



# Improving maternal and child health in Asia through innovative partnerships and approaches

## The case of Afghanistan

Fiona Samuels, Svetlana Ancker and  
Mohammad Anwar Haneef

August 2015



**Overseas Development Institute**

203 Blackfriars Road  
London SE1 8NJ

Tel. +44 (0) 20 7922 0300

Fax. +44 (0) 20 7922 0399

E-mail: [info@odi.org.uk](mailto:info@odi.org.uk)

[www.odi.org](http://www.odi.org)

[www.odi.org/facebook](https://www.facebook.com/odi.org)

[www.odi.org/twitter](https://www.twitter.com/odi.org)

Readers are encouraged to reproduce material from ODI Reports for their own publications, as long as they are not being sold commercially. As copyright holder, ODI requests due acknowledgement and a copy of the publication. For online use, we ask readers to link to the original resource on the ODI website. The views presented in this paper are those of the author(s) and do not necessarily represent the views of ODI.

© Overseas Development Institute 2015. This work is licensed under a Creative Commons Attribution-NonCommercial Licence (CC BY-NC 3.0).

ISSN: 2052-7209

Cover image: CBE visits Sharifa, 23 and her first baby Fatima. © CARE International/Jenny Matthews, 2015

Inside image, page 7: CBE Momina during FHAG training session in the community, Afghanistan © CARE International, 2014

---

# Acknowledgements

This research brief is part of a series capturing the impact of project interventions and analysing and documenting CARE's best practices under GSK '20% Reinvestment Initiative' in Asia. We would like to acknowledge contributions from the CARE Afghanistan project team and Christine Galavotti from CARE USA. We would also like to thank GSK UK for its financial support for this research initiative.

---

# Contents

---

Acknowledgement	<b>3</b>
Abbreviations	<b>6</b>
1 Overview of maternal and neonatal child health in Afghanistan and in the project district	<b>8</b>
2 Overview of the project	<b>10</b>
3 Innovative tools and processes	<b>11</b>
4 Conclusions and considerations for the future	<b>17</b>
References	<b>18</b>

---

---

# List of tables, figures and boxes

## Tables

**Table 1:** Afghanistan health indicators **8**

---

**Table 2:** Training of CBEs and CMWs **12**

---

## Figures

**Figure 1.** Map of Kabul District 1 **9**

---

# Abbreviations

<b>ANC</b>	Antenatal care
<b>BCC</b>	Behaviour change communication
<b>BPHS</b>	Basic package of health services
<b>CBE</b>	Community-based educator
<b>CBHC</b>	Community-based health care
<b>CBSS</b>	Community-based surveillance system
<b>CMW</b>	Community midwife
<b>FHAG</b>	Family health action group
<b>GSK</b>	GlaxoSmithKline
<b>IEC</b>	Information and education communication
<b>MMR</b>	Maternal mortality ratio
<b>MoPH</b>	Ministry of public health
<b>OMID</b>	Opportunities for mother and infant development
<b>PNC</b>	Postnatal care
<b>ToT</b>	Training of trainers



This briefing is the third in a series of three that summarise key processes and outcomes emerging from an innovative partnership between CARE and GlaxoSmithKline (GSK) to improve maternal and neonatal child health in six Asian countries: Afghanistan, Bangladesh, Cambodia, Laos, Myanmar and Nepal. The partnership focuses on increasing the effectiveness and capacity of frontline health workers, strengthening health systems and enhancing community mobilisation.

This briefing focuses on the Opportunities for Mother and Infant Development (OMID) project in Afghanistan. It first gives an overview of maternal and neonatal child health in Afghanistan and then provides details of the project sites, the background to the project, and its goals, objectives and main achievements to date. The major part of the briefing describes the innovative tools and mechanisms that have been used by the project to improve maternal and neonatal child health in District 1 in Kabul. The briefing concludes with some lessons learned and recommendations.

# 1 Overview of maternal and neonatal child health in Afghanistan and in the project district

Following over three decades of conflict, Afghanistan faces considerable challenges in rebuilding its health system. The shortage of skilled health staff, particularly female staff, remains one of the biggest constraints to scaling up health service delivery. Lack of infrastructure, low managerial capacity, a fragile socio-political situation, limited access to remote areas, and restrictive cultural norms are other key challenges to adequate, affordable, accessible and good quality health care.

Though overall health indicators are improving, they remain below the desired level and maternal health is of particular concern. Afghanistan has the second highest

maternal mortality rate in the world with a lifetime risk of maternal death of approximately one in fifty (MoPH, 2010). The major causes of maternal mortality are haemorrhage, obstructed labour, sepsis and hypertensive disorders. While contraceptive prevalence has increased from 16% in 2005 to 21.2% in 2010, Afghanistan continues to observe one of the highest birth rates in the world (estimated average 5.2 total fertility rate).

