% of women. In cases of sexual violence, 60% of women experienced injuries.

Most women did not tell anyone. Only 41% either sought help or told someone. Fewer women told anyone about sexual violence. When they did seek help, it was usually from their family, sometimes the in-laws or occasionally a friend. Very rarely did anyone seek help from a religious leader, a doctor, the police or a social work organization.

GBV still, however, remains acceptable to most men and women in Afghanistan. Eighty percent of women and 72% of men believed that a husband was justified in beating his wife for one reason or another. The most important reason was going out without telling him. While the overall level of acceptance was less in urban areas (74%), there was little difference in attitudes depending on their age or the level of family wealth. Education level only made a difference if the woman had a post-secondary education (61%).

7.8.1 Strengthen the Health System Response to Gender-Based Violence
- Ensure availability of the MOPH Standard Operating Procedures for Healthcare Sector Response to Gender-based Violence (2013) in all health facilities and that staff are familiar with its contents.
- Support the development of provincial and district protocols for the provision of mental health support to GBV survivors with severe mental health consequences.

7.8.2 Prevention of Gender-Based Violence and the Provision of Social and Legal Support for the Survivors of Gender-Based Violence
- Promote the formation of provincial and/or district steering committees of relevant government departments, religious leaders and civil society organizations concerned with GBV;
- Promote the development of local protocols for the provision of social and legal help to GBV survivors.
- Prepare and disseminate IEC materials to increase awareness on gender-based violence as a human rights violation, the rights and legal protection available for GBV survivors, the negative health effects and consequences of GBV and Information on where and how survivors of gender-based violence can seek help. Make these available to shuras, CDCs, and FHAGs.
- Advocate increased availability of Family Protection Centres (referrals, counselling and treatment).

7.9: Nutrition
Prevention and treatment of malnutrition, support of healthy nutritional practices, and micronutrient supplementation are the primary responsibility of the Public Nutrition Department, which has developed a detailed strategy relevant to many aspects of RMNCAH. The RMNCAH Directorate will support the Nutrition Department in the following ways.
### 7.9.1 Support and promote exclusive breastfeeding.

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

The DHS reports that 91% of all newborns were breastfed within the first day, but that only 41% began breastfeeding within the first hour. Of babies born in health facilities, still only 43% were breastfed within the first hour. Prelacteal feeds were also the regular practice in 39% of facility births and 48% of home deliveries.

The median duration of breastfeeding is 20 months. The median length of exclusive breastfeeding is 1.5 months and of predominant breastfeeding, 3 months. Only 33% of children aged 4–5 months are still exclusively breastfeeding. This pattern varies little between urban and rural areas, and between different levels of education or family wealth.

- Ensure that providers who attend deliveries in facilities or in the community are trained in breastfeeding support.

### 7.9.2 Support the promotion of micronutrient supplementation.

The coverage of vitamin A supplementation to children 6–59 months is 46%. Iron supplementation for the recommended 90 days or more is taken by only 7% of pregnant women. Another 26% take iron tablets for up to 60 days, but 55% take no iron supplements at all. Iodized salt was found in 57% of household samples tested (urban 82% and rural 48%).

- In collaboration with implementing partners, promote the provision of vitamin A capsules to young children.
- In collaboration with implementing partners, support the availability of required micronutrient supplements to women during and following pregnancy.
- Support the distribution of micronutrients to girls in grades 9-12 at school.
- Develop and disseminate nutrition education messages regarding micronutrient intake and utilization during pregnancy and after delivery.

### 7.9.3 Support the Nutrition Department in its advocacy role.

- Advocate for maternity legislation allowing working women to breastfeed. Legislation should be aimed at compliance with the International Labor Organization’s recommendation for 14 weeks of maternity leave, with income replacement of salary and accommodations for breastfeeding.
- Advocate for the establishment of breastfeeding rooms in institutions to ensure that employed mothers can breastfeed their children. The RMNCAH Directorate will set an example by providing breastfeeding rooms in the buildings under its control.

### 7.10: Mental Health for Pregnant and Postpartum Women and Survivors of Gender-Based Violence

The Mental Health Department of the MoPH assumes overall regulatory, technical, and coordination oversight of Afghanistan’s mental health and psychosocial support services. The RMNCAH Strategy aims to prevent and manage the common mental and psychosocial problems associated with pregnancy and GBV by integrating cost-effective interventions into
existing services. This will be achieved in close collaboration with the Mental Health and Gender Departments through the following strategic directions.

7.10.1 Develop and promote a program for maternal mental health.
- Include maternal mental health screening and psychosocial support in the pre- and in-service training curricula of health workers (obstetricians, midwives, and community midwives).
- Ensure development of guidelines, standards, protocols, and job aids in maternal mental health screening and psychosocial support for service providers in clinical and community-based settings.
- Train health workers in provision of maternal mental health screening and psychosocial support, including the framework for supportive supervision.

7.10.2 Develop and promote a program for mental health support of survivors of gender-based violence.
- Integrate mental health screening and psychosocial support into the GBV Treatment Protocol for Healthcare Providers in Afghanistan.
- Ensure the development of effective district and provincial plans for the coordination of mental health resources to be available to assist survivors of GBV and their families.
IMPLEMENTATION FACTORS

Institutional Approach

Institutional development is a process aimed at strengthening an organization’s capacity to provide quality and effective services, and at the same time to be viable as an institution. In this regard, capacity building is an essential aspect, of which there are two major dimensions. The first is the underlying organizational and management capacity that an organization needs to function. This includes a clear direction and plans for carrying it out, clearly defined roles and responsibilities, effective leadership and management, effective teams, accountability, and the capacity to engage stakeholders. The second is strengthening the institutional capacity to make effective use of technical interventions, such as health accounts, costing exercises, internal controls, and human resources management. Adequately and effectively addressing these institutional dimensions will contribute greatly to the overall sustainability of the health system.

