



NATIONAL REPRODUCTIVE  
HEALTH POLICY

**2012-2016**

ISLAMIC REPUBLIC OF AFGHANISTAN  
MINISTRY OF PUBLIC HEALTH

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Prepared by  
Reproductive Health Task Force

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## **FORWARD**

In order to effectively lead the health sector and to deliver quality health services, the Ministry of Public Health needs to develop policies, strategies, guidelines, and standard protocols. Of course, these infrastructural documents require revision and reconsideration in process of time. This way, revising the National Reproductive Health Policy (2012- 2016) is one of the significant achievements of the Ministry of Public Health in improving the health system of Afghanistan.

The Reproductive Health Directorate is one of the core components of Afghanistan Health Ministry where it contributes to the reduction of maternal mortality and morbidity in Afghanistan.

National Reproductive Health Policy( 2006- 2009) was known to be one of the key documents of the Ministry of Public Health and was made possible by the Ministry of Public Health with technical efforts of the entire health partners including donor agencies, UN, and NGOs. So, as to cover other areas connected to Reproductive Health and to satisfy current needs, this policy got revised. Now the revised policy is ready to be implemented for the years 2012 through 2016.

Based on the revised policy, all Afghan families have the right to have access to the highest reproductive health standards. Reflecting the steady commitments of Ministry of Public Health and its partners, this policy aims at providing needed opportunities so as to enable all Afghan families to have access to quality reproductive health services.

The four main priorities of the National Reproductive Health Policy include Maternal & Child Health, Family Planning/ Birth Spacing, Sexually Transmitted Infections (STI) and Breast and Cervical Cancers.

Other areas comprise of Infertility, Obstetric Fistula, and cross-cutting issues. Implementation of these areas remains as long- term objectives for the present policy.

In line with this policy, the Reproductive Health Directorate of the Ministry of Public Health owns the roles of monitoring, setting standards, advocacy, motivation, guidance, relationship, and being cooperative with other counter- parts.

Therefore, I would appreciate Reproductive Health Directorate of the Ministry of Public Health for making its attempts to revise the present policy. In addition, I would like to appreciate the efforts of Reproductive Health partners who contributed to the revision of this policy.

I do believe whenever the Reproductive Health Directorate and its health partners do their best to coordinate their activities in implementing the present policy, they will, undoubtedly succeed to develop a strong Reproductive Health partnership for the benefit of Afghan families.

Best regards,

Suraya Dalil, MD, MPH  
Minister of Public Health  
Kabul, Afghanistan

## **BACKGROUND:**

Afghanistan has made significant progress in rebuilding its health system, despite years of continuous conflict. The National Reproductive Health Strategy 2006–2009 contributed to improving the health of the people of Afghanistan, especially women and children, through the implementation of the basic package of health services (BPHS) and the essential package of hospital services (EPHS) as the standard, agreed-upon minimum package of health care services to be provided at each level of the health system.

Between 2003 and 2012, the number of graduated midwives in Afghanistan increased from 467 to 3,001, according to the Afghan Midwifery Education and Accreditation Board report. In addition, there has been a gradual increase in the number of births attended by skilled birth attendants (SBAs). In 2006 the Afghanistan household survey showed that 19% of births were attended by SBAs, while the National Risk and Vulnerability Assessment 2007/2008 showed that 24% of women delivered with a skilled birth attendant. More recently, the Ministry of Public Health (MoPH) Partnership Contracts for Health 2010 Household Survey showed that about one-third (38%) of deliveries were attended by an SBA.

According to the Reproductive Age Mortality Survey (RAMOS), in 2003 Afghanistan had one of the highest maternal mortality ratios in the world, estimated at 1,600/100,000 live births. The Afghanistan Mortality Survey (AMS) 2010 estimated that the ratio had fallen to 327 per 100,000 live births. The differences appear to be consistent with the level of skilled assistance during delivery, skilled birth attendance, and delivery in a health facility, all of which have increased rapidly in Afghanistan in recent years. Based on 1999–2002 data collected from four sites, Bartlett et al. (2005) estimated the lifetime risk of maternal death at between one in six and one in nine. According to the 2010 AMS, approximately one in every 50 Afghan women dies of pregnancy-related causes.

