TERRE DES HOMMES

MATERNAL AND CHILD HEALTH HOME VISITING PROGRAMME, KABUL, AFGHANISTAN 1996 - 2001

REPORT

> ***'Women who know the price of conflict so well, are also often better equipped than men to prevent or resolve it. For generations, women have served as peace educators, both in the family and in their societies. They have proved instrumental in building bridges rather than walls. They have been crucial in preserving social order when communities have collapsed'.***
> Kofi Annan - in Afghanistan 2001 UN Appeal

Based on the findings of
BRENDA JENKINS' Evaluation
in December 2000

PROJECT SUMMARY

Context 1996 to 2001

The Terre des hommes Kabul Maternal & Child Health Home Visiting Programme (Tdh-MCH-HVP) commenced in January 1996 with the prime aim of reducing maternal and infant mortality in the city of Kabul. Impetus for the project stemmed from recognition that the health service infrastructure of Afghanistan had been severely disrupted as a result of long-standing war, conflicts, deprivation and population dispersal.

i) **At onset of HVP**

Data given in relation to Kabul at the onset of the Tdh-MCH HVP indicated that some *23%* of women were of childbearing age and children under five comprised approximately *17%* of the 1,200,000 population. Depending on the region infant mortality (< five) was estimated to be *25% to 45%.* In Kabul home births were a dominant feature, with approximately *80%* of women giving birth at home. Reportedly *only 20 – 30%* of the women attended antenatal and post-natal care at the MCH clinics established in the city. The concept of the HVP emphasized post-natal care for mothers and babies, with proportional less antenatal care for pregnant women.

ii) **Since onset of HVP**

Data obtained during this evaluation indicates that 80% of Afghanistan people are living below the 'poverty level with an accompanying adult life expectancy of 44 years. Over 70% of the population are illiterate, with this figure rising to nearly 90% amongst the female population. Only 12% of Afghans have access to safe drinking water, with a breakdown of 5% for rural areas and a corresponding 39% in urban areas. Access to health care appears to be variable between town and country areas. Although the trend in most developing countries is for urban areas to have more health resources it is pertinent to note that a recent publication in 'AINA' (UN Magazine) indicated that *'there are more health services in rural areas than at any time in the past'.*

The availability of health facilities and appropriate resources is indeed a crucial factor when considering a population's access to health care, but other factors, such as the actual freedom and ability to seek advice and treatment are equally relevant. In the context of Afghanistan there is also the question of who actually provides a health care system, as a high proportion of the existing services are dependant on international assistance. The plight of health care provision is exacerbated by the 'brain drain' of health professionals, who are amongst the 2.6 million Afghans who have sought refuge in other countries.

Information from a sample survey undertaken by AICF in Kabul during February 2000 shows *62.1%* of women had home deliveries, with *29.7%* and *8.2%* giving birth in hospitals or private clinics respectively. Of these women, *40.8%* attended an MCH or consulted a doctor during the last trimester of their pregnancy. The fertility rate of women is given as 6.9 by UNDP. Maternal Mortality ranks as the second highest in the world, with 1,700 deaths per 100,000 live births and Maternal Morbidity is given as the fifteenth highest in the world.

Children, between birth and one year, are dying at the rate of 165 per 1,000 live births; equally disturbing is that over one quarter (257 per 1,000) of Afghan children die before reaching the age of five years. It was recently reported that: -

'Living conditions are so precarious that easily treatable diseases accounted for the death of 180,000 children a year'. (UN press release 7.4.00)

As malnutrition is clearly a causative factor in lowering a child's resistance to infection, then the high mortality rate also mirrors the proportion of young children suffering from acute malnutrition in Kabul. There was a notable increase from 5.1% in December 1996 - 8.7% in February 1999, with 61% of children aged <five years suffering from stunted growth. WFP confirmed that the rate of malnutrition in Kabul was the highest in four years. These concerns are exacerbated by the lack of access that Afghanistan people have to food, with a reported negative trend in consumption and nutrition due to the high level of unemployment in the country. In the city, some 270.000 people are fed daily through the WFP supported bakeries for widows and an estimated one quarter of the city's current 1.8 million inhabitants are reliant on aid survival.

A more recent report from AICF noted a '*surprising decrease in the prevalence of acute malnutrition <5years in Kabul compared to the previous five years*'. The reasons for this finding were unclear and attributed to several possible factors, such as the return of several NGO's to the city and the re-opening of feeding centres. At the same time, chronic malnutrition remained high, with 53.7% of children between 6-59 months stunted, including 27.3% severely stunted.

The AICF survey also indicated a slightly improved nutritional status amongst the mothers screened, with 14.8% mothers undernourished, compared to 17.2% in 1999. However, it is relevant to record that '*the physical and physiological effects of under-nourishment, the lack of maternal care during pregnancy and the socio-economic difficulties of a majority of Kabul families draw to an even more precarious health and nutritional status of a large part of women, increasing their vulnerability'.*

The effect of Afghanistan's worst drought in the country for more than 30 years, which has resulted in a serious fall in the 2000 cereal harvest, with an estimated 44% loss below the drought-reduced crop of 1999, can only have fuelled food insecurity.

The UN ranks the country low on its Human Development Index, whilst the UNDP has Afghanistan as the lowest of 130 countries on the Gender Disparity Index. The imposition of restrictions by the Taliban leadership remains a harsh reality of life for Afghans. The strict segregation of male and females outside the home, specific dress codes for men and women, a curtailment of education for girls, and a ban on female employment, except in the health sector continue to be implemented. The effects of these restraints are potentially greater in the urban areas, such as Kabul, where education and work for women had gradually become more attainable for them – in comparison with their rural contemporaries.

The scenario depicted has highlighted the many difficulties encountered by Afghans, who are considered to be amongst the poorest people in the world. Conflict, wars and natural disasters have perpetuated their situation.

PROJECT OBJECTIVES

The 1996 Tdh project proposal defined the following objectives: -

Immediate targets: -

1. Prevention, early diagnosis and treatment of medical complications and/or disease for both the mother and child during the postpartum period.
2. To plan and implement a training programme for home visitors (midwives), which will include all aspects of mother and child health care.

3. To increase the knowledge and awareness of personal hygiene, health education and preventable disease amongst the families where there are newborn children.
4. To diagnose other medical problems in the families where the mother and newborn are living, which could affect the health of the mother and child.
5. To set up and implement a referral system between the maternity hospitals and MCH Clinics in Kabul. To ensure good liaison and continuing follow-up of the mother and child by the home visitors following delivery.