Institutional development encompasses the following areas: leadership in health, health management, systems strengthening, health financing and revenue generation, coordination, health planning, health standards, the private sector and public-private partnership, and the provincial level and decentralization. Its main objective is to strengthen and expand the health system by building a sustainable institutional and financial base in the public and private sectors, thus ensuring the availability of quality health care to the entire population.

There are issues and challenges with respect to multilevel stakeholders’ dialogue and coordination. The MoPH coordination with other line ministries is limited. Reports from the RMNCAH Subcommittee and Provincial Public Health Coordination Committees’ meetings are not disseminated widely, and decisions made at other high-level coordination meetings (e.g., call to action, health retreat, result conference) are not followed up and implemented properly.

Although many issues, gaps, and challenges exist, as well as some underlying barriers to institutional development, there are many strengths and opportunities that can be further built upon. The most important strength and opportunity is the strong visible commitment of the MoPH leadership to prioritize, advocate, and support institutional development and its associated strategies and interventions. In addition, all key stakeholders, particularly the key departments and partners, provide strong overall support to RMNCAH at the national and subnational levels.

Institutional Framework

As the steward of RMNCAH services in the country, the RMNCAH Directorate sets policy, strategy, and standards, develops clinical protocols and guidelines, monitors the quality of services and the capacity of implementing partners, and coordinates with other concerned stakeholders. The RMNCAH Directorate has primary responsibility for the RMNCAH components of the RMNCAH Strategy. In other areas, it coordinates and communicates with various parts of the MoPH, such as the Gender, Nutrition, Curative Medicine, GCMU (BPHS/EPHS), HMIS, and the Health Economics and Financing Directorate (HEFD). It also collaborates with other ministries, such as the Ministry of Religious Affairs, Ministry of Culture, and Ministry of Women’s Affairs, and with organizations such as the National Solidarity Programme. Thus, successful implementation of the strategy will depend on close collaboration with different directorates and departments in the MoPH and the cooperation
and support of other ministries and government agencies. Success will likewise require partnerships with civil society and nongovernmental institutions, media, professional organizations, religious leaders, community-based organizations, and the private sector.

**District and Community Levels**

Increasing the impact of community-level interventions will be a major emphasis during implementation of this strategy. This includes promoting the sustainability of the health *shuras* at the facility and community levels and the FHAGs. It means advocating for an increased number of CHWs, particularly female CHWs, and ensuring that they are adequately supported, motivated, and supervised. Close relations and coordination with NGO implementing partners will be key factors in this regard. In addition, it will be essential to advocate for increases in qualified female staff and the capacity building of SHCs, BHCs, CHCs, and district hospitals.

**Provincial Level**

RH and CAH officers in each province are responsible for the implementation of the strategy at the provincial level, communicating it to the staff at peripheral levels, and providing support there as necessary. Provincial technical officers have provided significant input into the development of this strategy, and their views on its implementation have been solicited. RH/CAH officers will, in turn, receive support and reinforcement from the national level.

An RMNCAH Monthly Coordination Subcommittee and PPHCCs have been established within each province to coordinate the activities of implementing partners to achieve MoPH priorities at the provincial level. In any given province, multiple partners participate in implementing health programs. Under the direction of the Provincial Public Health Director, the PPHCCs will play a critical role in ensuring effective implementation of RMNCAH programs throughout the province. The RMNCAH Scorecard is a key program monitoring tool to be used at provincial level.

**National Level**

The success of this strategy starts with strong and consistent leadership from the central MoPH. The RMNCAH Directorate will not only oversee its own part of the implementation but will also advocate, coordinate, collaborate, and negotiate with the other Directorates to accomplish the strategies and tasks that are not under its direct responsibility. However, the Directorate’s capacity to effectively plan, coordinate, and communicate the national RMNCAH program is severely restricted because of a lack of human and financial resources. The RMNCAH Directorate will actively solicit support in this area from both governmental and nongovernmental sources.

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

**Coordination**

*Partnerships and Technical Coordination within the MoPH*
The MoPH, as steward of the health sector, sets policies and standards, develops guidelines, and coordinates actions with all MoPH departments as well as with all partners, implementing NGOs, and donor agencies. In line with national policies, the MoPH has established the Management Technical Advisory Group. This group is the key high-level group within the MoPH to coordinate the actions of the various parts of the Ministry regarding RMNCAH. Any new technical or policy recommendations drafted at the RMNCAH Directorate are forwarded to the MoPH Management Technical Advisory Group for review before being forwarded to the Executive Board for approval.

Poor coordination with partners at different times was highlighted at several meetings and by missions from the provinces. For this reason, the RMNCAH Directorate has decided to have an RMNCAH Coordination Committee to further strengthen all vertical projects relevant to RMNCAH. It will review and discuss updated reports and information with partners from relevant MoPH departments and implementing NGOs. In addition to the monthly RMNCAH coordination meetings at the central level, there are RMNCAH Coordination Subcommittee meetings at provincial level. Their objective is to provide recommendations on policy, intervention strategies, implementation guidelines, and program monitoring.