Use of family planning also has increased remarkably in the last seven years in Afghanistan. According to the AMS 2010, the total fertility rate is 5.1 per 1,000 and more than one-fifth of married women use some method of family planning (22%), with the vast majority (20%) using a modern method.

The 2010 National EmONC Assessment showed that none of Afghanistan's health facilities has yet achieved the national goal of one skilled attendant for every 100 expected births. In district and regional hospitals, the ratio of midwives to 100 expected births was 0, and health facilities, Regional Hospitals, and Specialized Hospitals all had small ratios of 0.1 midwives per 100 expected births.

The adjusted under-five mortality rate for Afghanistan is 97 deaths per 1,000 births and the infant mortality rate is 77 deaths per 1,000 births.

## **GUIDING PRINCIPLES:**

The Policy is based on the following core values and operational principles which are in line with the Ministry of Public Health's mission, vision and with the National Development Framework.

## **CORE VALUES:**

### Human Rights:

Based on a human rights approach, the RH policy promotes the rights of all people, especially women and children, to life and the highest attainable standard of health.

### Gender:

The policy aims at promoting gender equality as the basis of RH programmes especially maternal and newborn health programmes, by addressing the lower status of women and discrimination against women.

### Equity:

The actions promoted within the policy aspire to contribute towards decreasing the inequities in health in the country, with priority attention to the rural areas and poor and underserved groups.

### Culture:

The policy aims at improving reproductive health, highlighting maternal and newborn health through working with women, families, communities and policy makers and uses a culturally-sensitive approach that takes into consideration the socio-cultural dimensions and specifics of the country.

## **OPERATIONAL PRINCIPLES:**

### Quality of Care:

All interventions for Reproductive health should be made available with the highest standard of quality and safety, and services should be delivered according to evidence-based best practices. Addressing providers' needs and community views, particularly those of women, on the quality of service provision is key to ensuring improved quality and increased access and utilisation.

### Continuum of Care:

All women have a right to the best possible care before and during pregnancy, childbirth and the postpartum period at all levels of the health system, as appropriate for each woman or

newborn's needs. These levels range from the household to the first service level, and to the higher level service site. Primary care should be strongly connected to a referral system in order to effectively manage life threatening complications. This continuum of care encompasses the life-cycle of the woman, from adolescence through to the birth of her own child.

#### An Integrated Approach:

Comprehensive services are made available to all especially to women and newborns, integrating maternal and newborn care, family planning, nutrition, immunization, child survival, prevention and treatment care of malaria, sexually transmitted and HIV infections, and other aspects of primary health care. Because of the close links between the different aspects of reproductive health, interventions in one area are likely to have a positive impact on the others. Existing services will be strengthened and used as entry points for new interventions, looking for maximum synergy.

#### Ownership, Partnership and Responsibilities:

Goals, objectives and strategies are commonly agreed upon and pursued by the government and their partners, and supported by the international community through coordinated actions and activities determined by national plans. The Basic Package of Health Services - BPHS (2010 and the Essential Package of Hospital Services - EPHS (2005) are two key examples;

#### Good Governance, Peace and Security:

These elements are vital components of a sustained effort to improve the health of all people including the health and survival of mothers and their newborns, and are especially relevant to the country;

#### Sustainability through Technical and Financial Capacity Building:

Financial and technical self-reliance is a target for the government and partners working collectively, with ongoing development of infrastructure;

#### Policies and Strategies Based on Evidence and Best Practices:

The choice of policies, strategies and practices is informed by research findings, surveillance, monitoring and evaluation, need assessments, economic analysis, and by the sharing of lessons learned and other available evidence-based norms and standards.

#### *Policy, Vision and Mission Statements of National Reproductive Health Policy*

##### Policy

Ministry of public health (MoPH) is committed to /should work effectively and efficiently reduce the high levels of maternal and neonatal morbidity and mortality by serving as steward of RH services: motivating, mobilizing, setting standards, monitoring progress, coordinating and collaborating with partners in RH services.

## Vision

Healthier families in Afghanistan Where all individual would have access to comprehensive Reproductive information and quality services throughout their lifecycle.

## Mission

To improve the reproductive health status of families in Afghanistan by ensuring the provision of quality reproductive health care services and the promotion of reproductive health in an equitable and sustainable manner.

## Goal

The goal of the reproductive health policy is to improve the reproductive health status of families in Afghanistan through the provision of integrated reproductive health services in partnership with communities, development partners and the private sector.