There has been an increase in the number of functioning health facilities across the country from 496 in 2002 to over 2,324 in 2014 (MoPH, 2014). However, utilisation of the health facilities remains low, especially with regard

**Table 1: Afghanistan health indicators**

<b>Maternal health indicators</b>	
Maternal mortality ratio (per 100,000 live births)***	327
Coverage of antenatal care (%)****	At least one visit – 51.2% At least four visits – 9.9%
Births attended by Skilled Birth Attendants (%)****	39.9%
Coverage of tetanus vaccination (% of pregnant women)****	35%
<b>Family planning indicators</b>	
Total fertility rate (per woman)***	5.2
Contraceptive prevalence (% of women 15-49)*	21.2
Crude birth rate**	34
<b>Child health Indicators</b>	
Full immunisation coverage*	18%
Vitamin A supplement (6-59 months)*	51%
Exclusive breastfeeding (0-6 months) including additional liquids in first day*	54%

\* CSO (2012)

\*\* World Bank (2015)

\*\*\* MoPH (2010)

\*\*\*\* CSO (2014)

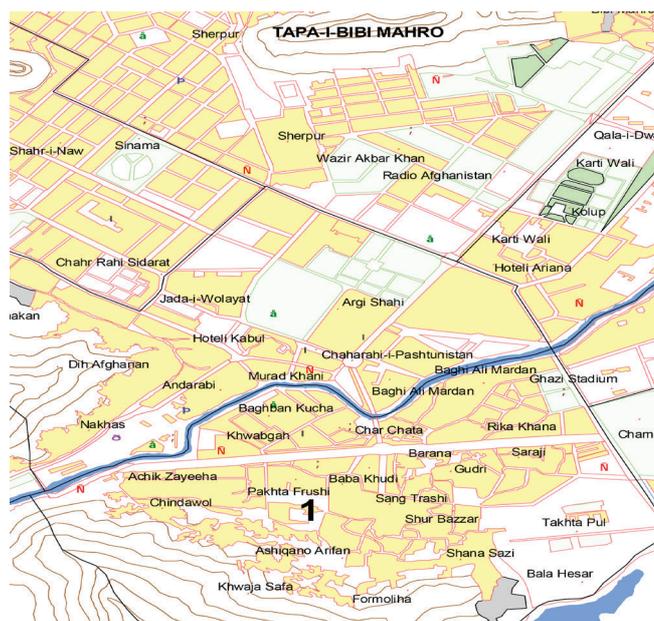
to maternal and infant health as most women are not allowed by men to access them. In 2010, even though 51.2% of pregnant women received at least one antenatal care visit and the use of Skilled Birth Attendants increased from 16% in 2005 to 39.9% in 2010, most women still delivered at home (CSO, 2014). One of the main reasons for the low use of birth attendants is that the vast majority of health care workers are male and stringent cultural practices prevent many women from approaching them.

Women's inability to access health and education services has a significant impact on child welfare. Two out of five children suffer from malnutrition and child mortality in Afghanistan is one of the highest in the world: the probability of dying among children under 5 is 102 per 1,000 (CSO, 2012). Most causes of mortality are preventable and treatable, such as diarrhoea and acute respiratory infections. Chronic malnutrition among all children under five is still very high (39%) and micro-nutrient deficiency is widespread (MoPH, 2012). Table 1 contains additional information on maternal and child health related indicators in Afghanistan.

The Ministry of Public Health (MoPH) identified the improvement of maternal and child health as a high priority in the National Reproductive Health Strategy, which was developed to 'improve the health of the people of Afghanistan, especially women and children, through implementing the basic package of health services (BPHS)', which is being rolled out across Afghanistan. This package of basic services now forms the core of service delivery in all primary health care facilities, bringing coherence and a unified approach to Afghanistan's health system and ensuring effective health interventions are made accessible to all citizens. The BPHS is consistent with and based upon the principles contained in the 2008-2013 Afghanistan's National Development Strategy and 2007-2013 Health and Nutrition Sector Strategy. Through OMID, CARE is committed to supporting the MoPH's mission by working in areas not covered by the BPHS to overcome the barriers to accessing maternal and newborn health care and facilitating the holistic chain of service delivery.

CARE International has been working in Afghanistan since 1996. Due to the large population of Kabul (which although officially estimated as 3,435,000 in the 2014

**Figure 1. Map of Kabul District 1**



Source: [http://www.aims.org.af/services/regional/kabul/maps/districts/kbl\\_dist\\_1.pdf](http://www.aims.org.af/services/regional/kabul/maps/districts/kbl_dist_1.pdf)

census is probably double that), the existing public health facilities are inadequate to cover the large urban population.

The focus for this project was on 23 communities in District 1 in Kabul city. District 1 in Kabul has been identified by the MoPH as a priority, following a 2010 survey highlighting poor socio-economic and living conditions and increasing vulnerability of its population. The district is located at the central part of Kabul with a total population of 87,400 people or 14,800 households. There are a total of 25 *Guzar* (localities/streets), each of which has one community leader. The OMID project was operational in 15 out of 25 *Guzar*, which were divided into 23 communities. District 1 was picked as the project location and activities were designed to align with MoPH's recommendations and priorities. Persistent barriers to maternal health care include lack of knowledge by pregnant women and family decision-makers (mothers-in-law and husbands), the expense of transportation and of treatment, and the poor quality of service provision.