The MoPH has also established the RMNCAH Steering Committee, chaired by H.E. the Minister. This will improve the coordination of RMNCAH-relevant projects within the ministry, with UN agencies, and with national and international organizations. It will mainstream all resources and harmonize activities for better results and outcomes at the central and provincial levels.

The strategy calls for the RMNCAH Directorate to have partnerships with many other directorates and departments of the MoPH. These include the Evaluation & Health Information System, GCMU, HSS, Health Promotion, NCD, Mental Health, Private Sector, Nursing and Midwifery, Nutrition, EPI, HIV/AIDS, Malaria, ANPHI/research, Human Resources, CBHC, M&E, and HEFD directorates and departments. Where partnerships are needed that go beyond RMNCAH membership, specific technical working groups will be created.

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

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

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

- Ministry of Agriculture, Irrigation and Livestock (nutritional status of women, infants)
- Ministry of Commerce and Industry (breast milk substitutes, food safety)
- Ministry of Justice (breast milk substitutes, maternity leave laws)
- Ministry of Rural Rehabilitation and Development (services in rural areas)
- Ministry of Haj and Awqaf (support of religious leaders)
- Ministry of Culture and Information (IEC/BCC messages)
**Other Partners**
The RMNCAH Directorate collaborates with numerous partners apart from governmental agencies to realize the goals of the RMNCAH strategy. Some of these are listed below.

**International and bilateral agencies**
The RMNCAH Directorate collaborates closely with USAID, Department of Foreign Affairs, Trade and Development of Canada, and Japan International Cooperation Agency, as well as several United Nations agencies, such as the UNFPA, UNICEF, and WHO, and with partner programs and international organizations, such as AFGA, AKDN, ASMO, Care, the Italian NGO EMERGENCY, HEMAYAT, MSF, MSI, and Save the Children.

**NGOs**
In its role as steward of RMNCAH services in Afghanistan, the RMNCAH Directorate guides NGOs that implement the RMNCAH Strategy. Numerous NGO partners operate the BPHS and EPHS throughout the country. Since women’s, children’s, and adolescent health are major parts of BPHS and EPHS services, working with the NGOs that support them is essential to the strategy’s success. Recognizing these NGOs as key collaborators, the RMNCAH Directorate has invited many of them to participate in the process of strategy development.

**Associations of health professionals**
Health professional associations, especially AFSOG, AMA, ANPHA, and APA, play an important role in carrying out the RMNCAH Strategy. These associations have all participated in the development of the strategy and will support its implementation. In addition, they will continue to contribute by:

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

**Private Sector**
The private sector’s role in RMNCAH must be entirely in line with all components of this strategy (see section 7.6). Health services are increasingly being offered by private practitioners. Collaboration with this group will be essential to ensuring that minimum national standards of care are maintained. In addition, the private commercial sector needs to be especially involved in the provision of pharmaceuticals and FP methods.

**Reporting and Feedback Mechanisms: Roles and Responsibilities**
Data often refers to raw numerical data (numbers of functioning health facilities) and information usually refers to processed data which is presented in some sort of context. An evidence-based decision uses information when a decision is to be made or a question needs to be answered rather than relying upon intuition or political influences. This section describes the steps involved in data collection, analysis, interpretation, communication planning, decision-making, monitoring, evaluation, and supervision and reporting.
The purpose of this section is to assist all health services providers to better understand and to develop skills to be able to use data effectively. The steps involved include: interpret and analyze data, results and information; identify good and bad trends; and make decisions about how best to implement actions to maintain or improve health outcomes. Good data are used by health service providers to measure progress against specific objectives or indicators. Sound, accurate, and reliable data and information underpin monitoring, evaluation, and supervision practices.

Information will flow up and down from three levels, as Figure 7 shows:

1. Central level (RMNCAH Directorate, M&E & GCMU, HMIS)
2. Provincial level (Provincial Reproductive and Child Health officers, HMIS and BPHS/EPHS implementing partners)
3. Health facility level

Figure 7: Information flow

Central Level

- A well-organized feedback and response system from central to provincial level will be established in the RMNCAH Directorate.
- A summary of overall RMNCAH indicators and other important relevant information will be analyzed by province and nationally and presented to the RMNCAH and HMIS taskforces. It will be issued as a newsletter on a quarterly basis. It will be sent
to all provinces to be shared with PPHCCs as well as the RMNCAH and HMIS subcommittees for further dissemination and appropriate follow-up.

- The provincial RMNCAH indicators and monitoring mission reports are analyzed at the central level to monitor the trends of performance against the targets set at the health facility level, and then shared with BPHS/EPHS implementing partners to take action and fill the gaps.
- Joint monitoring missions will be coordinated with GCMU, M&E, HMIS, PHO, and other relevant partners as well as BPHS/EPHS implementing partners.
- Regional review, planning, and reporting workshops will be conducted regularly to monitor program implementation. This will also contribute in strengthening the analytical and managerial skills of Provincial RMNCAH Officers.
- Every year a summary report detailing both routine RMNCAH indicators and survey information (if any) will be produced by the central MoPH HMIS and RMNCAH Directorates. At least one improvement cycle will be completed each year.