## **DEFINITIONS:**

To clarify the objectives of the national reproductive health policy and to further an understanding of the key elements of RH, MNH and BS/FP and other RH components, the definitions noted below will be used in Afghanistan. While reproductive health contains many elements, and should be implemented as a comprehensive package, certain elements are considered a high priority at the present time in Afghanistan.

### *Textbox 1: Definition of Reproductive Health*

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

WHO [http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)

### *Textbox 2: Reproductive Health Components, in the context of Afghanistan*

Reproductive Health includes the following essential components:

- Family Planning counseling, information, education, communication and services.

- Safe Motherhood; education and services for healthy pregnancy, safe delivery and post natal care including breast-feeding
- Care of the new born
- Prevention and management of the complications of abortion
- Prevention, screening and referral of women with mental health disorders
- Prevention and management of RTIs/ STIs / HIV/AIDS and other reproductive health conditions
- Information education and counseling, Behavior Change Communication (IEC/BCC) for adolescent and young people
- Prevention and management of sub-fertility/infertility
- Life cycle reproductive health care including breast and cervical cancer, cancer of the reproductive system, obstructed fistula, prolapse and reproductive health problems associated with menopause.
- Nutrition
- Reduction of harmful practices such as early marriage and violence against women

*Adapted from: Reproductive Health Strategy for the African Region 1998-2007 (WHO Regional Office for Africa)*

The availability of emergency obstetric and neonatal care (EmONC) indicates how well the health system can respond to the obstetric and newborn complications that are the proximate causes of maternal and newborn deaths. The Averting Maternal Death and Disability Program (AMDD) and the United Nations have defined nine essential EmONC services that directly treat these complications. These are termed *signal functions*<sup>1</sup>.

### *Textbox 3: Definition of Essential Obstetric Care*

The functional status of an EmONC facility depends on the round-the-clock availability of these life-saving signal functions and whether they have been performed recently.

To qualify as a *basic* EmONC facility, health centers and hospitals must have performed the following seven signal functions within the past three months

- Administration of parenteral antibiotics;
- Administration of parenteral anticonvulsants;
- Administration of parenteral oxytocics;
- Manual removal of placenta;
- Manual vacuum aspiration (removal of retained products of placenta);
- Assisted vaginal delivery (with vacuum extractor or forceps); and
- Neonatal resuscitation with bag and mask.

To qualify as a comprehensive EmONC facility, health centers and hospitals must have performed all seven basic services listed above plus the following two additional signal functions within the past three months:

<sup>1</sup> WHO/UNFPA/UNICEF/AMDD. Monitoring Emergency Obstetric Care. WHO, Geneva



- Blood transfusion; and
- Caesarean section

*WHO, Fact sheet N°245, June 2000*

Emergency obstetric & neonatal care is a subset of essential obstetric care which deals only with the management of obstetric emergencies (for example, hemorrhage, sepsis, eclampsia, obstructed labor and incomplete abortion).

EmONC services do not include the provision of normal antenatal or postpartum/neonatal care, nor does it include management of normal delivery. Therefore, a national maternal and neonatal health program which excludes the provision of normal care is not in the best interests of the country.

In addition to clarifying what is essential obstetric care, the MoPH herein clarifies the concept of skilled attendance at birth in Afghanistan.

#### *Textbox 4: Definition of Skilled Birth Attendant*

A skilled attendant is an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

#### ***Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. 2004***

Skilled birth attendants in Afghanistan include doctors (with specific clinical training and experience in maternal health<sup>2</sup>), midwives and community midwives. Other cadres and community-based providers (nurses, community health workers, family health action group members and traditional birth attendants) play a role in the overall provision of maternal health services; however, they are not considered skilled birth attendants.

It is RH policy direction and strategic goal of the MoPH to work toward ensuring that a skilled birth attendant is available for every delivery in Afghanistan.

While there is no clear international definition of “neonatal care provider” it is understood that these skills are part of the role of the skilled attendant and that qualified doctors, midwives and community midwives in Afghanistan would be considered as providers of neonatal care if they are skilled birth attendants.

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<sup>2</sup> Note: Given the cultural context of Afghanistan, male physicians may not have been given the opportunity in their training to adequately develop their obstetric skills. Therefore, for purposes of assessing availability of skilled attendants, consideration should be given to counting only females as skilled attendants.