---

# 2 Overview of the project

## 2.1 Overview of the GSK 20% Reinvestment Initiative and the CARE-GSK partnership

To help respond to a shortage of 7 million health workers worldwide and a growing overall burden of disease, CARE International UK entered into partnership with GlaxoSmithKline (GSK) as the implementing partner of GSK's 20% Reinvestment Initiative in Asia. This corporate community investment initiative aims to reinvest 20% of company profits into strengthening community health systems in a number of least developed countries where GSK operates. This strategic partnership between CARE and GSK focuses on improving maternal and neonatal child health by improving the quantity and quality of frontline community health workers in the most remote and marginalised communities in Afghanistan, Bangladesh, Cambodia, Laos, Myanmar and Nepal. Through a mix of programming, lesson-learning and advocacy, the initiative hopes to galvanise further national and international action on the health workforce issue. The CARE-GSK partnership is about to complete its first phase (2011-2015) and plans to continue and scale up its projects in 2015-2020.

## 2.2 Goals, objectives and achievements

One in every 50 women in Afghanistan will die from pregnancy-related complications – or one every two hours. CARE Afghanistan's experiences have shown that women's awareness and education enhances their empowerment as family and community agents and plays a critical role in improved health outcomes for newborns and mothers. With this in mind, over three years (2012-2015), CARE Afghanistan and GSK have implemented the OMID project in 23 targeted communities in District 1 of Kabul City. The overall goal of the project was to contribute to the reduction of maternal and infant mortality and morbidity through community-based intervention by Community-Based Educators (CBEs) and Community Midwives (CMWs) in these communities.

The specific objectives of this project are to:

- Establish a community-based surveillance system in 23 communities in District 1 of Kabul city to assess perinatal health outcomes for improved maternal and child health indicators;
- Enhance community mobilisation and participation of influential community members in community-based

health services and strengthen local networks (e.g. *shuras*) as preventive maternal and child health care centres; and

- Intensify the community outreach program to expand project interventions in urban and semi-urban settings of Kabul districts, through a review of data on maternal and child health indicators and an assessment of one of the other Kabul districts.

The project's achievements between 2012 and 2015 are:

- 414 frontline health workers, including 4 CMWs, 12 CBEs, 264 members of the Family Health Action Groups (FHAGs) and 134 members of the male health *shuras* (committees) have been trained on various health-related training packages
- 2 maternal health centres were opened and staffed with 4 community midwives
- 12,176 women of reproductive age, as well as their infants and toddlers, have directly benefited from the project
- 46,650 visits have been conducted to 3,204 households in targeted communities by CBEs and CMWs. The visits included 3,725 to pregnant women, 611 to postpartum women, 9,718 to lactating women and 7,185 to preconception women; and 8,972 children have been provided basic health services
- 37,235 members of the families of direct project beneficiaries and other community members benefitted from the project through education and awareness-raising activities
- 22 FHAGs and 10 male health *shuras* have been established and are functioning
- 2,038 pregnant women received four recommended antenatal care (ANC) services and 1,325 postpartum women received postnatal care (PNC) services
- CBEs have referred 16,679 cases to OMID health centres, who in turn have referred 879 cases – including high-risk pregnancies, sick mothers and children – to higher level government health facilities and hospitals
- Total of supplies and drug distributed:
  - 1,922 pregnant women received 1,922 safe delivery kits
  - 3,164 women received 64,771 condoms and 1,369 women received 4,378 packs of contraceptive pills
  - 3,414 women have received 134,004 tablets of Iron and Folic Acid to treat anaemia.

---

<sup>1</sup> Data was obtained from project CBSS, see section 3.2

---

Over the lifetime of the project the following impacts have been identified in 23 target communities (or 3,204 households) in District 1<sup>2</sup>:

- Reduction in maternal mortality ratio from 309.6 to 121.5 per 100,000 live births
- Reduction in perinatal mortality rate from 18.3 to 12.2 per 1,000 live births
- Reduction in infant mortality rate from 15.5 to 10.2 per 1,000 live births
- Exclusive breastfeeding of infants (0-6 months) increased from 46.7% to 70.9%
- Coverage of ANC visits increased from 46% to 98%
- Contraceptive use increased from 25.7% to 76%
- Institutional delivery rates increased from 87.5% to 98.5%
- Pregnant women's knowledge of danger signs in pregnancy (three or more signs) increased from 7.4% to 99.5%.

## 3 Innovative tools and processes

In this section we explore three core components of the OMID project, which are similar to those found in other CARE-GSK partnership projects: the training of community health workers, the innovative approaches used to mobilise and engage community members and the role of advocacy and partnership with the government in the project.