**Provincial Level**

- Each month HMIS data will be analyzed by the provincial team to identify unusual trends, and these reports will be discussed and presented in the PPHCC and HMIS & RMNCAH subcommittee meetings with contributions and technical support from BPHS/EPHS implementing partners.
- Monthly feedback will be provided to health facilities on the quality of their reports, identifying any discrepancies in the reported data, asking them to examine the root causes of any unusual trends, and to develop and implement remedial actions through an improvement cycle. This should be verified by PPHOs, and HMIS, RH, and CAH Officers, with the technical support of the BPHS/EPHS implementing partners.
- A PPHO M&E committee will be established, and an annual joint supervision and monitoring plan will be developed. Feedback will be provided to facilities and practical action plans made based on the feedback. Copies of reports will be shared with the central level.
- A catchment area map and key RMNCAH indicators will be displayed at each health facility. The map will highlight area demographic data and will locate specific at-risk populations and those service coverage areas requiring extra attention. This map will be updated annually at a provincial planning meeting for all health facility in-charges.
- The annual provincial planning meeting will be coordinated by the Provincial Public Health Director and the BPHS/EPHS implementing partners. The HMIS and RMNCAH Officers from the PPHOs and the implementing partners will assist by providing appropriate health information. This event should include analysis of data, interpretation of trends, prioritization of activities, and setting of targets for the following year. National-level indicators, as well as indicators, specific for each province, will be monitored and discussed at this level.

**Health Facility Level**

- Monthly feedback will be provided to the staff of each health facility on the quality of their reports and any discrepancies in the reported data. These should be verified by the head of the health facility with technical support from the BPHS/EPHS implementing partner supervisors.
- Each month HMIS data will be analyzed by the health facility staff to identify any unusual trends, examine the root causes, and develop and implement remedial actions. They will be assisted by their technical supervisors as necessary.
They will regularly review the monitoring missions’ reports and other information provided to them by the central and provincial teams, and ensure that appropriate action has been taken and its effects assessed.

Annual plans will be prepared. These will set out targets, an action plan of interventions including community interventions, how the interventions will be supervised, and how the targets will be monitored.
  - Gather the information and ensure that the information is accurate.
  - List the villages in the catchment area and estimate the catchment population.
  - Prepare a situational analysis.
  - Identify and prioritize problems and interventions.
  - Plan and implement activities to improve poor health with prioritized interventions.
  - Calculate target groups.
  - Set targets.
  - Monitor targets.
  - Communicate results.

**Internal MoPH Processes**
To ensure that data will be used for better planning and decision-making, the RMNCAH Directorate will collaborate closely with the HMIS and M&E departments to ensure adequate monitoring and evaluation of the RMNCAH Strategy. The specific mechanisms for data collection, use and documentation will be detailed in the implementation plan.

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

**Operational Research in Support of RMNCAH Strategies**
When an important question related to the strategy arises for which monitoring and surveys do not provide the answer, operational research may be employed. A study would be designed and carried out to find the answer, which would then be fed back to the appropriate levels of the health system as part of the routine feedback procedure.

Research priorities will be based on program needs, major health challenges, institutional capacities, and available resources. An important role for the RMNCAH Directorate is to advocate with partners and donors for research funds.
MONITORING THE STRATEGY’S PROGRESS