*Text box 5: Definition of Uterotonic Drug:*

Uterotonic are the drugs that give tone to the uterine smooth muscle or an agent that over comes relaxation of the muscular wall of the uterus.

***Uterotonic Drugs:***

Uterotonics (also known as “oxytocics”) are life saving medications given to cause a woman's uterus to contract, or to increase the frequency and intensity of the contractions. These drugs are used to induce (start) or augment (speed) labor; facilitate uterine contractions following a spontaneous abortion; prevent postpartum hemorrhage during active management of the third stage of labor; treat hemorrhage following childbirth or abortion; and for other gynecological reasons.

The three uterotonic drugs used most frequently are the oxytocins, prostaglandins, and ergot alkaloids. Uterotonic drugs may be given intramuscularly (IM), intravenously (IV), and as a tablet that can be given orally, vaginally, rectally, or buccally.

**AVAILABILITY AND ACCESSIBILITY OF REPRODUCTIVE HEALTH SERVICES**

Reproductive health services should be provided as an integrated approach, and not as vertical programs. Within that integrated approach, MNH, FP and STI services are of particular importance to the MoPH. The screening services for Breast and Cervical cancers, other RH services and cross cutting areas are also including.

**1- MATERNAL AND NEONATAL HEALTH:**

MoPH and its partners who are implementing the BPHS and EPHS, should ensure that all components of Maternal and new born health services are available, accessible and functional at each level. Whenever feasible, they will ensure that services are available on a 24-hour basis. Services are *available* when the facilities providers are on duty at the facility; services are *accessible* when providers can be called from their homes and have access to a functional facility. MoPH and its partners must ensure the fully functional implementation of a referral system from household to all health facility levels when either services are not available or the condition of the patient requires more intensive attention.

The maternal and new born services must be standardized through using endorsed *National Reproductive Health Clinical standards and Guidelines*<sup>3</sup> and ensure the quality of care in MoPH and private sector health facilities and hospitals. The standard post-natal care should be for 24 hours after delivery with follow up visits on, 3rd, 7<sup>th</sup> and 28<sup>th</sup> day.

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<sup>3</sup> National Reproductive Health Clinical Guidelines have been endorsed and are in effect for Antenatal Care, Intrapartum Care, Postpartum Care and Neonatal Care.

Skilled providers are those who are licensed and certified by the MoPH to provide maternal and neonatal health services and fit into officially recognized cadre. Uncertified health care workers who have inadequate training should be trained on required competencies licensed and certified by MoPH. MoPH/ HR and RH should ensure that all skilled providers' knowledge and skills are updated and performance is continually improved.

Community-based maternal and newborn health care services should be provided through trained community midwives and health workers by supporting family health action groups and strengthen linkage between community and health facility.

MoPH must ensure that essential supply for maternal and neonatal services, are available and accessible based on MoPH standards.

RH Services should be made more user-friendly to reflect not only the clinical needs but also the gender-specific needs of users. Privacy, dignity and respect should be maintained at all level and times, the physical layout of facilities should take into account the needs and the views of women. Reproductive health services should be integrated into other services such as child and adolescent health services in order to be seen as accessible to women who are coming to the facility for other health services.

All RH implementing partners will engage in health promotion activities to increase demand for MNH services through RH MNH communication strategies with emphasize on role of male, family and community. Male involvement in maternal and newborn health should be increased

#### Prevention and Management of the complications of Abortion

All health services should follow the national guideline on the effective management of post abortion care. Health facilities should have required equipment for management of complication of abortion.

MoPH and its partners will no longer provide formal training for TBAs, these women are not barred from continuing their supportive role, as respected members of their communities they should be encouraged to work with community health workers and the health Shura in promoting messages to help families plan for delivery, improve the safety of home birth and be aware of danger signs and the need for urgent referral.

#### Availability and accessibility of uterotonic drugs:

These medications should be readily available in health facilities that provide EOC (Essential Obstetric Care), staffed and equipped to provide essential obstetric care; Currently in Afghanistan uterotonic drugs are openly available in pharmacies and “bazaars” without temperature-controlled storage and protection from light. Often patients are required to buy oxytocin, methergine or misoprostol for their own use in health facilities.

Uterotonic drugs should not be available to the general public and should be dispensed by prescription only especially misoprostol should be prescribed by Obstetrics and gynecologist.