### 3.1 Training of Community Health Workers

A central focus of the OMID project has been capacity building of frontline community health workers, particularly the CBEs and CMWs. A total of 12 CBEs and 4 CMWs have been recruited by the project; 11 of the CBEs are female and all the CMWs are female. The CBEs were selected by CARE Afghanistan in consultation with community leaders according to the criteria set by the MoPH. The CBEs needed to be literate, aged 30-50 and resident in the community in which they are working. They also needed to be able to cover a catchment area of over 300 households depending on density of population and presence of women of reproductive age. Recognising health-seeking behaviours are formed at the household and community level, these selection criteria ensured that CBEs would be in a position to overcome cultural barriers and build trust and understanding in their communities.

The CMWs are midwives registered with the MoPH who have completed the standard two-year midwifery course. They work at two OMID health centres that the project has set up in District 1. CBEs refer cases to OMID health centres as the primary point of contact. CMWs in OMID health centres provide ANC, PNC, newborn and

child care, as well as family planning services. All other cases, including complications and deliveries, are referred to the government comprehensive health centres and tertiary hospitals within District 1. It is important to note that OMID health centres are located within governmental health facilities, the Behzad and Central Polyclinic public health centres, both of which provide services free of charge<sup>3</sup>. Thus, there are strong referral linkages between the OMID health centres and government health facilities/hospitals, increasing patient coverage. For example, the leadership of Behzad Central Polyclinic<sup>3</sup> indicated that there is a good working relationship between the OMID health team and the government clinic and recognised the contribution of OMID centre to directing patients to the government clinics, especially women attending for ANC and family planning services.

Both the CBEs and CMWs were recruited and paid by CARE Afghanistan on a monthly basis. However, this has gradually been reduced and at end of the project they have become part of the government system, paid by the MoPH. As part of CARE's gradual two-year (2015-2017) exit strategy in District 1, the CMWs are now stationed in the government health facilities in District 1 and each of them serves patients referred by the CBEs.

The capacity building of the CBEs and CMWs consisted of regular training and refresher courses. The overall aim of the training was to ensure that staff are equipped with up-to-date knowledge, information and skills related to maternal and newborn health interventions. The CBEs and CMWs received a full package of training for Community

---

2 Estimated population of Kabul City by district and sex 2012-2013, CSO, 2014

3 Behzad is a government clinic and categorised as Comprehensive Health Centre in the national health system. In District 1, there are two main government health centres, Behzad and the Central Polyclinic. CARE has built linkages with both of them.

**Table 2: Training of CBEs and CMWs**

Type/title of training	Year 1	Year 2	Year 3
Health system in Afghanistan and MCH profile and project objective in line with MoPH priorities	2 days	One refresher	One refresher
Information and Education Communication (IEC) skills and proper use of IEC material & interview techniques	3 days	Two 2-day refreshers	Two 2-day refreshers
Community mapping /Community mobilisation Surveillance /Data collection tools	5 days	One 3-day refresher	One 3-day refresher
Hygiene & Sanitation / Food preservation	3 days	One 2-day refresher	One 2-day refresher
Safe water and water-borne diseases (Diarrhoea, Typhoid, Cholera, Polio)	4 days	4 days	4 days
Birth preparedness and emergency readiness	2 days	Two 1-day refreshers	Two 1-day refreshers
Antenatal Care/ Anaemia and importance of iron-folic acid	4 days	Three 3-day	Three 3-day refreshers
Intra-natal Care	3 days	Three 2-day refreshers	Three 2-day refreshers
Postnatal Care/ Newborn care	4 days	Three 2-day refreshers	Three 2-day refreshers
Sexually transmitted infection prevention		4 days	Two 2-day refreshers
Common seasonal diseases	6 days	6 days	6 days
Breastfeeding (exclusive and colostrum, weaning, lactational amenorrhoea method)	4 days	4 days	4 days
Immunisation	10 days	6 days	6 days
First Aid		10 days	10 days
Family planning and birth spacing		10 days	10 days
Do No Harm, Training of Trainers		10 days	10 days
Nutrition and malnutrition		8 days	Refresher, two 2-day phases
Postpartum depression		3 days	One 2-day refresher
Behaviour change communication (BCC)/Interpersonal Counselling and Communication workshop		5 days	Two 4-day phases
Reproductive rights / Human rights		2 days	2 days

Health Workers developed and recommended by the MoPH. The training was conducted by CARE Afghanistan master trainers on health education.

See Table 2 for details of the trainings received.

The main activities of CBEs, most of which are carried out on a monthly basis, include:

- Visiting families in their neighbourhood/catchment area to identify pregnant and postpartum women and collect data on specific health indicators, making use of the community-based surveillance tool (see below).
- Delivering Information and Education Communication materials and health messages on neo-natal and maternal health and informing women of community support groups, existing health services, and referring them to CMWs in the two OMID project health centres.

