International Journal of Scientific & Engineering Research
ISSN 2229-5518

Observing of Antenatal and obstetric care in Afghanistan – a study among health care receivers and health care providers

Dissertation submitted in partial fulfillment of the requirement for the award of the degree of Master of MHA

Submitted by

Drs. Yalda Nazari Husaini

RollNo. 16035352110004

MHA Batch 2018

Supervisors

Dr Rashmi Rathore

Associate Professor

Ms. Bhawna Sati

Assistant Professor

Maulana Azad University

Co- Supervisor

Dr. Saida Said

Executive Manager of Maternal Hospital

Department of Public Health, Maulana Azad University, Jodhpur

International Journal of Scientific & Engineering Research
ISSN 2229-5518

Observing of Antenatal and obstetric care in Afghanistan – a study among health care receivers and health care providers

Dissertation submitted in partial fulfillment of the requirement for the award of the degree of Master of MHA

Submitted by

Drs. Yalda Nazari Husaini

RollNo. 16035352110004

MHA Batch 2018

Supervisors

Dr Rashmi Rathore

Associate Professor

Ms. Bhawna Sati

Assistant Professor

Maulana Azad University

Co- Supervisor

Dr. Saida Said

Executive Manager of Maternal Hospital

Department of Public Health, Maulana Azad University, Jodhpur

International Journal of Scientific & Engineering Research
ISSN 2229-5518

Observing of Antenatal and obstetric care in Afghanistan – a study among health care receivers and health care providers

Dissertation submitted in partial fulfillment of the requirement for the award of the degree of Master of MHA

Submitted by

Drs. Yalda Nazari Husaini

RollNo. 16035352110004

MHA Batch 2018

Supervisors

Dr Rashmi Rathore

Associate Professor

Ms. Bhawna Sati

Assistant Professor

Maulana Azad University

Co- Supervisor

Dr. Saida Said

Executive Manager of Maternal Hospital

Department of Public Health, Maulana Azad University, Jodhpur

Certificate

This is to certify that the Dissertatin entitled " **Observing of Antenatal and obstetric care in Afghanistan – a study among health care receivers and health care providers" is a record work undertaken by Dr. Rashmi Rathore in partial fulfillment of the requireents for the award of the degree of MHA under my guidance and supervision.**

Signature of Site-Supervisor:

Name of Site- Supervisor: Prof. Dr. Saeda Saeed
Director of Maternity
hospital

Name of Site- Supervisor: **Drs. Saeda Saeed**

SUPERVISOR:

Date: 09-27-2018

JODHPUR SCHOOL OF MASTER OF HOSPITAL MANAGEMENT

DECLARATION BY THE CANDIDATE

I hereby declare that this Dissertation entitled" **Observing of Antenatal and obstetric care in Afghanistan – a study among health care receivers and health care providers**" is a bonafide and genuine record of my original l field research. It has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text**.**

Signature of Candidate:

Name: Drs. Yalda Nazari Husaini

Date: 09-21-2018

Table of Contents

LIST OF ANNEXURES

INTRODUCTION

Research Question:

Why Afghanistan has been one of the worst countries for pregnant mothers and babies with respect to high level of maternal and child mortality?

Abstract

Background

The mortality and morbidity of pregnant women and new born babies has been still in tough issues in Afghanistan. There were multiple obstacles to prevent pregnant women to reach and visiting doctors. The situation of rural pregnant people was completely hardest due to lack of knowledge, transportation, security, female staffs and wrong virtue to visits doctors.

Objectives:

1- To understand the factors associated with High Mortality for both mother and child.
2- To get an understanding of problems like finance, transportation, lack of knowledge .

Methodology and Study design:

We conducted a qualitative explorative study to gather information from participants from the selected rural and urban areas in Heart city. We employed face-to-face in-depth interviewing (IDI) and focus group discussion (FGD) methods to generate data.

Results

In recent reports, It has been showed which the morbidity and mortality of pregnant women and new born babies is declined since 2014. The government and International organization have been investing in a very large scale to train staffs and improve the quality of clinics and hospitals in both urban and rural to reduce the hardest issues. The research showed the educated family has been visited monthly for checkups during pregnancy, on other hand; it was still an issue in rural area which most of the pregnant women have been visiting once they confronted with complication (Vaginal Bleeding, Ecclempcia, absent fetal movement …)

Conclusion

There are clinics in all districts of Herat provinces. They diagnosed some simple disease because the specialist trainers could not able to work on those clinics due to lack of transportation and security issues. Therefore, there were not applicable to treat like obstruct labour, ecclampsia and when they deliver to the city due to lack of securities and transportation most of pregnant women were death.