Developmental Objectives: -

1. To expand the HVP to include visits to all pregnant women, in order to identify risk factors prior to delivery and to encourage women to receive antenatal care from MCH clinics.
2. To expand the HVP to include the presence and assistance of home visitors (midwives) for home deliveries where there are no complications. Cases, which have been assessed as having risk factors, should be referred to hospital for delivery.

DESIGN OF Tdh/HVP/MCH Programme.

At the early stage of the Kabul HVP a specific training schedule was designed to meet the project's principal objective, namely, the provision of a professional community midwife service offering antenatal and postnatal care in the clients home, together with liaison alongside other Kabul based MCH services. An external midwife consultant was employed to undertake this responsibility for Tdh.

Specific Goals

1. To provide antenatal care to the clients in their homes, whereby the health of the client can be assessed and potential problems or complications may be identified at an early stage.
2. To refer the client to an MCH clinic for Tetanus Toxoid vaccination.
3. To distribute Iron and Folic Acid medication on a routine basis as a prophylaxis measure during both the antenatal and postnatal periods.
4. To make the birth safer -
   - By providing a home-birth kit to all antenatal women in the programme after the 36th week of pregnancy.
   - By Tdh midwives assisting at the birth if invited by the family.
5. To promote breast-feeding immediately following birth.
6. To refer the newborn baby and mother to MCH Clinics for BCG, DPT and Polio immunizations at 40 & 42 days of age.
7. To provide postnatal care to the mother during the involution and specific attention on the prevention and treatment of health problems during the postpartum and newborn period, for 42 days post delivery.
8. To provide treatment for complications during the pregnancy or postnatal period at home.
9. To continually improve the referral and follow-up system for mothers and babies with health problems from family homes to MCH clinics and back to the HVP midwives.
10. To diagnose, treat or refer family members who have health problems, which could impact negatively on the health of the mother and/or infant, and who live in homes where there are pregnant women and/or infants.
11. To emphasize health promotion and disease prevention through the provision of health education during each home visit.

12. To support a motherless baby until 4 months of age. The mother may or may not have been a Tdh client.
13. To provide refresher training in home visiting for all newly employed midwives before their work begins - to include all aspects of maternal and child health throughout pregnancy and the neonatal period.
14. To provide the midwife home visitors with close field supervision and monitoring, as well as regular continuing (*education*) sessions.

Home Visiting Schedule

The prime goals of the MCH/HVP are shown in Table 1. Apart from minor modifications, the schedule has followed the same format since its inception. The original training protocols for the home visits provide an in-depth description of the work to be undertaken by the midwives, as well as tools for supervision.

	Time of Scheduled Visit	Health Education Message
1st Antenatal Visit	When client becomes known to the programme	General personal care during pregnancy including diet, rest & hygiene
2nd Antenatal Visit	In the last month of pregnancy– Ideally around 36 weeks	The contents of the Home Birth Pack. Preparing where to give birth: how to cut the cord: how to care for the umbilical cord stump.
1st Postnatal Visit	First day of life or close to it	The promotion of breast-feeding and care of the baby to prevent hypothermia and umbilical stump care.
2nd Postnatal Visit	Third day of life or close to it	How to care for a baby with diarrhoea and the importance of breast-feeding during a baby's illness. When to seek medical help.
3rd Postnatal Visit	Seven to Ten days after birth	How to care for a baby with an acute respiratory infection, the importance of breast-feeding. When to see medical help.
4th Postnatal Visit	Twenty eight days after birth	Immunizing your baby: Birth Spacing: Promotion of breast-feeding.
5th Postnatal Visit	Forty to forty two days after birth	A discussion about weaning – why, when, how and what foods to introduce to the baby's diet, plus the importance of continuing breast-feeding.

Chronological progress of significant events in the Kabul MCH-HVP

- January 28th 1996

  Commencement of MCH-HVP in accordance with a contract signed between Ministry of Public Health (MoPH) and Terre des hommes.

  Five areas piloted – Shash Darak, Shahr Awa, Parwan-I-Se, Bibo Mahro & Khair Khana 1.

  September 1996

  Taliban took control of Kabul City.

- January 1997

  Expansion into Khair Khana 3, Qala-I-Wazir and Qala-I-Zamankhan.
- May 2nd 1998

  Expansion into Aqa Ali Shams, Allaudin, Char Qala-I-Wazir Abad & Qala-I-Bakhtyar.
- May 1998

  The Taliban suspended the MCH-HVP. Programme continued in a low-key unofficial capacity.

  NGO's expelled from Kabul during 1998.
- April 28th 1999

  Official re-commencement of the programme.
- May 1999

  Tdh was the first NGO to sign a protocol with the MoPH to allow female health workers to operate in the community.
- July & September 1999

  Protocols for post-partum hemorrhage and pathological jaundice completed

  Due to the on-going obstacles being faced in country a core objective during 1999 was that the Kabul team take on increasing responsibility and autonomy for the management of the MCH-HVP programme.
- Year 2000

  Training

  Protocol for Puerperal Infection completed.

  Protocols for the standardization of health education messages developed > on-going.

  Refresher Training courses for Midwives.

  Training of Trainers course

  July 2000

  Closure of 27 MCH Clinics in Kabul City

  July 12th 2000

  Programme suspended by the Ministry of Planning, with the employment of Afghani women banned in foreign agencies and NGO's.

  On 2nd August women were given permission to work only in the health sector.

  October 2000

  First distribution of BP-5 biscuits to malnourished pregnant and lactating mothers - Donated by CARE. Initial project duration for 2 months.
- May 2001

  Tdh was the first NGO to sign a protocol with the MoPH to establish a women & girls health center in Kabul.

  Larger distribution of BP-5 biscuits to malnourished pregnant and lactating mothers - Donated by CARE – 9 months.

Security difficulties have continued to hinder the project's operation and accompany the acute and chronic difficulties encountered by the Kabul population and HVP as a whole. The MCH team continue to pursue their work in the 12 identified areas, with the aim of reaching mothers, infants, female relatives and neighbours of beneficiary families.