- Establishing two Family Health Action Groups (FHAGs), which function as preventive and educational groups at the community level and link with CMWs.
- Training community health volunteers who are members of the FHAGs and male community groups, *shuras*.
- For the male CBE, attending *shuras* monthly meetings to share reproductive health education information with men and to interview them on their knowledge of appropriate care, health and support for their wives and female family members. Gathered information was used to assess their level of understanding about maternal health issues, which in turn informed future maternal health education sessions in male community groups.
- Distributing health supplies, such as safe delivery kits, condoms, oral contraceptive pills and iron and folic acid tablets.

The main activities of the CMWs who work in the two health centres, established by the project include:

- Receiving patients referred by CBEs in the targeted communities.
- Providing health care services to women of reproductive age and their infants/toddlers, including: patient checks and physical examination, such as blood pressure and testing; health advice and basic health services, such as immunisation.
- Distributing basic health items, such as birth control.
- Referring complicated cases to higher-level health facilities as required.

Achievements include:

- 2,038 pregnant women received the four recommended ANC visits and 1,325 postpartum women received postnatal care services.
- 16,679 cases have been referred by CBEs to the two OMID health centres which included 7,664 pregnant and 1,419 postpartum women, and 610 high-risk pregnancies and 1,709 sick children.
- 879 cases, including high-risk pregnancies, medically sick mothers and children were referred by OMID health centres to the higher-level government health facilities and hospitals.
- 4,398 women received family planning counselling.

*‘Because of the many trainings we received from the OMID project, we were empowered with skills, knowledge and attitudes to influence the attitudes of women and their decision makers to adopt health seeking behaviours, for instance, to receive antenatal services, improve hygiene and adopt delivering in hospitals.’ Female CBE at Behzad Clinic, Kabul.*

### 3.2 Community mobilisation

Community mobilisation has been a central feature of the project in Afghanistan and a number of innovative processes have been set up, including the Community-based Surveillance System (CBSS) and the Community Health Groups.

#### Community-Based Surveillance System Process

CBSS is a process whereby CBEs collect data about pregnant and post-partum women and their newborns on a monthly basis. Through this process, the project can identify high-risk populations or geographic areas where interventions should be targeted. It also allows the project to measure progress against specific health indicators related

to pregnant and post-partum women and their babies. Data was collected from both case and comparison communities, with the case group being exposed to health interventions, education and BCC activities through the project.

Three distinct data collection tools were used by the CBEs to collect the data:

- **Pregnancy, Post-Partum and Birth weight and Age-at-death for an Intervention and Evaluation System (BABIES)<sup>4</sup>** data collection tool: this tool is used to track each pregnant woman starting from the time when her pregnancy is confirmed (first trimester) through to completion or termination. With a full-term delivery the woman is followed over a period of 42 days after delivery (postpartum). This helps to assess the health of the mother and child and determine causes of any complications. The BABIES tool allows CBEs to collect, organise, analyse and translate data into information for improved mother and newborn health interventions. It provides information about the health status of newborns and allows trends to be measured in specific health indicators, such as infant mortality rate, low birth weight rate and so on.
- **Lactating data collection tool:** CBEs also collect data on non-pregnant women twice a year. January and July were the months selected in order to provide seasonal variation. During this time, CBEs collect surveillance data as part of their monthly visits to all women of reproductive age. Information collected includes use of family planning methods, husband and mother-in-law awareness regarding women’s and children’s health, as well as women’s knowledge about pregnancy and delivery.
- **Children and Toddler data collection tool:** CBEs collect data on children under two twice a year. February and August were selected based on the prevalence of common seasonal illnesses that can be fatal to children. During their monthly visits to all homes that include children under two, the following data is collected: immunisation status, safe water access, Vitamin A intake, newborn caretaker identity and additional information related to mother and child’s health, nutrition and hygiene. The gathered data is then consolidated and analysed to improve project interventions and inform future planning.

#### Achievements of the CBSS

Census data collected during the lifetime of the project in 23 communities of District 1 shows positive changes in health outcomes (when compared with data collected in the first six-month period of the project, June-December 2012). See Box 1 for more information.

<sup>4</sup> BABIES Tool was developed collaboratively by CARE International and the US Centre for Disease Control (CDC).

## Community Health Groups – Family Health Action Groups (FHAGs) and male *shuras*

### Process of FHAGs and male *shuras*

There are two types of community health groups promoted by the project: Family Health Action Groups (FHAGs) and male *shuras*.

*The Family Health Action Group.* The FHAG is a support group set up to promote preventative and health seeking behaviour among women of reproductive age and their children in order to reduce maternal and child mortality rates. FHAGs are led by female CBEs on a monthly basis and are used to increase awareness and spread key health messages among mothers, which in turn increases the use of available health services. FHAGs have built a strong information and referral system that improves access to quality health services at the community level.

The formation of the FHAGs and selection of its members is based on the principles and procedures of the urban Community-Based Health Care (CBHC) strategy of the MoPH. Each female CBE, in line with the overall national health policy and in consultation with community leaders, establishes at least two FHAGs near her catchment area. Each FHAG is composed of 10-15 members. FHAG members must be of reproductive age, respected in the community, trusted by the CBE, willing to dedicate time

to volunteering and, ideally, have basic literacy skills or education.