The MoPH has an obligation to monitor and evaluate its programs and their impact as part of its stewardship role and responsibilities for oversight of the Afghan health system. This requires collection of good-quality data for undertaking regular analysis, interpretation, and feedback, as part of the management of the health system. The MoPH has created its HMIS for this purpose. To assess the Ministry’s progress in achieving the strategies identified in this document requires that indicators be identified to measure progress and impact of the various RMNCAH interventions specified in this strategy. The indicators in Table 5 are identified for measuring progress in achieving the National RMNCAH Strategy 2017–2021.
<table>
<thead>
<tr>
<th>Key Output</th>
<th>Indicator Name</th>
<th>Unit of Measure</th>
<th>Base-line from Previous Year’s Study</th>
<th>Base-line 2016</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
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<td>Strategic Area 1: Maternal Health</td>
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<tr>
<td>1.1</td>
<td>Maternal mortality ratio (annual number of maternal deaths per 100,000 live births)</td>
<td>#</td>
<td>695</td>
<td>695</td>
<td>656</td>
<td>617</td>
<td>578</td>
<td>539</td>
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<tr>
<td>1.2</td>
<td>Percent of BHCs and SHCs with a midwife</td>
<td>%</td>
<td>90</td>
<td>90.7</td>
<td>91.3</td>
<td>92</td>
<td>93.5</td>
<td>95</td>
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<tr>
<td>1.3</td>
<td>Rate of midwives per 10,000 population</td>
<td>#</td>
<td>0.86</td>
<td>0.91</td>
<td>0.96</td>
<td>1.02</td>
<td>1.07</td>
<td>1.12</td>
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<tr>
<td>1.4</td>
<td>Percentage of facilities with functional BEmONC</td>
<td>%</td>
<td>76</td>
<td>80</td>
<td>84</td>
<td>88</td>
<td>92</td>
<td>96</td>
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<td>1.5</td>
<td>Percentage of facilities with functional CEmONC</td>
<td>%</td>
<td>77</td>
<td>81</td>
<td>85</td>
<td>89</td>
<td>93</td>
<td>97</td>
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<tr>
<td>1.6</td>
<td>Percentage of institutional deliveries</td>
<td>%</td>
<td>48</td>
<td>51</td>
<td>54.1</td>
<td>57.1</td>
<td>60.1</td>
<td>63.1</td>
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<tr>
<td>1.7</td>
<td>Skilled birth attendance (SBA)</td>
<td>%</td>
<td>51</td>
<td>53.5</td>
<td>56.5</td>
<td>68.5</td>
<td>Every five years / Quarterly</td>
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<td></td>
<td></td>
<td></td>
<td>51</td>
<td>53.5</td>
<td>56.5</td>
<td>DHS / HMIS</td>
<td>Number of deliveries assisted by SBA in period of time * 100/estimated number of deliveries in same period</td>
<td></td>
</tr>
<tr>
<td>1.8</td>
<td>Caesarean section deliveries as a percentage of all deliveries</td>
<td>%</td>
<td>3.5</td>
<td>3.5</td>
<td>4.1</td>
<td>5.9</td>
<td>Quarterly</td>
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<tr>
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<td></td>
<td></td>
<td>3.5</td>
<td>4.1</td>
<td>4.7</td>
<td>HMIS</td>
<td>Total number of C-section in a specific period of time * 100/estimated number of deliveries in same period based on area population</td>
<td></td>
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<tr>
<td>1.9</td>
<td>Percentage of women who attended ANC provided by an SBA at least once during pregnancy</td>
<td>%</td>
<td>55</td>
<td>55</td>
<td>57</td>
<td>63</td>
<td>Every five years/ Quarterly</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>55</td>
<td>55</td>
<td>57</td>
<td>DHS / HMIS</td>
<td>Number of women attended at least 1 ANC visit, related to pregnancy to an SBA, during pregnancy in a specified period of time * 100/estimated number of pregnancies during the same time period</td>
<td></td>
</tr>
<tr>
<td>1.10</td>
<td>Percentage of women who attended ANC provided by a SBA at least 4 times during pregnancy</td>
<td>%</td>
<td>18</td>
<td>18</td>
<td>20</td>
<td>35</td>
<td>Every five years / Quarterly</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>18</td>
<td>18</td>
<td>20</td>
<td>DHS / HMIS</td>
<td>Number of women attended at least 4 ANC visits, related to pregnancy to an SBA, during pregnancy in a specified period of time * 100/estimated number of pregnancies during the same time period</td>
<td></td>
</tr>
<tr>
<td>1.11</td>
<td>Proportion of women who have postpartum contact with a health provider after delivery</td>
<td>%</td>
<td>40</td>
<td>40</td>
<td>44</td>
<td>60</td>
<td>Quarterly</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>40</td>
<td>40</td>
<td>44</td>
<td>DHS / HMIS</td>
<td>Number of women who attended at least 1 PNC visits in a specified period of time * 100/estimated number of deliveries during the same period of time</td>
<td></td>
</tr>
<tr>
<td>1.12</td>
<td>Proportion of provinces having functional maternal and neonatal death review committees</td>
<td>%</td>
<td>18</td>
<td>34</td>
<td>51</td>
<td>100</td>
<td>Annual</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>18</td>
<td>34</td>
<td>51</td>
<td>MNDSR/ reports</td>
<td>Number of provinces having functional maternal and neonatal death review committees * 100/total number of provinces</td>
<td></td>
</tr>
<tr>
<td>Key Output</td>
<td>Indicator Name</td>
<td>Unit of Measure from Previous Year's Study</td>
<td>Base-line 2016</td>
<td>Targets YR1</td>
<td>YR2</td>
<td>YR3</td>
<td>YR4</td>
<td>End Target</td>
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<tr>
<td>1.13</td>
<td>Proportion of pregnant women receiving antenatal home visits by CHW</td>
<td>%</td>
<td>60</td>
<td>64</td>
<td>68</td>
<td>72</td>
<td>76</td>
<td>60</td>
</tr>
<tr>
<td>1.14</td>
<td>Percent pregnant women referred for tetanus toxoid vaccination</td>
<td>%</td>
<td>13.6</td>
<td>15.9</td>
<td>18.2</td>
<td>20.4</td>
<td>22.7</td>
<td>25</td>
</tr>
<tr>
<td>1.15</td>
<td>Percent pregnant women referred for normal delivery</td>
<td>%</td>
<td>30.2</td>
<td>34.2</td>
<td>38.1</td>
<td>42.1</td>
<td>46.0</td>
<td>50.0</td>
</tr>
<tr>
<td>1.16</td>
<td>Percent pregnant women referred for obstetric complication</td>
<td>%</td>
<td>5.2</td>
<td>7.2</td>
<td>9.1</td>
<td>11.1</td>
<td>13.0</td>
<td>15.0</td>
</tr>
<tr>
<td>1.17</td>
<td>Percent of postpartum women receiving home visit for postnatal and newborn care</td>
<td>%</td>
<td>36</td>
<td>40</td>
<td>44</td>
<td>48</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>1.18</td>
<td>Percent health posts with an active FHAG</td>
<td>%</td>
<td>41</td>
<td>47</td>
<td>53</td>
<td>58</td>
<td>64</td>
<td>70</td>
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</table>
### Strategic Area 2: Newborn Health

#### 2.1 Neonatal mortality rate (annual number of newborn deaths per 1,000 live births)

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline from Previous Year’s Study</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>22 12</td>
<td>36</td>
<td>34.2</td>
<td>Every five years</td>
<td>DHS All neonatal deaths occurred up to 28 days after delivery in a specified period * 1,000/all live births in the same period of time</td>
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<tr>
<td></td>
<td></td>
<td>32.4</td>
<td>30.6</td>
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<td></td>
<td></td>
<td>28.8</td>
<td>27</td>
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</tbody>
</table>