> ***'The reality of oppression, not as a closed world from which there is no exit, but as a limiting situation which they can transform…Just as objective social reality exists not by chance, but as the product of human action, so it is not transformed by chance.'*** Pedagogy of the Oppressed: Paolo Friere:1972

Life in Kabul City

Before presenting the findings of this evaluation a brief explanation of the clients' living situation is given, in order that the comments and opinions expressed by the people are disseminated against the background of their day to day living conditions. It is acknowledged that the number of women interviewed was relatively small, but their chronically poor situation is echoed throughout families in Kabul City. This fact was observed and confirmed by the MCH/HVP team who, themselves, are part of the complex situation in Afghanistan.

The women and children visited were generally living in extreme states of impoverishment and austere home conditions. In many areas the 'habitable' places that represented homes were, in fact, remnants of bombed out buildings; this fact was particularly applicable in the Shash Darak area. Most of the dwellings seen were rudimentary and generally only served the purpose of very basic shelter for several families. Likewise, an area visited in Shara-ara presented a picture of an ancient and historic place that no longer thrived, apart from visible evidence of local pot making. This visit not only depicted hardship, but despair combined with hope. When asked what was the most important thing for them to have – these were the replies from three wives: -

> ***'My husband went to jail, when he comes free I become happy'***
> ***'My husband went to jail and I do not know the reason why'***
> ***'To have peace in our country'***

The situation of the families is mirrored in the low level of rehabilitation being undertaking in Kabul. The number of people without employment magnifies this lack of regeneration further, as anecdotal reports indicate that approximately **10%** of the male workforce are employed. It is not known whether this is the total amount in the formal work sector or includes both formal and casual labour. The consequences of such a high unemployment rate affect all family members, male and female.

In the areas visited children were seen in abundance. Whilst not an unusual feature in 'developing' countries, the disturbing factor underlying the presence of so many older children is simply that many of them are not at school. This applies to children of both sexes, due to the shortage of teachers for boys and the ban on female education for girls. The boys were seen playing outside their homes or on the streets begging, often alongside, or accompanied by burqa clad women, which is the compulsory attire for females in the public gaze. Within their homes the women remove the burqa, but for men the removal of their compulsory long beards is not possible.

Home Visits to Clients

The beneficiaries of MCH were visited in 5 of the 12 areas covered by the HVP. The midwives attend their allocated MCH/MoPH Clinics between 8 – 9a.m. where they either take direct referrals from clients and/or communicate with MoPH staff for referrals. The

remainder of the day is occupied by home visiting to pregnant and post-partum women, when the midwife provides the range of activities outlined in Table 2 – this includes the routine distribution of medicines to clients (iron, folic acid, vitamins and, if necessary, antibiotics).

The home visits involved talking to clients, plus an observation of transactions between midwives and clients, in order to assess the effectiveness and impact of the HVP, as a result of the midwives technical skills and the health education given. Amongst the participants who came to the client's home during the presentation of health education messages were several previous Tdh clients and their children.

The questions asked were not necessarily the same for each household visited, as it was important to be sensitive to individual situations. At times it was not possible to talk beyond the issues immediately covered by the midwife - i.e. one post-partum woman was obviously severely anaemic, with associated breathlessness and to question her further would have been inappropriate. In another instance a visit was made to a client married to a member of the Taliban and pregnant with her first baby, therefore additional documentation was not recorded.

A client perception of the MCH/HVP.

Before I know, but now I understand

Clients who were previous beneficiaries of the HVP

There were several mothers who had been recipients of the HVP and they were able to give examples of both short-term and longer-term benefits for them. Some of these mothers were again pregnant and being visited by the midwives.

Awareness of Hygiene

'The personal hygiene is better than before'

'We understand how to deliver the mother and cut the cord and washing our hands'.

Awareness of Nutrition

'Now I understand how to prepare the cheaper foods and feed the baby'.

This comment came from a new mother, but she had learnt about nutrition whilst attending health education messages given to other mothers receiving HVP visits.

'The midwife teaches us how to use cheaper food, which is still good for us'

Awareness of Breast-feeding

'I understand that I immediately put the baby to the breast following birth'.

The mothers knew about the importance of colostrum and how breast-feeding lactation is association with family spacing.

'After the Tdh came to the house I understood about vaccination…&…there are many things I understand from the midwife, like personal hygiene'.

This mother also talked about the visits she had received from the midwife following the birth of her son -

'At the time I was a Tdh client my blood pressure was so high and my son got oomphalitis. The midwife gave me drugs and provided me with bandage, soap and washing soap'

Awareness of ARI

'I keep the child away from other children when he is ill and keep him warm…&…if the child has a severe fever I go to the hospital for medicine…&…if there are no medicines, we use cloths put into cool water and put onto the child'.

Awareness of treating Diarrhoea

'You (Tdh midwife) teach me a lot about diarrhoea and now there is no more diarrhoea'.

This mother could describe the making up of ORS and knew how to make rehydration fluid at home, without the use of ORS. Her comment relating to the absence of diarrhoea could relate to the lower incidence in winter, compared to the summer months.

'Before, I did not understand about vaccinations, but now all my children have immunizations, especially the Tdh baby'

New Clients to the HVP

These mothers reported no antenatal care during their previous pregnancies and admitted to having little knowledge about the issue, nor of hygiene and breast-feeding during previous pregnancies. The women had received no formal education.

Raising of knowledge and awareness through health education messages

'I put the babies to the breast 3 days following delivery. The older women used to tell us to wash our breasts and cover them with green plants. The early milk was wasted, but now I understand the benefit of the colostrum'.

This pregnant client had previously lived in the provinces - pregnancies x 6.

'I understand about personal hygiene, more frequent breast-feeding because my baby is small and also more food for my baby because of his jaundice……'I also understand how to cut the umbilical cord and how to care for my baby more than I did before. When I was in the village I did not understand at all'.

The mother had moved from the northern provinces – previous pregnancies x 2 including one stillbirth. Additional visits came from the midwife because of post-partum infections.

Also from the same mother in relation to the passing on of health messages to others: –

'My neighbour got diarrhoea and I said please come to my house and I will prepare ORS for you. When she came, I gave it to her and she was fine. Other people come when sick with diarrhoea. All this I understand from the midwife'.

'The benefit, for me, is that I did not have any milk before, but the midwife advised me and supported me'.

From a post-partum mother, who had experienced problems with breast-feeding. During this visit it was particularly noticeably that the mother washed her hands before feeding her baby and also provided clean water for the midwife to wash her hands.

Comments relating to effectiveness and impact.

The health messages delivered by the midwives show that they are effective in raising awareness for the mothers on key target topics. There were clear signs that benefits were transformed into longer-term impacts, such as the initiation of breast-feeding immediately following the infant's birth; sterile cutting and care of the cord and improved knowledge on child care.