Using a community map, CBEs divide the households up into neighbourhood groups of 10-15 families living close by and then they identify women in these groups that best fit the selection criteria. The selected women in each group then become leaders in their groups. The CBE then groups 10-15 women leaders together to form an FHAG. Each FHAG receives training on maternal health and family planning from CBE on a monthly basis. Examples of issues discussed in these meetings include, but are not limited to: factors that can affect maternal health during pregnancy and lactation; safe pregnancy and labour; danger signs during pregnancy, delivery and after birth; frequency and timing of seeking antenatal and postnatal care; and benefits of breast feeding and supplementary feeding.

Following their training, each member of the FHAG promotes healthy behaviours among the families in neighbouring households. Thus, for example, each FHAG member adopts healthy practices in their own homes and then demonstrates the benefits of these practices in her neighbourhood group of households, offering advice to women in her neighbourhood, promoting the use of health services from the CBE and the nearby health facility, and informing the CBE about local pregnancies, births and instances of sick women and children who need urgent care.

#### Box 1: Data collected through the CBSS

##### *Overall impact of project interventions:*

- Maternal mortality ratio (MMR) reduced from 309.6 to 121.5 per 100,000 live births
- Perinatal and foetal mortality rates reduced from 12.2 and 18.3 to 8.1 and 12.2 per 1,000 births respectively
- Infant mortality rates reduced from 15.5 to 10.2 per 1,000 live births
- Low birth weight rates reduced from 42.5 to 36.3 per 1,000 live births

##### *Utilisation of reproductive health services:*

- Prevalence of antenatal care increased from 46% to 98%
- Institutional delivery rates increased from 87.5% to 98.5%
- Intake of iron and folic acid by pregnant women increased from 12.3% to 73.6%
- Neonatal vaccination increased from 68.9% to 91.8%
- Intake of vitamin-A by post-partum women increased from 5.7% to 29.3%
- Prevalence of child vaccination increased from 72% to 94.9%
- Utilisation of family planning methods increased from 25.7% to 76%

##### *Behaviour change:*

- Joint (wife and husband) planning for receiving institutional care during pregnancy increased from 49.1% to 55.4%
- Planning for institutional delivery increased from 82.8% to 99.2%
- Institutional delivery planning by pregnant women increased from 82.8% to 100%
- Exclusive breastfeeding of children under six months of age increased from 46.7% to 70.9%
- Knowledge of three key pregnancy danger signs increased from 7.4% to 99.5%
- Family planning counselling provided to women and their husbands increased from 48.9% to 62.9%
- Home non-skilled deliveries decreased from 9.1% to 1%

## Box 2: The impact of CBEs

Halima\* is a CBE who established one of the FHAGs in Kabul. She regularly conducts training on maternal, neonatal/infant health and family planning issues to the group. One of the group members, Khadija,\* explains why the training has been so beneficial:

*‘One of the pregnant women in my neighbourhood was not attending the training sessions. I was going to her home to convince her about the importance of the issues we are teaching. The woman’s labour started. Unfortunately, she did not have opportunity to go to the hospital for delivery. She gave birth at home, but the placenta was obstructed and the woman was in a serious condition. I suddenly recalled the lessons from the CBE – Halima, who said that when the placenta is obstructed after delivery of the baby, the mother should immediately start breastfeeding. We then took the baby to the mother’s breast to help delivery of the placenta. Fortunately, the placenta was delivered. All the women present were surprised. They thanked me a lot and said that I have learned a lot of important things. They requested me to teach them everything I learned in the group. After that day I gained respect and dignity and everyone trusts me. I never thought I would gain such respect, trust and love from my people.’*

\* Halima and Khadija’s names have been changed to protect their identities

**Male shuras.** Since Afghanistan is a male-dominated society, where men are the primary decision-makers including in health-related matters, the involvement of male community members and male religious leaders in project activities has been critical for securing their understanding, support and commitment to positive behaviours, health services and family planning. This targeting of men is necessary not only to improve their knowledge on maternal and newborn health, but also to explain the importance of their support in terms of improved maternal health. Thus an important aspect of the work of the male CBE recruited by CARE Afghanistan was the establishment and capacity building of the male health committees, or *shuras*. He currently works with 10 male *shuras*, one in the catchment area of each female CBE; two he established while the remaining eight already existed as Community Development Councils but were rearranged to work as health *shuras*.

Each male *shura* is composed of 6-9 members, who are selected by the male CBE in consultation with community leaders and representatives. They may be, for example, community opinion makers, religious scholars, and other respected community members. Selection criteria for *shura* members include residency in female CBEs’ catchment areas, their status in the community (influence, reputation and leadership) and a fair distribution of membership to ensure equal representation between various communities of District 1 in Kabul.