#### 2.2 Proportion of newborns breastfed within one hour after birth

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline from Previous Year’s Study</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>41</td>
<td>48.8</td>
<td>Every five years</td>
<td>DHS Number of newborn breastfed within one hour after birth * 100/total number of births</td>
</tr>
<tr>
<td></td>
<td></td>
<td>56.6</td>
<td>64.4</td>
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<td></td>
<td></td>
<td>72.2</td>
<td>80</td>
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</table>

#### 2.3 Proportion of newborns who have postnatal contact with a health provider after delivery

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<tr>
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<th>Baseline from Previous Year’s Study</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>12</td>
<td>Quarterly</td>
<td>DHS Number of newborns attended at least 1 NBC visits in a specified period of time * 100/estimated number of deliveries during the same period of time</td>
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<td>15</td>
<td>18</td>
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<td>21</td>
<td>25</td>
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### Strategic Area 3: Birth Spacing and Family Planning

#### 3.1 Modern contraceptive prevalence rate

<table>
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<th>Year</th>
<th>Baseline from Previous Year’s Study</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>20</td>
<td>20</td>
<td>Every five years</td>
<td>DHS Modern contraceptive prevalence rate of all women of reproductive age who are using (or whose partner is using) a modern method of contraception at a point in time</td>
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<td>22</td>
<td>24</td>
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<td>26</td>
<td>28</td>
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<td></td>
<td>30%</td>
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<th>Key Output</th>
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<th>Targets YR1</th>
<th>Targets YR2</th>
<th>Targets YR3</th>
<th>Targets YR4</th>
<th>End Target</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
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<tbody>
<tr>
<td>3.2</td>
<td>Percent of women with an unmet need for contraception</td>
<td>%</td>
<td>25</td>
<td>23.3</td>
<td>21.7</td>
<td>20</td>
<td>18.3</td>
<td>16.7</td>
<td>15</td>
<td>Every five years</td>
<td>DHS</td>
<td>Proportion of women who (1) are not pregnant and not postpartum amenorrheic and are considered fecund and want to postpone their next birth for 2 or more years or stop childbearing altogether but are not using a contraceptive method, or (2) have a mistimed or unwanted current pregnancy, or (3) are postpartum amenorrheic and their most recent birth in the last 2 years was mistimed or unwanted.</td>
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<tr>
<td>3.3</td>
<td>Couple years of protection (x 1,000) – health facilities</td>
<td>#</td>
<td>520</td>
<td>520</td>
<td>572</td>
<td>624</td>
<td>676</td>
<td>728</td>
<td>780</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Estimated protection based on numbers of different methods distributed in the time period</td>
</tr>
<tr>
<td>3.4</td>
<td>Couple years of protection (x 1,000) – health posts</td>
<td>#</td>
<td>163</td>
<td>163</td>
<td>179</td>
<td>195</td>
<td>212</td>
<td>228</td>
<td>244</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Estimated protection based on numbers of different methods distributed in the time period</td>
</tr>
<tr>
<td>3.5</td>
<td>Couple years of protection (x 1,000) – all public health providers</td>
<td>#</td>
<td>683</td>
<td>683</td>
<td>751</td>
<td>819</td>
<td>887</td>
<td>955</td>
<td>1,023</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Estimated protection based on numbers of different methods distributed in the time period.</td>
</tr>
<tr>
<td>3.6</td>
<td>Percent primary care facilities providing pills, condoms &amp; injectables</td>
<td>%</td>
<td>84</td>
<td>86</td>
<td>88</td>
<td>91</td>
<td>93</td>
<td>95</td>
<td></td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Number of primary facilities providing all three methods in time period * 100/total primary facilities</td>
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<tr>
<td>3.7</td>
<td>Percent primary care facilities providing IUDs and/or implants</td>
<td>%</td>
<td>83</td>
<td>85</td>
<td>88</td>
<td>90</td>
<td>93</td>
<td>95</td>
<td></td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Number of primary facilities providing IUDs and/or implants in time period * 100/total primary facilities</td>
</tr>
<tr>
<td>Key Output</td>
<td>Indicator Name</td>
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<tr>
<td>3.8</td>
<td>Percent secondary &amp; tertiary facilities providing IUDs and/or implants</td>
<td>%</td>
<td>92</td>
<td>93 95 97 98 100</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Number of secondary &amp; tertiary facilities providing IUDs and/or implants in time period * 100/total secondary &amp; tertiary facilities</td>
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<tr>
<td>3.9</td>
<td>Percent of female doctors and midwives trained in implant insertion and removal</td>
<td>%</td>
<td>3</td>
<td>9 15 30 45 60</td>
<td>Annually</td>
<td>Training database</td>
<td>Number of female doctors and midwives trained on implants * 100/total number of female doctors and midwives</td>
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</tr>
<tr>
<td>3.10</td>
<td>Percent of female doctors and midwives trained in postpartum IUD insertion and removal</td>
<td>%</td>
<td>8</td>
<td>15 20 37 53 70</td>
<td>Annually</td>
<td>Training database</td>
<td>Number of female doctors and midwives trained on postpartum IUDs * 100/total number of female doctors and midwives</td>
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<td></td>
</tr>
<tr>
<td>3.11</td>
<td>Percentage of RH commodities availability</td>
<td>%</td>
<td>85%</td>
<td>87% 89% 91% 93% 95%</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Number of applicable RMNCH commodities available with unexpired quantities based on HF type * 100/number of applicable commodities</td>
<td></td>
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</tr>
<tr>
<td>3.12</td>
<td>Average percentage of time out of stock</td>
<td>%</td>
<td>10%</td>
<td>8% 7% 5% 4% 2%</td>
<td>Quarterly</td>
<td>HMIS</td>
<td>Days out of stock within observed period of time for each commodity * 100/total number of applicable commodities * total number of days for stock-out</td>
<td></td>
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</tbody>
</table>