However, there are specific health messages that involve more than the acquisition of knowledge in order to create change, benefits and long-term impact, especially in relation

to - nutrition, personal hygiene, and birth spacing. Alongside the positive comments given by the clients the following observations were made during discussions with clients and the HVP team. The views given demonstrate the most common obstacles being faced during their relationship.

Obstacles

From the Tdh Midwives

'I tell a lot, but they can only introduce a little of what I advise'

(Shara-awa) All the women present during this visit agreed.

'Our clients live in very bad conditions and are always asking us for help, like food and contraception' (Microrayon 3) ***'Most of the families ask for more help – food etc'***

'We do not actually face problems, but lots of questions are asked about food and contraceptives' (Qala-Zamankhan)

'When we present health education on personal hygiene the mother says 'where is the soap?' (Parwan 3)

'The difficulty is the low economic situation of the people in Kabul City'..&…most of the families live in poor conditions' (Parwan 3)

From the clients

'The midwife helped me to understand the importance of washing our hands and not letting the chickens come into the house, but there is no money for soap' (Shash Darak)

Client could afford soap before, '***but now the situation is so bad that we use just water if there is no soap… &… there is not enough food. My husbands works outside the house and sells vegetables from a handcart'*** (Parwan 3)

'We know about cutting the fingernails, washing the hands with soap before and after handling the baby and washing hands after going to the toilet and before eating food – but there is usually only a little soap available, (because of the cost***) but washing soap is used instead.*** (Shash Darak)

'We did not have education, but would like our children to go to school…&…at first it is very important to have peace in our country, for our children to be educated and to have enough food' (Parwan 3)

The last comment was not an isolated case, as food and education were concerns raised during several visits.

There is clear evidence to indicate that the health messages explored above cannot easily be put into practice by the mothers. Unfortunately, knowledge applied to action and change is being severely hampered by poverty. The theme of food, hygiene and contraception are again referred to: -

Food

Most of the women seen were receiving supplementary food supplies from *CARE* in the form of BP-5 biscuits in efforts to improve the nutritional status of malnourished mothers identified by the Tdh team. The women were highly appreciative of this additional food to their normal, but inadequate, daily diet. CARE has agreed to fund the biscuits for an initial period of two months, but there is a definite need for this welcome assistance to be extended.

There is also the issue of supplementary feeding for the infant at the weaning stage, as babies <6/12 were shown to be moderately malnourished and deemed to be 'at risk' from a nutritional survey, undertaken by AICF in 1999. It was also maintained that the usual weaning practices in Afghanistan are not really appropriate for children. Steps were taken in August 2000 by the MCH team to ensure that the teaching of this health message is now more practically orientated, as opposed too purely theoretical. The HVP extends just to the end of the post-partum period, therefore the support and monitoring during the vital weaning stage is not possible – unless other methods can be found.

<u>Hygiene and Soap</u>

The messages relating to personal hygiene are aimed at protecting the mother and infant from infection, hence the provision of soap to clients at about 36 weeks of pregnancy. According to the Tdh co-ordinator the soap will last for a maximum of three to four weeks, as it is highly probable that other members of the family will use it.

A lack of soap was cited as being insufficient to meet the needs of clients. The longer-term problem of sustaining hygiene is a much greater problem and requires more discussion by the HVP team with families, together with linkage into organizations who are working on the basic issues of water and sanitation. In any event it would be advisable to have sufficient soap in order to cover the eventuality of 'no soap' before the end of the 42 days post-partum. At the same time it is important to consider that personal hygiene is not just applicable to the mother, but also to the father, particularly with regard to sexual hygiene.

<u>Contraceptives</u>

Although birth spacing is discussed with the mother during the postnatal visits it was apparent that women are finding difficulty in obtaining a suitable method of family planning. Other NGO's, such as Medicins du Monde, are reportedly providing <u>free</u> contraceptives to their female clients within the MoPH clinics they support, thus denoting that family planning is acceptable, even under the very strict interpretation of Islam found in Afghanistan. One way of assisting women and men to reduce their poverty is for contraceptives to be a part of an MCH programme, particularly if there is an acute shortage of women's reproductive health needs.

<u>Immunizations</u>

There was particular interest during this evaluation to seek out information on whether mothers are seeking UNICEF funded vaccines.. According to the study conducted by AICF in February 1999 the uptake of immunizations in Kabul was very low, with only 14.5% of children found to be fully covered before one year of age, increasing to 20.45% for under two-year olds. A similar poor uptake of tetanus toxoid was also found amongst mothers who were surveyed. The reasons for the low immunization rate were attributed to low-attendance at vaccine (MCH) centres.

The question of immunization was mentioned by relatively few mothers and was subsequently followed up with the Tdh midwives. Wherever possible the Tdh teams check on immunization when meeting present and past clients; there was confidence voiced that mothers who accepted the health education would take their babies for vaccines. MoPH staff at Microrayon 3 clinic appeared confident that mothers are regularly coming with their children to complete the immunization schedule; it was also implied that out-reach services operate. However, the findings of the AICF study cannot be disregarded and give impetus to strengthen the follow-up mechanisms from the HVP.

a) Motivating factors

Without exception, all the midwives stated that the prime reason for working with the HVP was financial. The reality is that out of a total number of female staff (31) there are only two women who have husbands in employment. The women identified this change as taking place after the arrival of the Taliban into Kabul City. The Tdh team are working totally to support their families, whilst the husbands are in a role reversal situation and caring for the children. On being asked to look deeper into other motivating factors that induce them to work the following comments were made: -

'The important thing here is that we go outside the house and take more opportunities for education and human rights. For other educated women there is not the opportunity to go outside the home, like teachers, doctors, nurses and midwives'.

'I like to work outside the home, as I am an educated woman'

'The health services and access to them is so low and the Tdh programme is a benefit'.

'I work outside the home for pleasure also.

'Because we get a chance to work, as the Taliban do not allow women to work. We are very interested in work outside the house and we get education and information from Tdh'.

(The education factor related into their own professional status as midwives)

Monitoring and Supervision

There was general satisfaction expressed by the midwives on the monitoring and supervision that was given from the senior MCH/HVP staff. The usual procedure is for the 4 supervisor/trainers to visit the midwives daily, either in the morning or afternoon. Although the visits were not scheduled to specific times, this did not appear to present a problem to the midwives. Clinic and home visits are also undertaken by the supervisors, with or without the presence of the home visiting teams. The supervisors expressed concern that the two vehicles required by them to undertake their role are not always available, as one has often to be used for other MCH purposes.