These drugs also require temperature-controlled transport /storage and protection from light. It is the policy of the government to provide necessary medications for all in-patient procedures as well as to make these medications appropriately available to those providing obstetric care in the community setting.

Skilled attendants should offer oxytocin to all women for prevention of PPH in preference to ergometrine/methylergometrine.

In order to prevent PPH at home birth in absences of SBA, trained CHWs can distribute misoprostol with its education package to women and their family based on nationally accepted protocol under close monitoring and effective supervision in selected areas.

Recommendations for selection of the uterotonic drug:

Oxytocin is the drug of choice for induction and augmentation of labor. (For dosage and use please refer IMPAC/MCPC and national treatment protocols) and for Selection of the uterotonic drug for the prevention of postpartum hemorrhage refer to WHO Recommendations.<sup>4</sup>

## **2- BIRTH SPACING/FAMILY PLANNING:**

With respect to the mechanisms of service delivery, family planning methods can be divided into two categories in Afghanistan: those that are universally available and those that are available in specific circumstances, or selectively available. Universal availability means that BS/FP variety of methods available at all levels of the health system (health post, BHC, CHC, DH and PH, as well as in the commercial sector from trained pharmacists) and counseling on natural and traditional family planning methods. The BPHS provides clear direction regarding the availability of these methods from trained providers – all community health workers, nurses, community midwives, midwives and doctors should be trained on counseling skills and to safely and competently provide these FP methods. As well, doctors and midwives should be able to manage complications and side effects of these methods.

CHWs currently are authorized and trained to provide the first and repeat doses of injectable and oral contraceptives.

Other methods – intrauterine contraceptive devices (IUCDs) and surgical methods of contraception (vasectomy and tubal ligation) – are selectively available according to the following scheme:

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<sup>4</sup> WHO Recommendations for the prevention of postpartum haemorrhage. WHO: Geneva; 2006. Available at: [www.who.int/making\\_pregnancy\\_safer/publications/WHOREcommendationsforPPHaemorrhage.pdf](http://www.who.int/making_pregnancy_safer/publications/WHOREcommendationsforPPHaemorrhage.pdf).

ICM and FIGO. Prevention and Treatment of Post-partum Haemorrhage: New Advances for Low Resource Settings Joint Statement. The Hague: ICM; London: FIGO; 2006. Available at: [www.figo.org/docs/PPH%20Joint%20Statement%20%20English.pdf](http://www.figo.org/docs/PPH%20Joint%20Statement%20%20English.pdf).

1. PPIUCDs and IUCD interval: available from community midwives and midwives<sup>5</sup>, as well as female doctors who have been trained; available at all appropriately equipped relevant health facilities.
2. Vasectomy: available from trained doctors at appropriately equipped DHs, PHs and regional hospitals.
3. Tubal Ligation: available from trained doctors at appropriately equipped DHs and PHs
4. Implants( applied by trained doctors, midwives and nurse)
5. Emergency contraception

Emergency contraception refers to back-up methods for contraceptive emergencies which women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptives are not suitable for regular use.<sup>6</sup>

In case of failure of other contraceptive methods or incorrect use of spacing methods Emergency Contraceptives could be used. For detail information refers to Family Planning Global Hand Book for Providers which can be used as justification for preposition of Emergency Contraceptives inclusion in BPHS.

Those who have been trained to provide the above mentioned selectively-available FP services should work in an adequately equipped environment that allows them to provide the method and manage the needs of clients.

While the needs for surgical contraceptive methods are rare in Afghanistan due mainly to the unavailability of such services, there are occasional circumstances when the health of the woman is such that subsequent pregnancies pose an unacceptable risk to her health. Given that this is already happening at the discretion of some qualified physicians, it is important that appropriate guidelines and quality standards be followed. Informed consent must be achieved and documented in all cases prior to the provision of surgical contraceptive methods. Techniques with local anesthesia should be preferred to follow the global standards.

All facilities that provide EmONC services should also be equipped and supplied to provide BS/FP services, and should have an appropriate and continuous supply of contraceptive commodities. All women should receive information, education and counseling for access to BS/FP methods as a part of routine antenatal and postnatal care.