Similar to FHAGs, members of male *shuras* are trained by the male CBE and then provide maternal health awareness to other men in the community so that they can support and address maternal and child health needs in their families. The male CBE holds monthly *shura* meetings and discusses various maternal and reproductive health issues with each of 10 male *shuras*. Thus, for example, the CBE explains: reasons behind maternal and child deaths in

the community and how they can be prevented by seeking available health services; the effects of mothers’ health on the survival and wellbeing of newborn babies; barriers in accessing health services; and the role men can play in preventing maternal and child morbidity and mortality. As a group, male *shuras* then come up with local solutions to address these issues at the household and community level. In addition to participating regularly in monthly meetings, male *shura* members provide support to the male CBEs’ work in the community by carrying out awareness raising sessions and mobilising community members to improve maternal and child health outcomes.

### Achievements of FHAGs and male *shuras*

- 22 FHAGs with a total 264 members were established and built capacity on issues related to maternal and child health in accordance with the MoPH training curriculum for FHAGs.
- 264 members of 22 FHAGs conducted awareness-raising activities on various maternal and child health issues, such as hygiene, antenatal, delivery and postpartum care, newborn care, breastfeeding and nutrition, reaching 18,011 women of reproductive age.
- Four project staff attended FHAG Training of Trainers (ToT) organised by MoPH in partnership with the Health Service Support Project, a USAID-funded project.
- Following the ToT training, four OMID project master trainers conducted FHAG training to 10 female CBEs and four CMWs.
- 10 male health *shuras* are now functioning and 134 members have been recruited and trained by male CBEs based on the MoPH curriculum.
- Members of the male *shuras* distributed health messages to over 2,000 male community members during community gatherings in mosques and other traditional gatherings, such as wedding parties.

---

### 3.3 Advocacy and partnership

Despite a challenging political and security situation, the project team has been successful in building a strong relationship with policy stakeholders and partners, contributing to national discussions on maternal and child health and influencing the adoption of best practices and models.

Community-Based Health Care (CBHC) is the foundation for successful implementation of the Basic Package of Health Services (BPHS) implementation package. While the BPHS does not address inter-sectoral or private sector linkages with community health, it does provide the context for comprehensive interaction between the formal health system and the communities it serves. Its success depends on community participation and an effective and functional relationship between the community and the MoPH through its community-based health staff. Project findings indicate that the OMID project has complemented government's efforts in implementing the BPHS framework.

Over the project's 2012-2015 phase, the team has participated in a number of meetings with MoPH and various technical groups not only to provide a progress update on project interventions and to discuss project activities, findings and challenges, but also to share learning among stakeholders, provide technical input into key strategies and policy documents, and streamline and coordinate activities on maternal and child health in Afghanistan. Thus, for example:

- The project team participated in monthly CBHC Taskforce meetings, chaired by CBHC Director of the MoPH, with participants representing the different NGOs that are implementing the CBHC services in Afghanistan. In these monthly meetings organisations shared updates on their achievements and interventions, future plans, and provided complementary expertise. CARE also held separate meetings with the CBHC Taskforce to discuss plans for the establishment of the FHAGs in CARE-GSK target communities, an initiative that was greatly welcomed by the Taskforce.
- The project team participated in the Reproductive Health Taskforce meeting, chaired by the Director of the MoPH Reproductive Health Department, as well as Maternal and Neonatal Health meetings. The purpose of these meetings and Taskforce is to coordinate all activities around improved maternal and child health in Afghanistan.
- The project team attended regular meetings held by the MoPH and attended by the World Health Organisation, UNICEF, UNFPA and other international NGOs to improve coordination and information sharing between various international health-related projects.
- At the provincial level, CARE Afghanistan contributes to the Kabul Provincial Health Directorate meetings, including Health Management Information System, CBHC and Provincial Health Coordination meetings.
- The project team organised and participated at national and international health observance days, such as Community Health Workers' Day, International Women's Day and Mothers' Day, and showed support for women's and children rights at events organised by the Afghanistan White Ribbon Alliance, Afghanistan Women's Rights Commission and UN Women.
- The project contributed to the wider adoption of the BABIES tool by the MoPH.

---

# 4 Conclusions and considerations for the future

Overall, the OMID project has been successful in building the capacity of frontline health workers (the CBEs and CMWs) and mobilising the community and in this way increasing the demand for and utilisation of maternal and child health services. This has resulted, as shown by the data collected through the CBSS, in the improvement of maternal and child-related health indicators in the project district. The work of frontline health workers (awareness raising, house-to-house visits, referrals) has been critical in this, while the creation of community groups – the FHAGS and male *shuras* – to extend and multiply this knowledge to other members of the community has been vital in terms of replicability, scaling-up and sustainability. The male *shura* groups have been particularly successful in involving men, given their central role in determining the health-seeking behaviour of female family members.

Another factor that has enhanced the sustainability of the project is close linkages and partnerships with the MoPH: the project has supported the mission of the MoPH to overcome barriers to accessing maternal and newborn health care and complemented its approach by focusing on urban areas; government stakeholders were involved in project design, implementation, monitoring and evaluation; the project's CBEs and CMWs were selected and trained using MoPH criteria; the CBEs and CMWs have and will become part of the public health system once OMID stops; referrals between the OMID health centres and the government health facilities have been established; and the project team has played an active role in government-led taskforces and other national and provincial-level meetings focusing on community-based and maternal and child health.