The HVP has operated under very difficult conditions and the midwives appreciation of the co-ordinator's support and that of the supervisors was overwhelmingly positive.

'I am happy with the line manager and all the supervisors. There are no problems with the team, either in the home or in the clinics'.

'We are happy of the monitoring and supervision. Dr.Noorkhanum is like a mother to us. She solved the problems of the Taliban for us'.

'The other supervisors are very good. We found a way in the programme with guidance from them'.

Training and identification of training needs from midwives and trainers.

All the staff meet on a once-weekly basis at the MCH office in order to pursue continuing education. A session was observed during the evaluation and confirmed that education was geared towards case studies presented by a midwife or midwives, with follow up teaching by a trainer. Regular staff meetings have helped to overcome problems

encountered with the health education topics, as standardized protocols had not been drawn up during the early stage of the HVP: this situation is now being resolved. Further new protocols will be introduced over time, based on the supervisors' observation of field activities and after appropriate review and revision.

According to the midwives the training is sufficient for their needs. However the 4 trainer/supervisors expressed specific requirements, which would help them be more effective in their work. They explained that there is a deficit in new up-to-date educational material being made available to the programme. Relevant information was needed for the production of new protocols, in order to deal with the obstetric complications faced by the field midwives, as some clients do not accept the advice to attend either the hospital or MCH clinics. The latter could be for a variety of reasons, but was associated with socio-economic factors and transportation.

Training wanted – from the midwives

* For the staff to learn English.
* Seek information/training from other NGO's working in MCH.

Training wanted – from the supervisor/trainers

* Management training
* Liaison with Tdh staff in other countries
* The opportunity for team members to attend workshops/seminars outside Afghanistan..
* Seek access on up-to-date information – books/journals/internet.

Training wanted – from the co-ordinator

* Management
* Project Proposal Writing
* Training on budget control
* Gender Issues

Comments on Training Needs

Support for the above requests would not only benefit the beneficiaries of the programme, but also provide means whereby the professional status of the midwives is enhanced. There would also be the potential to provide psychological sustenance for the MCH team, especially if opportunities are offered to enable staff to broaden their horizons in alternative environments and/or cultures.

Problems and Obstacles: Antenatal & Postnatal

Staff were asked to consider the underlying causes of MCH infections that are regularly reported, namely – oomphalits (cord infection) endometritis and conjunctivitis. At the same time the possible underlying causes for stillbirths, infant and neonate deaths were discussed.

Comments from the midwives.

Oomphalitis

'The hospital is not good with sterility and cord care'.

'Most of the cases are not our programme clients and did not receive health education messages…if it is our clients, then the cases are very low'.

The general consensus of opinion from the midwives is that cord infections are related to hospital deliveries and that within the Tdh programme mothers deliver safely and with no infection, although a lack of health education for non-programme clients is also mentioned.

Endometritis

'Most cases are hospital deliveries… but others could be due to low socio-economic circumstances and poor personal hygiene'.

"I have an endometritis client now who was delivered in hospital and after delivery stayed one hour in blood'.

'Because of deliveries by the families'

'The soap is not enough.

Linkages are again made into infection arising from hospital deliveries, although it is pertinent to note that one midwife commented on home deliveries by family members, which in turn was associated with economic factors and hygiene.

Conjunctivitis

The midwives stated that the eye infections were transmitted to the baby because of a mother's existing infection (vaginal or urinary) at the time of birth, poor hygiene and the use of kohl around the babies' eyes were also cited as causes.

Stillbirths

Besides medical reasons, there were strong indicators from the midwives that related again to poor social-economic factors, a lack of access to antenatal care and night deliveries. There was also an association with stillbirths occurring in migratory families, where travel could be on donkeys or horse.

Neonate and Infant Deaths

These deaths were mainly attributed to congenital abnormalities and Acute Respiratory Infections.

It was noted that although the midwives give intra-partum care, it is not the main focus of their work. The data given in Table 3 highlights this factor, along with the fact that home deliveries are undertaken primarily by family members and for the first ten months of 2000 have accounted for over 50% of all births.

Comments

The findings on the given causes of infection are revealing and significant. The opinions of the midwives certainly help to explain the underlying reasons for morbidity, which are consistently seen in the monthly MCH reports. There needs to be further statistical evidence on the rate of infection and how hospital and home deliveries alike affect it. Whilst it is more difficult to resolve the socio-economic problems that exist for women, the potential to reduce morbidity, as a result of infection, should be attainable.

Other issues

The staff empathized with the educated mothers they visited. This was reported as being a distressing experience for them, to meet with woman who could no longer work. The concerns they expressed gave emphasis to the emotional problems that the midwives confront, both with educated and non-educated women importance. This situation also

highlights the importance of the HVP, as the Tdh teams are amongst a minority of professional females working in Kabul, therefore others could view them as role models for what might be possible - in the future.

Referral mechanisms

The referral process of the MCH/HVP operates mainly on the identification of pregnant women for entry into the Tdh home visiting service. The data shown indicates that referrals stem from two methods – by means of the random house-to-house surveys and through the regular communication with the MCH/MoPH Clinics.

A summary of Home Visiting Program activities during 2000:

Annual statistics 1st Jan – 31 Dec 2000	Total
New houses visited	**11.567**
With target person	**5.257**
Target persons visited	**5.259**
Total number of clients visited	**28.179**
Number of women present during visit	**84.789**
Total number of revisits	**22.894**
*Antepartum	**6..062**
*Intrapartum	**200**
*Postpartum	**16.632**
New visits to target persons	**9.458**
To women	**5.285**
*Antepartum	**4.248**
*Intrapartum	**19**
*Postpartum	**1.018**
Total number of new visit to newborns	**4.173**
HVP Deliveries	**219**
Low Birth Weight	**100**
Congenital conditions	**16**
No of babies visited at 40-42 days old	**3.336**
Target person referred for complication	**247**
*To hospital	**212**
*To MCH for complication	**35**
For routine care or vaccination	**8.350**
MCH referrals to HVP	**2.388**
Antepartum women	**1.444**
Postpartum women	**479**
Newborn	**465**
Referrals from Malalai Hospital to HVP	**56**
No of mothers present during demonstration of supplementary food	**1.115**

However, when the midwives were asked to identify the prime source of referral to them, their responses overwhelmingly endorsed communities, as the following comments show: -

> ***'There is more contact from the people than from the MCH'***
> ***'When the MCH Clinic is open the communication is with the people'***
> ***'The people know us and if my son goes to the street he is known as the son of the delivery woman'***.