OVERVIEW ABOUT STUDY POPULATION

Acknowledgement:

Writing a research is always a lengthy and time consuming affair. The research was a result of developing ideas and formulating strategy; then taking another large chunk of time actually writing, rewriting, editing, and then rewriting again. Throughout this process, a number of individuals have provided incredible support and inspiration. Some have helped to build the intellectual foundation while others have provided the intense personal support to push ahead and finish the research. All together they are the driving forces behind this research.

I wish to acknowledge the effort of our major professors and mentors in our academic programs: Professor Bahwna sati of Maulana Azad Univeristy; Professor Rashmi Rathore of Mawlana Azad University. Without the formative insight of these individuals and their guidance and acknowledgement would never have been followed.

Special thanks is also given to my co supervisor Dr. Saeda saeed who granted me to take interviews from pregnant women in hospitals and provided significant reports about the mortality and morbidity of mothers and antenatal care of pregnant mothers during pregnancy.

Moreover, I do special thanks to my beautiful family; Mr. Sayed Ramiz Husaini the National Administrator of the Philip C. Jessup International Law moot court competition that have provided hours of intellectual debate, sometimes lasting deep into the evening hours.

Background

Every year some eight million women suffer preventable or remediable pregnancy-related complications and over half a million will die unnecessarily. Most of these deaths could be averted at little or no extra cost, even where resources were limited, but in order to take action, and develop and implement changes to maternity services to save mothers and newborns lives, a change in cultural attitudes and political will, as well as improvements in the provision of health and social care, is required.[1]

In sub-Saharan Africa, a number of countries halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway was made. Between 1990 and 2015, the global maternal mortality ratio (the number of maternal deaths per 100 000 live births) declined by only 2.3% per year between 1990 and 2015. However, increased rates of accelerated decline in maternal mortality were observed from 2000 onwards. In some countries, annual declines in maternal mortality between 2000–2010 were above 5.5%.[2]

The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occurred in developing countries. More than half of these deaths occurred in sub-Saharan Africa and almost one third occur in South Asia. More than half of maternal deaths occur in fragile and humanitarian settings.[3]

The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries. There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural versus urban areas.

[1] The World Health Organisation Annual Report for 2005

[2] Lewis G, de Bernis L. Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development. Geneva: WHO Organization, 2007. See: www.who.int (ISBN 92 4 159367 9) [PubMed]

[3] Global Causes of Maternal Death: A WHO Systematic Analysis.

Over 99% of mothers die in developing countries. To better understand the true burden of maternal deaths worldwide, the WHO and its UN partners developed statistical estimates of the true number of maternal deaths and each country's own MMR.[a] The latest estimates, for the year 2005, are shown in Table 1.[2]

Table 1

Maternal mortality estimated by World Health Organization/United Nation Regions: 2005[4]

Region	**Maternal mortality ratio (MMR)**	**Numbers of maternal deaths**	**Lifetime risk of maternal death, one in:**
World total	400	536,000	92
Developing regions*	9	960	7300
CIS (central Asian states)[†]	51	1800	1200
Developing regions		533,000	75
Africa	820	276,000	26
Northern Africa	160	5700	210

[4]Maternal Mortality in 2005. Estimates Developed by WHO, UNICEF, UNFPA and The World Bank. Geneva: WHO, 2007. See: www.who.int/reproductivehealth

Sub-Saharan Africa	900	270,000	22
Asia	330	241,000	120
Eastern Asia	50	9200	1200
South Asia	490	188,000	61
South-Eastern Asia	300	35,000	130
Western Asia	160	35,000	130
Latin America & the Caribbean	130	15,000	290
Oceania	430	890	62

There were very less researches taking place about the antenatal care in Afghanistan. However, the potential of antenatal care for reducing maternal morbidity and improving newborn survival and health has been widely acknowledge. The antennal period provides excellent opportunities to reach pregnant women with prophylactic medication, vaccinations, diagnosis and treatment of infectious diseases, as well as with health education programs. Proven effective antenatal interventions included serologic screening for syphilis, provision of malaria prevention, anti-tetanus immunization and prevention of mother-to-child-transmission of HIV.

Based on report the Antenatal care in Afghanistan was not professional[5]. Moreover, multiple obstacles were identified, including lack of knowledge regarding the importance of antenatal care among the women and their families, financial difficulties, traditional birds and transportation problems in Afghanistan. Despite these serious concerns, there were lack of Maternal Hospitals in Herat city and there were not enough professional staff to prevent well from morbidity of Mothers and new born babies in Hospitals. But, the women expressed gratitude for having even limited access to health care, especially treatment provided by a female doctor. Health professionals were proud of their work and enjoyed the opportunity to help their community.