The process has not been free from challenges. At the beginning of the project there was resistance from some members of the male *shuras*, but as the project progressed they became more receptive and willing to encourage women and their husbands to adopt good health-seeking behaviour. The ongoing security situation remains an issue, with the largely female CBEs, for instance, sometimes facing challenges in accessing households due to security operations or the risks posed by visiting deeply traumatised households. Despite partnerships between the project and the government, this situation remains somewhat fragile: on the one hand some government officials want to be more involved in the decision-making, monitoring and evaluation; on the other hand, there was limited support from the government in terms of taking responsibility for continuing

project activities beyond its lifetime, even if the activities were part of the functions of the MoPH personnel.

A number of issues could be considered by CARE Afghanistan and other partners:

- In order to ensure the ongoing sustainability of the project, further efforts need to be made at different levels, starting from the highest level of the health system, to share the findings and promote the effectiveness of the OMID approach, including through further mining of CBSS data.
- Findings can be disseminated through further advocacy, by sharing findings at different levels (including among beneficiaries) and by carrying out peer-to-peer activities. These will not only have a positive effect on behaviour change, but may also encourage other organisations, both government and non-governmental, to take up the approaches and replicate them.
- Working alongside the MoPH, different ways of promoting the OMID approach and improving access to maternal and child-related health information should be explored. Thus, for instance, mass media campaigns and the use of alternative information channels (e.g. mobile phones) could enhance the CBEs' work. Such approaches may also enable wider access to health-related information, especially for poor households.
- Processes and mechanisms need to be put in place to strengthen the partnership between the project, the government and other key stakeholders. For instance: setting up a steering committee consisting of NGO and government stakeholders, among others, which meets regularly; sharing findings from the CBSS in an accessible format with the relevant authorities; and developing a joint plan for replicability, sustainability and scale-up.
- Support and strengthening of government health facilities and community health groups and building strong linkages between them is key not only to their long-term sustainability but also to improving access to emergency services and coordination between different levels of care.
- Investment in continued capacity building for health service providers is crucial for improving the quality of health care, which has a direct effect on overall maternal and child health outcomes. However, in the context of political instability and a challenging socio-economic situation, frontline health workers' incentives and remuneration need to be addressed. For example, they may require longer-term financial support

- 
- from international NGOs as the state may not yet be prepared to take full responsibility and ownership.
- In terms of services provided, in addition to what is already offered, and given the fragile setting of Afghanistan, psychosocial support services could be

considered as part of the package of services provided to beneficiaries. CBEs and/or CMWs could be trained in basic counselling skills and they could refer and link severe cases to other appropriate psychosocial support services, both government and non-governmental.

## References

CSO (2012) Monitoring the situation of women and children: Afghanistan Multiple Indicator Cluster Survey 2010/11. Kabul: Central Statistics Organisation and UNICEF (<http://cso.gov.af/Content/files/AMICS.pdf>).

CSO (2014) National Risk and Vulnerability Assessment 2011-2012. Afghanistan Living Condition Survey. Kabul: Central Statistics Organisation (<http://cso.gov.af/Content/files/NRVA%20REPORT%20Introduction%20Pages1.pdf>).

MoPH (2010) Afghanistan Mortality Survey 2010. Kabul: Ministry of Public Health (<http://moph.gov.af/Content/Media/Documents/AMS2010F>).

MoPH (2012) National Reproductive Health Strategy 2012-2016). Kabul: Ministry of Public Health (<http://moph.gov.af/Content/Media/Documents/FinalRHStrategy1092012222657442553325325.pdf>).

MoPH (2014) Health Management Information System. Kabul: Ministry of Public Health (<http://moph.gov.af/en/documents/category/hmis>).

World Bank (2015). Birth Rate, Crude (per 1,000 people). Online database. Geneva: The World Bank Group, 2015. Available at: <http://data.worldbank.org/indicator/SP.DYN.CBRT.IN>.

Readers are encouraged to reproduce material from ODI Reports for their own publications, as long as they are not being sold commercially. As copyright holder, ODI requests due acknowledgement and a copy of the publication. For online use, we ask readers to link to the original resource on the ODI website. The views presented in this paper are those of the author(s) and do not necessarily represent the views of ODI.  
© Overseas Development Institute 2015. This work is licensed under a Creative Commons Attribution-NonCommercial Licence (CC BY-NC 3.0).  
ISSN: 2052-7209

**Overseas Development Institute**  
203 Blackfriars Road  
London SE1 8NJ

Tel +44 (0)20 7922 0300  
Fax +44 (0)20 7922 0399

Cover image: CBE visits Sharifa, 23 and her first baby Fatima. © CARE International/Jenny Matthews, 2015  
Inside image, page 7: CBE Momina during FHAG training session in the community, Afghanistan © CARE International, 2014