The above comments give credence to the establishment and reputation of the MCH/HVP within the areas they function.

The referral mechanism appears to be fairly flexible, with the main focus to provide maternal and child health care to women who are not receiving care from other sources. The midwives generally see the women during the last trimester of pregnancy and this reflects the earlier findings from the AICF survey in February 2000. The late contact is also shadowing the original implementation of the HVP, which defined two home visits to pregnant women. There was no apparent duplication of maternal health services or iron/vitamin medication for women. This fact was clarified during a meeting with the medical director/paediatrician at the MoPH clinic in Microrayon 3: -

> ***'it is a bi-lateral arrangement and it is very good and much appreciated'***
> Dr.Said Sarwar, Medical Director, Microrayon 3 MCH Clinic

Additionally, the HVP is now recognized by the *Char Qala* MoPH clinic, which is supported by AICF (referrals from this clinic during 1999 were reported as nil). It is the intention of ACIF/MoPH to refer all pregnant women who are under their care to the HVP midwives for post-partum care. This action could be extended to *Aqa Ali Shams Clinic* if AICF commence MCH activities in this district.

Increasing workload.

NGO funding of MoPH Clinics in Kabul now cover 10 of the 15 MCH centres that are currently operating. These clinics are a fraction of the original 42 facilities, as the closure of 27 clinics this year severely curtailed MCH services to women. In turn the closures will directly influence the workload of the midwives, as more women are likely to seek the services of the HVP. Indeed, the number of houses surveyed were considerable less in 2000 than in 1999, this drop could be linked into the fact that people are approaching the midwives directly, thus lessening the need to seek pregnant women out in their homes

Evidence of an increase taking place could be reflected in the numerical comparison of data that covers years 1999 (9 *months*) and 2000 (*10 months*). The difference in time span inhibits an accurate analysis, but it is possible to speculate that the workload is growing. Calculations of the average number of women seen monthly during 2000 = *2363.* When this figure x one month is added onto the 1999 figures it is shown that there has been an increase of approximately 3300 visits during the year 2000. The overall increase indicates a trend towards further growth for the programme.

Ultimately there is a strong likelihood that the workload of the HVP team will increase, not only due to clinic closures and the obvious needs of people, but also because of their growing reputation as service providers for MCH care. The team's perception and reality of their current workload has direct implications on future initiatives for the programme.

Other relevant issues have been raised in respect of MoPH/MCH clinics and referral mechanisms to and from the Tdh/HVP -

Access in relation to the closure of clinics

'Now I see a lot of patients'…&…'it is also presenting difficulties for the women to travel a longer distance to reach this clinic'. (Dr.Humani, a female doctor working at Microrayon 3 Clinic)

A mother visited in the area of *Shara-awa* was being seen for the first time at 36/40 gestation with her 4th pregnancy. The clinic at *Shara-awa* is one of the MoPH clinics that have been closed and the UNICEF Vaccinator referred the woman to the Tdh Midwives.

This same client had not received previous antenatal care for her 3 previous pregnancies and there was no history of her having received tetanus toxoid vaccine.

'The main problem for the women is that there is no opportunity for them to go to the clinic. No burqa, no shoes, no money for transportation, no MCH clinic in the area'.

The closure of 9 clinics within the Tdh 12 designated areas has also created problems for the midwives as they now travel longer distances to reach the relocated MoPH clinics.

'It takes time to reach the MCH clinics and can mean less time for work. We leave home earlier. There are more transportation costs, as it is further to travel – for some, not for all'

The effect for pregnant women will be felt even more acutely, as their low economical situation inhibits the women from seeking transportation or alternative health care. Equally relevant is the reality that seeking MCH care far from their own home could be prohibitive within the current climate of their society.

Access to care in relation to Tdh referrals.

From another client in Shash Darak who was receiving care from the midwives during her 10th pregnancy and booked for a hospital delivery due to her past obstetrical history (4 live births + 6 early neonate deaths): -

'Just one time in my life I went to the hospital because of the HVP referral, but at the hospital they asked about payment to estimate my blood – I had no money and come home'

It is not possible to comment more fully on this situation without knowing more facts, but it is known that there is a problem with diagnostic testing. At the Microrayon 3 MCH clinic clients are frequently requested to seek a blood test outside the centre at a private laboratory. Additionally a supervisor/trainer identified that there was a severe lack of good laboratory clinics in Kabul.

Supervisors and midwives also described how some families do not accept the advice to go to the hospital or MCH. This situation relates into the poor socio-economic circumstances of families, with transportation costs cited as being a problem. There is the additional difficulty of the nightly curfew, with families having to face obstacles in the process of travelling 'after hours'.

Late presentation of pregnant women for antenatal care

All of the women visited during the evaluation were in the latter stages of pregnancy and relate to the HVP policy of normally visiting twice during the antenatal stage. The Tdh/MCH team acknowledged that women generally presented late in their pregnancy for

antenatal care.** This fact was associated with cultural norms and the difficulties mentioned in respect of access to MCH care.

However, another rationale could be based on the women's own personal expectations of maternal care, based on their previous experiences of the availability or non-existence of services – as shown below: -

'I did not receive ante-natal care during previous pregnancies, as I lived in the provinces before coming to Kabul'. (Mother pregnant with her 7th child visited in Parwan 3 area by the Tdh midwife following an MCH referral) Two female relatives also present confirmed this same situation. One of the women had moved to Kabul during her last pregnancy in order to receive care because of obstetric problems in a previous pregnancy.

A post-partum client seen in *Parwan 3* had fled to Kabul because of the fighting in the Northern Provinces and echoed the same sentiments - ***'this is the first time I have received care. I was referred to Tdh from the MCH clinic'.***

** Reference made in 2.1 from the AICF survey.

How expectations can change

Appreciation for the Tdh midwives came from several homes visited, but a particularly positive outcome of the HVP was seen in the area of Qala-Bakytar. At this visit the midwives saw 3 pregnant women and 1 post-natal mother, but another 3 previous clients of the HVP also joined the group. Families were obviously well known to the midwives and they actively sought out pregnancy care when needed, thus proving how expectations could change when an appropriate and regular antenatal and postnatal health service was provided in communities. Without exception the women expressed much appreciation for the work of the Tdh midwives.