Rational

Based on WHO reported; It was obligatory which all pregnant women should have at least 4 visits during their pregnancy. But, In Afghanistan 60% of pregnant women attend at least one antenatal visit, only 16% attend the recommended number of four antenatal visits.[6] Although, they faced completion during pregnancy and also the morbidity of mothers and new born babies were in high level, but It was still unknown why mothers and families do not attend for visits during pregnancy.

Objectives

This research were clarified several obstacles which must be addressed to improve reproductive health care in Afghanistan. Because, we needed to understand the factors associated with High Mortality for both mother and child. In addition, It was needed to understand the Importance of antenatal care provided by care givers. Moreover, advice about family planning and teach the mother about child care, nutrition, sanitation and hygiene. Furthermore, the study will guide the Mothers to know the basic care to decrease maternal and infant mortality and morbidity during antenatal.

[5] UNICEF manual report
[6] UNICEF Report

REVIEW OF LITERATURE

Literature Review

Barun Bhai Patel **et al (2016)in their study on knowledge and practices of antenatal care among pregnant women Hospital of Pune,**

Maharashtra found that about 58% women had adequate knowledge regarding ANC. It was found that almost all the variables such as age, education, occupation, parity, type of family, and socioeconomic status (SES) had a significant association with awareness about ANC. 100% women were having a positive attitude toward ANC. Around 70%, women were practicing adequately, and variables such as education and SES had a significant association with practices about ANC.

Bartlett LA ,et al (2005)in their study found Maternal mortality in Afghanistan is high and becomes significantly greater with increasing remoteness.

Gross K et al(2011)in their study about **Antenatal care in practice in the Kilombero Valley, south-eastern Tanzania** found The delivery of antenatal care services to pregnant women at the selected antenatal care clinics varied widely. Some services that are recommended by the Focused Antenatal Care guidelines were given to all women while other services were not delivered at all.

Zuhal Rahmani et al (2013) in their study about **Antenatal and obstetric care in Afghanistan found** Despite attempts from the government to improve ante- and perinatal care, Afghanistan has once again been labeled “the worst country in which to be a mom” in Save the Children’s World’s Mothers’ Report.

R. Arnold et al in their study about **Understanding Afghan healthcare providers: a qualitative study of the culture of ca**re in a Kabul maternity hospital found A large workload, high proportion of complicated cases and poor staff organisation affected the quality of care. Cultural values, social and family pressures influenced the motivation and priorities of healthcare providers.

P. Mannava et al in their study about **Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review** found

High maternal mortality and morbidity persist, in large part due to inadequate access to timely and quality health care. Attitudes and behaviours of maternal health care providers (MHCPs) influence health care seeking and quality of care.

Yasir bin et al(2016) in their study about Qualitative exploration of facilitating factors and barriers to use of antenatal care services by pregnant women in Pakistan Found several policy-relevant facilitating factors and barriers to visiting a health facility for antenatal care services as reported by urban and rural women, and healthcare providers. There is a need to formulate and implement intervention packages based on these findings to increase the coverage of the recommended four antenatal care visits in Pakistan.

J Roberts et al (2015) in their study about The patient-provider relationship and antenatal care uptake at two referral hospitals in Malaw found Approximately 90% of Malawian women attend antenatal care at least once during their pregnancies; however, most mothers first present during months five and six and do not adhere to the World Health Organization's recommended four visits. The objective of this study was to explore the role the patient-provider relationship has on antenatal care uptake.

Samim faramarz (2017) about Maternal, Child Mortality Rate Still A Cause For Concern found maternal and child mortality rate in Afghanistan is still a matter of concern and that midwives should work to help eradicate the problem.a number of midwives said the lack of basic healthcare services and the lack of development in the sector are key problems they face.

- Kaisa Raatikainen(2007) about Under-attending free antenatal care is associated with adverse pregnancy outcomes found pregnant population, 1.0% had no antenatal care visits and 0.77% had 1–5 visits. Under- or non-attendance associated with social and health behavioral risk factors: unmarried status, lower educational level, young maternal age, smoking and alcohol use. Chorio-amnionitis or placental abruptions were more common complications of pregnancies of women avoiding antenatal care, and pregnancy outcome was impaired.