Accordingly, services in all health facilities will follow the *National Clinical Guidelines for Family Planning for Birth Spacing* and its accompanying standards. Special attention will be given to improving the quality of FP care, especially counseling and informed choice of family planning methods; evidence-based medical eligibility; management of side effects and complications; and infection prevention. Physical facilities, that are designated to provide FP services, must allow for privacy of individuals and/or couples for FP counseling male and religious leaders involvement as well as client assessment and provision of services, especially IUD services. Nationally developed implementation tools to improve provision of quality FP services, especially the FP Decision Making Tool and the FP Commodities Guidelines, should be implemented at all service delivery sites.

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<sup>5</sup> Community midwives and midwives trained according to the new curriculum of the IHS (2004) are trained to competency in the provision of IUD services. Other midwives in the country who were not trained according to one of these curricula should be assessed for their ability to provide IUD services and be trained if they are not currently competent.

<sup>6</sup> World Health Organization Fact sheet No244 revised October 2005

In-service training courses should be revised/designed to address the needs of specific cadres to increase their skill in providing FP services. Aspects of FP knowledge and skills should be incorporated into pre-service education curricula for doctors and nurses, and enhanced as necessary in the curricula of community midwives and midwives.

### **3- STI/HIV:**

HIV is a component of STI; HIV activities should be planned in close coordination with RH STI program incorporating program monitoring and supervision.

### **4- BREAST AND CERVICAL CANCER:**

Advocate for the establishment of specialty diagnostic and treatment centre at country level. Coordinate with other RH partners to develop resource package for knowledge and skills update for health services providers to screen, diagnosis at earliest stage of development and refer patients to specialized level of health services provision.

### **OTHER RH SERVICES:**

To keep track of services mentioned in RH policy and strategy documents, a national registry shall be established for reporting other serious RH conditions including obstetric fistula, reproductive tract cancers (especially prostate, breast and cervical cancer) and genital prolapse, in an effort to begin to understand the prevalence of these manageable, yet debilitating, reproductive health conditions. This will provide RH Directorate with updates on status of services provision inform decision making process and policy development process.

#### **1. Obstetric Fistula (O.F.)**

Reproductive health Directorate will establish the O. F. national committee to lead the advocacy process, monitor the implementation, develop and update training materials and oversee O.F. programme of Afghanistan.

#### **2. Infertility**

National clinical guideline for the diagnosis and basic management of infertility will be developed and made available to service providers.

### **CROSS CUTTING ISSUES:**

#### *RH In Emergency:*

RH directorate will coordinate with Emergency Prepared Response Office on the development of provincial emergency preparedness plan to ensure that RH issues and needs are well addressed.

Provision of Minimum Initial Services Package (MISP) should be ensured during the onset of emergencies; RH directorate will collaborate with EPR and stakeholders to provide MISP training to all RH officers in provinces.

### *Gender and RH Research:*

Reproductive Health services are provided on rights based approach and with involvement of Male. Health response to GBV (SV) should be reflected in the development of treatment protocols and guidelines.

### *Nutrition:*

Every woman during ANC & PNC should receive micronutrients supplementation (importantly, Folic acid, iodized slats) at each level of healthcare provision. Every woman should receive de-worming tablets during 2<sup>nd</sup> trimester of pregnancy; while early breast feeding and exclusive breastfeeding for 6 months should be initiated in each of the health facilities as well as at community level.

### *IEC / BCC:*

IEC / BCC materials development is led by the Health Promotion Department. All IEC/BCC materials for reproductive health will have to be approved by RH Directorate and should be culturally acceptable in Afghanistan.

### *Quality improvement:*

Reproductive Health Task Force will take the responsibility under the leadership of RH & Healthcare QI departments to establish a mechanism of RH quality services accreditation.

### *RH & the Private Sector:*

RH Directorate collaborates with MoPH Private Sector Department for the availability of Quality RH services in private facilities. Private service providers have to provide essential RH services and supplies as per RH guidelines, standards and treatment protocols.

### *RH Research:*

The RH Directorate and its provincial RH offices, and research department jointly plans researches as outlined in RH Strategy / policy documents to propose, evaluate and advocate for evidence based interventions in the area of reproductive health. The results of the researches will be also substantial to advocate for mobilization of relevant resources for

implementation of such locally tested and working interventions. Moreover, RH Directorate and all of its provincial offices will serve as the portal for discussions on RH research activities by other stakeholders all over the country.