This visit was also positive for other reasons, as women could break free from the restraints they face when they gave a short display of dancing and drum playing – in celebration of a wedding the day before.

Comments

There are apparent difficulties being faced by both clients and midwives in respect of access and referrals to MoPH/MCH clinics and hospitals. The problems have been exacerbated this year by the closure of more than 50% of MoPH MCH clinics. It is questionably if the remaining 15 clinics will be able to respond to the health needs of mothers and children in Kabul City.

The issue of availability of MCH care is also synonymous with accessibility and the actual provision of resources – human and material. A visit to Macrorayon 3 Clinic demonstrated the bleak working conditions that MoPH staff continues to endue. Besides the very low salaries paid to them, they lack chemical reagents for laboratory tests, very limited equipment, such as stethoscopes, blood pressure recording machines, adult weighing scales and medicines. The Microrayon 3 Medical Director, who constantly grapples with a chronic shortage of basic drugs, stressed the problem of being unable to treat mothers and children. The only solution was to give them a prescription in order to seek a private purchase. However, as clients had *'no money for food'* then it is certainly questionable how mothers could afford the cost of medicines.

Data Recording/Home Birth Kits and Medicines

Given the limited time available for this evaluation the data recording processes were not pursued in depth. In this respect it was, perhaps, unfortunate that the MCH team did not have access to the 1998 Evaluation Report, which concentrated heavily on the process of data collection within the program. Questions were raised with the team during this evaluation in respect of the large number of women present during the giving of health messages. It was clarified that the figures given comprised adults only, with children not included.

The distribution of iron, vitamins and folic acid were reviewed and the system of distribution was clearly seen to be adequate, both within the pre and postnatal visits. The administrator (also a pharmacist) described the supply of medicines as satisfactory, both in quantity and quality. Home Birth Kits provided sufficient and essential items, apart from the bars of soap; this fact has already been noted.

In respect of information for the client, she will keep a paper for herself and the baby, which she can take to the MCH clinic if needed. However, the results of a 2.5 month program evaluation, which was undertaken 1999, revealed that the mother and baby records were not being fully completed. This finding indicates that the MCH team is now actively seeking out shortfalls in their data collection and rectifying procedures, as necessary. Independent changes by the MCH team have also been made in the method of presenting the data findings, in order to clarify and avoid duplication of recording.

As the midwives work in pairs their roles are evenly divided between the process of recording home visit activities and the practical transaction between client and health worker. This method provides the main thrust of HVP quantitative data; it also ensures that a permanent reference of client/midwife contact is available. However, the fact that two well-trained midwives have to accompany each other (due to restrictions/culture) is, unfortunately, not a good utilization of human resources and poses questions on how/if this situation could be changed.

The HVP is unique in Kabul City.

There is no other home service being offered to women in need of ante-partum, intra-partum and post-partum care. Undoubtedly the work of the Tdh/MCH/HVP team has contributed towards making childbirth safer by the improvement of maternal and infant health.

Access to MCH health care for women at home has improved as a result of the HVP.
This report has given clear findings to validate how access of MCH has been enhanced for women. The TOR requested that equality of access be sought; however such an exploration was not truly feasible. Equality of access implies the inclusion of males and females and although it could be presumed that men have more freedom to gain access to health services, there are factors that are likely to inhibit men using them. For instance, in Kabul City the health resources do not appear to meet the needs of both the male and female population, and economic hardship affects the whole of the family, including men.

Maternal and Infant Mortality

Analysis of the data for the ten months of *2000*, with the assistance of Dr.Carlos at Tdh HQ, shows the following findings. (Having been an initiator of the HVP at its inception, Dr.Carlos expressed satisfaction with the results).

Maternal Mortality was 1.1% = 110 per 100,000

Perinatal Mortality (stillbirths and neonates) was 16.4% per 1,000

Neonate Mortality was 7% per 1,000

A key objective of whether mortality and morbidity of mothers and newly born infants has been reduced since the onset of the programme is less tangible. At the onset of the HVP it was not possible, due to conflict and constant migration of the population, to gain MCH statistics from the 5 piloted areas, therefore a comparison of data before and now has not been possible.

Recommendation

That continued careful data recording is maintained, in order that future evaluation of quantitative statistics will be accessible and accurate. Where possible, **indicators of change** should be introduced into planning procedures in order that future assessments will have guidelines on which to base their findings. The ongoing evaluation of the programme in a qualitative method should also be aimed for, wherever possible.

Maternal and Infant Morbidity

Infections are the main cause of both infant and maternal morbidity. The activities of the home-visiting midwives stress the importance of personal hygiene with every visit they make to clients. Infections, however, have continued to persist, for all the reasons stated within this report. It is difficult to resolve the socio-economic factors that predispose to poor hygiene, but actions could help to alleviate and reduce the incidences of infection during the post-partum period.

Recommendations

As the supply of soap to mothers is unable to last the whole of the post-partum period it is recommended that two bars of soap for every client are added to the Home Birth Kit. The soaps would not be given out to the women at the same time, but left to the discretion of the visiting midwife when to distribute the second bar.

If discussions on personal hygiene do not approach the question of sexual hygiene, then action to include this topic in the health messages is advised. The team may need to have clear guidance on how to introduce the issue within their protocols.

Liaison to take place between agencies that are working on water & sanitation to see if there are grounds for working together on mutual issues in relation to safe hygiene

That steps are taken immediately to differentiate and record between infections that are linked into hospital or home deliveries: this action should also distinguish between who actually performs the delivery of a mother, or baby, that becomes infected.

Immunizations

The midwives are promoting awareness amongst clients on the importance of vaccinations and referring women to MCH clinics for their Tetanus Toxoid immunizations. The report has shown evidence, albeit limited, that the level of immunization uptake in Kabul is poor. Although it was stated from a MoPH clinic that follow-up is made to the mothers, the midwives were not aware of this happening, unless it took place on National Immunization Campaign days.

The midwives are in the position of visiting families every day, thus making contact with many women, often on occasions other than the HVP.

Recommendation

That a policy of advocating and checking up on immunizations should be introduced into the programme – not just for Tdh clients, but whenever the midwife is visiting families. It is also possible that the task of promoting immunizations could be disseminated to other people, such as TBA's. It would be advised that discussion on the whole issue be pursued at the MoPH clinics with the MCH Vaccinators.