**Strategic Area 4: Child Health**

<table>
<thead>
<tr>
<th>Key Output</th>
<th>Indicator Name</th>
<th>Unit of Measure</th>
<th>Base-line from Previous Year’s Study</th>
<th>Targets</th>
<th>Frequency/Responsibility</th>
<th>Data Source</th>
<th>Indicator Definition/Calculation Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Post-neonatal mortality rate (deaths per 1,000 live births)</td>
<td>#</td>
<td>23</td>
<td>23 21.6 20.2 18.8 17.4 16</td>
<td>Every five years CAH</td>
<td>DHS</td>
<td>Number of deaths among children 1-11 months of age * 1,000/number of live births</td>
</tr>
<tr>
<td>Key Output</td>
<td>Indicator Name</td>
<td>Unit of Measure</td>
<td>Base-line from Previous Year’s Study</td>
<td>Targets</td>
<td>Frequency/Responsibility</td>
<td>Data Source</td>
<td>Indicator Definition/Calculation Methodology</td>
</tr>
<tr>
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</tr>
<tr>
<td>4.2</td>
<td>Child mortality rate (deaths per 1,000 live births)</td>
<td></td>
<td></td>
<td>YR1 17</td>
<td>CAH, BPHS, and EPHS</td>
<td>DHS</td>
<td>Number of deaths among children 1-4 years of age * 1,000/number of live births</td>
</tr>
<tr>
<td>4.3</td>
<td>Number of cases of diarrhea treated at health facilities (x 1,000)</td>
<td></td>
<td></td>
<td>YR1 5,604</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of diarrhea treated at health facilities</td>
</tr>
<tr>
<td>4.4</td>
<td>Number of cases of diarrhea treated at health posts (x 1,000)</td>
<td></td>
<td></td>
<td>YR1 1,835</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of diarrhea treated at health posts</td>
</tr>
<tr>
<td>4.5</td>
<td>Percent of total cases of diarrhea treated at health posts</td>
<td></td>
<td></td>
<td>YR1 25</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of diarrhea treated at health posts * 100/total cases of diarrhea treated at health facilities and health posts</td>
</tr>
<tr>
<td>4.6</td>
<td>Number of cases of ARI treated at health facilities (x 1,000)</td>
<td></td>
<td></td>
<td>YR1 15,235</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of ARI treated at health facilities</td>
</tr>
<tr>
<td>4.7</td>
<td>Number of cases of ARI treated at health posts (x 1,000)</td>
<td></td>
<td></td>
<td>YR1 3,001</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of ARI treated at health posts</td>
</tr>
<tr>
<td>4.8</td>
<td>Percent of total cases of ARI treated at health posts.</td>
<td></td>
<td></td>
<td>YR1 17</td>
<td>Quarterly HMIS</td>
<td></td>
<td>Number of cases of ARI treated at health posts * 100 / total cases of ARI treated at health facilities and health posts</td>
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<tr>
<td>4.9</td>
<td>Percent of children with diarrhea taken to a health care provider</td>
<td></td>
<td></td>
<td>YR1 54</td>
<td>Every five years DHS</td>
<td></td>
<td>Number of children with diarrhea taken to health care providers * 100/total children with diarrhea</td>
</tr>
<tr>
<td>Key Output</td>
<td>Indicator Name</td>
<td>Base-line from Previous Year’s Study</td>
<td>Targets YR1</td>
<td>YR2</td>
<td>YR3</td>
<td>YR4</td>
<td>End Target</td>
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<tr>
<td>------------</td>
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<td>-----</td>
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</tr>
<tr>
<td>4.10</td>
<td>Percent of cases of diarrhea treated with ORS or recommended home fluids</td>
<td>%</td>
<td>60</td>
<td>64.2</td>
<td>68.3</td>
<td>72.5</td>
<td>76.7</td>
</tr>
<tr>
<td>4.11</td>
<td>Percent of cases of diarrhea treated with zinc</td>
<td>%</td>
<td>12</td>
<td>20</td>
<td>28</td>
<td>36</td>
<td>44</td>
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<tr>
<td>4.12</td>
<td>Percent of children with ARI taken to a health care provider</td>
<td>%</td>
<td>62</td>
<td>65</td>
<td>68</td>
<td>71</td>
<td>74</td>
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<tr>
<td>4.13</td>
<td>Percent of children with ARI treated with an antibiotic</td>
<td>%</td>
<td>54</td>
<td>49.2</td>
<td>44.3</td>
<td>39.5</td>
<td>34.7</td>
</tr>
<tr>
<td>4.14</td>
<td>% of children &lt;6 months who are breastfed exclusively</td>
<td>%</td>
<td>43</td>
<td>45</td>
<td>45</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>4.15</td>
<td>Proportion of children 6–23 months who received timely complementary foods</td>
<td>%</td>
<td>56</td>
<td>61</td>
<td>66</td>
<td>71</td>
<td>76</td>
</tr>
<tr>
<td>4.16</td>
<td>Proportion of HF with at least 60% of workers trained in IMNCI</td>
<td>%</td>
<td>80</td>
<td>82</td>
<td>84</td>
<td>86</td>
<td>88</td>
</tr>
<tr>
<td>Key Output</td>
<td>Indicator Name</td>
<td>Unit of Measure</td>
<td>Baseline from Previous Year's Study</td>
<td>Targets</td>
<td>Frequency/Responsibility</td>
<td>Data Source</td>
<td>Indicator Definition/Calculation Methodology</td>
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<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Base-line 2016</td>
<td>YR1 YR2 YR3 YR4 End Target</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Base-line from Previous Year's Study</td>
<td>17 18 19 20 21</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Strategic Area 5: Adolescent Health</td>
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<td></td>
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<tr>
<td>5.1</td>
<td>Adolescent pregnancy rate</td>
<td>%</td>
<td>12 11.3 10.7 10 9.3 8.7 8</td>
<td>Every five years</td>
<td>CAH</td>
<td>DHS</td>
<td>Number of married women age 15-19 who have had a live birth or who are pregnant with their first child * 100/total number of married women 15-19 years of age</td>
</tr>
<tr>
<td>5.2</td>
<td>% of adolescent girls who are anemic</td>
<td>%</td>
<td>29.9 27.9 25.9 23.9 21.9 19.9 17.9</td>
<td>CAH, PND</td>
<td>NNS</td>
<td>Number of anemic adolescent girls * 100/total number of adolescent girls</td>
<td></td>
</tr>
<tr>
<td>Strategic Area 6: Reproductive Morbidity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Number of clinically confirmed fistula cases treated</td>
<td>%</td>
<td>90 100 120 150 180 200</td>
<td>Fistula centers' reports</td>
<td></td>
<td></td>
<td>Number of annual clinically confirmed cases treated in fistula centers</td>
</tr>
</tbody>
</table>
Table 6. Additional RMNCAH indicators that will be used based on availability of data