Evaluations of implementation of different pilot projects and policies, strategies and behavioral models require all the activities required for other types of researches. Therefore RH directorate will regard evaluations as critically and as carefully as other research activities during all phases from inception through development to implementations and reporting.

Reproductive Health Directorate will extend its services to RH research activities conducted by other organizations as well. All of the research activities in the field of reproductive health administered centrally should be brought to the attention of RH department, well in advance during the process of research protocol development process. Similarly, all research activities at provincial level, whether as part of a centrally conducted research or stand alone local research activities in provinces must be coordinated similarly with respective Provincial Health Directorate and provincial RHOs.

For the research conducted directly by RH Directorate, the protocols should be jointly designed and approved between RH Directorate and research department of APHI. The researches activities can be divided between the two departments and any other external research organization based on the nature and arrangements of each research activity.

In order to make sure that all the researches conducted in RH is available for the uses of all relevant individuals and organizations, RH Directorate will work closely with other respective departments (HMIS and Research) to ensure that results are always readily available for users as needed. To this end, RH Directorate will develop an inventory system for storing and usage of research results and findings. Also all efforts will be made to make the most important results on MoPH websites and disseminations of the results in other soft and hard copy forms such as CDs and DVDs.

The research topics encouraged include factors that limit access to and utilization of services, including financial/economical, transportation and socio – cultural barriers.

## **MONITORING AND EVALUATION:**

The RH and its partners will work with RHOs to support their understanding and use of the national Health Management Information System (HMIS) for data collection and program monitoring. Indicators for program monitoring will be set forth in the Reproductive Health Strategy and will be tracked on a periodic basis.

Implementing partners will work at the facility, district, province and national level to gather appropriate data regarding the delivery of health services, according to the RH strategy. population-based data will be reported through the HMIS system nationally and reviewed and responded to locally.



Monitoring of facility-based obstetric care will be done through the use of the Obstetric Register and be reported through the HMIS system using the Monthly Obstetric Activity Report. National Monitoring checklist will be used for reporting on the field implementation of RH services. In order to make sure that the NMC reflects RH services adequately, the contents of the checklist will be regularly reviewed with any concerns during any revision of the checklist addressed.

RH Directorate regards any monitoring mission going out to the facilities as an opportunity for monitoring RH services. Therefore RH will emphasize synergy in all monitoring activities with other MoPH departments (HMIS, HEFD, M&E, other special programs) as well as other supporting and implementing organizations to ensure that RH services are monitored as frequently and as accurately as possible.

The central office of the RH Directorate will develop a yearly monitoring plan for each year and will coordinate the implementation of the monitoring activities together with other departments and organizations. Therefore, RH Directorate will require all partner departments and organizations to provide information on any opportunities to visit the field and review field activities.

Similarly, the provincial RH offices will require all provincial stakeholders to inform the provincial RH office about possible missions to the field in order to draft the yearly monitoring plans. Joint missions with other departments and organizations will minimize the costs associated field visits and will ensure monitoring activities are carried out as accurately and as comprehensively as possible. The provincial monitoring plans will be completely independent of the central plan to ensure its responsiveness to local realities and needs; while not inhibiting close collaboration, coordination and synergy with central RH monitoring plans.

Evaluations, as described under the research section, will be carried out with the same vigor as other research activities. Evaluations are important to make sure the resources invested in RH have been effective and efficient. The results of the evaluations will also provide means for advocacy at the local, national and international levels to ensure continued support for the most successful interventions and strategies in the specific context of Afghanistan.

## **IMPLEMENTATION OF THIS POLICY:**

This policy will generate and inform the development of a National Reproductive Health Strategy, which will contain substantial elements on Maternal and Neonatal Health, Birth Spacing/ Family Planning, Breast and Cervical Cancer, STI, Obstetric Fistula, Infertility, RH in Emergency, Reproductive Health Rights, Nutrition, IEC, Quality improvement, RH Initiatives, RH Research and RH and the Private Sector. Work plans will be developed annually for implementing the RH Action Plan that will reflect the vision, priorities and direction of the MoPH and the contribution of all partners (including donors, technical agencies, NGOs, communities and members of civil society) toward that vision.

The policy and strategy will guide the development/revision of national clinical guidelines and implementation tools that will be used for uniform and consistent program implementation.



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