Food and Access Food

Without doubt the deepest problem being faced by women and their families has been the inability to access food because of poverty. This point was referred to many times during the report, both from the wider level of statistical data and from the voices of the clients and midwives. It is a fundamental fact that MCH care cannot be viewed solely from the standpoint of technical skilled care. Safe motherhood has its roots firmly embedded in the nutritional state of the mother, both on the macro and micro nutrient level. Her well being has repercussions on the health of her baby and the family as a unit. How to take steps to improve this situation is fraught with problems. In respect of the Tdh/HVP two steps could be taken: –

Recommendations

Further research be undertaken into the work being done by other International agencies, in respect of food aid to families in Kabul. Already evidence has been given of the work being done by AICF.

That Tdh undertake research into the daily food consumed within HVP households, i.e. type and quantity. If time constraints do not allow the midwives to research, then the study to be referred externally.

That the CARE funded BP-5 supplementary biscuits be supplied for as long as possible. There is no doubt that the biscuits would be going to those women that required them.

Contraception

Birth spacing is discussed during the health messages given by the midwives. It is closely linked into the relationship between lactation, very frequent breast-feeding and the reduction in a woman's fertility at that time. Mothers also asked for other methods of contraception. They are aware of contraception, as at least one NGO in Kabul is providing supplies. Whilst the funding and supply of contraception is not being recommended at this stage, it is suggested that Tdh consider this as a future option.

Supervision and Training

Mechanisms of supervision are being well provided to the midwives. Likewise the communication between all staff is evidently good. Accordingly, the training that the midwives receive is stated to meet their needs, apart from the fact that they are keen to learn English and to have more information and training from other NGO's working in Kabul. However, from the view of the trainers there are specific needs.

Recommendations

That up-to-date educational materials be provided for the senior staff in order that they can provide continuing education to meet the needs confronting them from the home visiting midwives. Journals or appropriate information from the Internet would be very helpful, but need the support and assistance of staff outside of Kabul.

Alternative learning and teaching mediums, such as workshops and seminars to be explored. This could be done through NGO's working in Kabul, but the opportunity to take individuals or small groups outside of the country for training is also suggested. By taking such action would not only help to fulfil a professional need for the staff, it would also provide support for them in their difficult circumstances.

The possibility of an English course for all the staff to be explored.

Assistance to be given to the co-ordinator in the training needs she has identified, namely, management, project proposal writing, budget monitoring and training on gender issues.

Consideration to be given to the request for additional transportation from the supervisors/trainers, in order that they can maximize their time in the field with the home visiting midwives.

Additional staff/communication

The workload is increasing for the administrative staff, as well as for the midwives. This situation is also intensified by the time-consuming task of preparing medications for delivery to clients, coupled with the process of recording stock intake and output.

Currently it is very difficult for both the Peshawar and Kabul teams to exchange information swiftly due to a lack of telephone in the MCH office and a lack of access to e-mail. This situation is particularly difficult for the female MCH/HVP staff

Recommendations

To appoint an additional female to assist the MCH administrator, as the office work is continuing to increase in volume. It is also suggested that a pharmacist be employed, possibly part-time, to take on the responsibilities of the medicine supplies.

In whatever way possible, that communication systems between the Kabul MCH and Tdh offices to the Peshawar office be improved. If feasible, that a female Tdh delegate be appointed in Kabul. Such action could greatly enhance the communication and support for all concerned in the HVP.

Expansion of the HVP

Throughout the process of this evaluation there has been the question of whether the Tdh/MCH/HVP should be expanded in order to meet the undeniable needs that exist in Kabul City. It is fully recognized that further development was being considered prior to this report and this issue has been considered throughout the report. Discussions took place in Kabul with the Co-ordinator, Dr.Noorkhamum on WHY an increased HVP was required and WHAT would be the best way forward.

The period since the re-commencement of official HVP activities in March 1999 has shown the most consistent flow of work and information stemming from the Kabul MCH team. Apart from a short gap this year, due to further impositions on female workers, the programme has grown in strength and reputation. The latter is reflected in the demands being made upon the team as a whole and, therefore, further contributes to how expansion of the programme would best be placed for the future.

One issue, questioned with staff in Peshawar and Kabul, was the need for earlier antenatal screening of pregnant women. It was evident that the HVP attended women in the latter stages of their pregnancy. This fact relates into initial project planning and also into

cultural norms and expectations of antenatal care. Suffice it here to say that the obvious advantages of early antenatal care are well known and documented.

The issue here is whether the HVP team can cope with the additional workload of more antenatal coverage – in spite of the obvious benefits to the client. It is also an undisputed fact that communities are expressing a need for a Tdh/MCH programme. The closure of the MCH MoPH clinics is already creating increased pressure for the midwives and Tdh staff, with midwives unable to cover the areas assigned to them. The distances are simply too far and the population too large for them to access on foot, which is their normal mode of travelling to clients. This assessment considers that earlier antenatal care would be advantageous to the clients not already served by other MCH providers. However, this statement has to be weighed against all the other points mentioned.

CONCLUSION

This report has tackled varying issues relating to the Tdh/MCH/HVP and it seems relevant at this final stage to contemplate how other changes could be introduced into the activities that are being so ably provided.

Within the context of Afghanistan's turbulent history over the past two decades it is not surprising that the Kabul MCH/HVP has followed a path of service delivery to the population its serves. However, in all situations there are chinks of light and possibilities to create project ownership from the people themselves by a move towards social development within the activities being undertaking. For instance, a few of the women seen (past and present clients) displayed a very keen willingness to share the knowledge they had gained; this was coupled with a confidence in their ability to teach other women. This demonstration of how knowledge has enabled some women to be 'empowered' is heartening and indicates that change is possible. Recognition of the importance of this small, but significant progress is vital.

The HVP has now been operating for more than five years, albeit on a stop and start basis at times. The time is ripe for exploring ways that social development and empowerment of the clients could be fulfilled – over time. The example given of health education providing mechanisms of change and empowerment has been given, and this could be enhanced. The examples from the Tdh programme in Gaza, have shown how the participatory work of **Community Animators/Health Education and Support Groups** has led to positive change – even in a very difficult environment. It is recommended that Tdh give consideration to introducing a similar, but less ambitious scheme (to begin with) into the context of the HVP in Kabul.

Practical and theoretical support would be required in order to assist the MCH team to bridge the transition from service tract delivery to that of service tract combined with social development. The HVP is fortunate to have the expert resource of the Tdh delegate in Peshawar, who has a strong background in social work and women's development.