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Name</th>
<th>Indicator Definition/Calculation Methodology</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percentage of pregnant women with pre-eclampsia or eclampsia treated appropriately</td>
<td>Number of pregnant women with pre-eclampsia or eclampsia treated * 100/number of women diagnosed with pre-eclampsia/eclampsia</td>
<td>Survey</td>
</tr>
<tr>
<td>2</td>
<td>Stillbirth rate</td>
<td>Number of stillbirth deaths occurred * 1,000/total number of deliveries</td>
<td>HMIS, Survey</td>
</tr>
<tr>
<td>3</td>
<td>Low-birth-weight rate</td>
<td>Number of live born babies who weigh &lt;2,500 grams in a period of time * 100/total number of live births in the same period</td>
<td>HMIS, Survey</td>
</tr>
<tr>
<td>4</td>
<td>Premature birth rate</td>
<td>Number of premature births * 1,000/total number of births</td>
<td>Survey</td>
</tr>
<tr>
<td>5</td>
<td>Maternal death rate per 100,000 population of women of reproductive age</td>
<td>Number of maternal deaths in community * 100,000/estimated number of women of reproductive age in that population</td>
<td>HMIS</td>
</tr>
<tr>
<td>6</td>
<td>Newborn death rate per 1,000 live births</td>
<td>Number of newborn deaths from community * 1,000/estimated number of live births in the community</td>
<td>HMIS</td>
</tr>
<tr>
<td>7</td>
<td>Percent pregnant women receiving misoprostol for home delivery</td>
<td>Number of pregnant women receiving misoprostol * 100/estimated number of births in the community</td>
<td>HMIS</td>
</tr>
<tr>
<td>8</td>
<td>Couple years of protection (x 1,000) – private facilities with MOUs</td>
<td>Estimated protection based on numbers of different methods distributed in the time period</td>
<td>HMIS</td>
</tr>
<tr>
<td>9</td>
<td>Couple years of protection (x 1,000) – ASMO</td>
<td>Estimated protection based on numbers of different methods distributed in the time period.</td>
<td>ASMO Annual Report</td>
</tr>
<tr>
<td>10</td>
<td>Proportion of children &lt;5 who die within 24 hours after admission in pediatric referral hospitals</td>
<td>Number of &lt;5 child deaths during 24 hours after admission * 100/number of total admissions</td>
<td>HMIS, PHI database</td>
</tr>
<tr>
<td>11</td>
<td>Case fatality rate of children &lt;5 from pneumonia admitted to health facilities</td>
<td>Number of &lt;5 child deaths due to pneumonia * 100/total number of &lt;5 children admitted to a health facility with pneumonia</td>
<td>HMIS</td>
</tr>
<tr>
<td>12</td>
<td>Case fatality rate of children &lt;5 from diarrhea admitted to health facilities</td>
<td>Number of &lt;5 child deaths due to diarrhea * 100/total number of &lt;5 children admitted to a health facility with diarrhea</td>
<td>HMIS</td>
</tr>
<tr>
<td>13</td>
<td>Percent of health posts doing community weighing sessions</td>
<td>Number of health posts doing community weighing sessions * 100/total number of health posts.</td>
<td>HMIS</td>
</tr>
<tr>
<td>14</td>
<td>Number of STI cases treated using syndromic management approach</td>
<td>Number of STI cases treated using syndromic management approach</td>
<td>HMIS</td>
</tr>
</tbody>
</table>