Klaus Hornetz et al (2016) in their study about **Antenatal Care Utilisation and Content between Low-Risk and High-Risk Pregnant Women** There were 26% of the high-risk women that had inappropriately low utilisation given that high-risk women were expected to have intensive utilisation for frequent visits to monitor their risk conditions. Around half of these 26% of the high-risk women were referred to a hospital for additional care. However, nearly the other half of these women had no documented referral to a hospital. This could partly be explained by possible non-documentation of these referrals. Some of the women might also have, out of their own initiative, attended private clinics parallel to receiving ANC at the public clinics which was not reported to the public clinics. This implies the need for further research.

- Fred Louckx et al (2010) about **Determinants of the number of antenatal visits in a metropolitan region found** Data on antenatal care trajectories in 333 women were collected. The multivariate analyses showed that women with a Maghreb or Turkish origin had 14% fewer visits compared with European (EU15) women. More highly educated women had 22% more visits compared with those with a low education. Women with a high income had 14% more antenatal visits compared with those with a low income. Fewer antenatal visits were observed in multiparae (15%), women initiating care after 14 weeks of gestation (31%), women without medical risks during the pregnancy (12%) and in women with a continuity of care index of 50% or more (12%). More visits were observed in delivering after week 37 (22% increase)
- Dr LaleSay et al (2014)in their study about Global causes of maternal death: a WHO systematic analysis found all maternal deaths between 2003 and 2009 were due to direct obstetric causes and deaths due to indirect causes accounted for 27·5% (672 000, 95% UI 19·7–37·5) of all deaths. Haemorrhage accounted for 27·1% (661 000, 19·9–36·2), hypertensive disorders 14·0% (343 000, 11·1–17·4), and sepsis 10·7% (261 000, 5·9–18·6) of maternal deaths. The rest of deaths were due to abortion .
- Haseebullah Niayesh et al (2015)in their study about Infant and under-five mortality in Afghanistan found.
- According to the State of the world's children, Afghanistan's under-five mortality rate of 257 deaths per 1000 live births is the third highest in the world, surpassed only by the rates for Angola and Sierra Leone1 Cited infant mortality rates for 2005 are also very high, at 165 deaths per 1000 live births.1 However, these are model-based projections that have not been updated

since at least 1993,2 despite widespread changes in Afghanistan over the intervening period, such as the implementation of the Basic Package of Health Services in 2003 and 2004.

- TaufiqMashalPhDd et al (2015) in their study about Achieving maternal and child health gains in Afghanistan found Between 2003 and 2015, Afghanistan experienced a 29% decline in mortality of children younger than 5 years. Although definite reductions in maternal mortality remain uncertain, concurrent improvements in essential maternal health interventions suggest parallel survival gains in mothers. In a little over a decade (2003–13 inclusive), coverage of several maternal care interventions increased—eg, for antenatal care (16% to 53%), skilled birth attendance (14% to 46%), and births in a health facility (13% to 39%). Between 2005 and 2013, the number of deployed facility and community-based health-care professionals also increased, including for nurses (738 to 5766), midwives (211 to 3333), general physicians (403 to 5990), and community health workers (2682 to 28 837). Multivariable analysis of factors contributing to overall changes in skilled birth attendance and facility births suggests independent contributions of maternal literacy, deployment of community midwives, and proximity to a facility.

  Kaartinen L et al (2002) in their study about Mother and child health care in Kabul, Afghanistan with focus on the mother: women's own perspective found Sixty one of the 100 women in the community delivered at home exclusively, 35 having experienced both home and institutional deliveries, four women had hospital childbirths only. Approximately half of the women decided about utilizing the modern MCH services themselves. Women valued in the MCH-clinic mainly medical care and vaccinations.

MATERIALS AND METHODS

7. Methodology

We conducted a qualitative explorative study to gather information from participants from the selected rural and urban areas in Heart city. We employed face-to-face in-depth interviewing (IDI) and focus group discussion (FGD) methods to generate data. The detailed methodology has been presented in another publication, in which we reported the findings on the perceptions and practices relating to iron/folic acid supplementation during pregnancy.

The data of research is accomplished by **qualitative** in different local and private clinics in Herat city.

Method	Sepecification	Number
Observation	ANC Clinics of selected hospital	3
FGDs	Pregnant women for ANC of Hospital Companion with Pregnant Women Antenatal Care providers of Hospital	3 3 3
KIIIs	MOPH RCH Officer/ Hospital Head/ 2 Gynecologists/ Political Leader/ Religious Leader/ Midwife / TBO	8

Sampling was purposive and the respondents were selected from the urban and the rural areas. I conducted six IDIs with LHWs, four IDIs with doctors, ten IDIs with currently pregnant women and ten FGDs with women who had a child aged 5 years or younger. In Karokh District, out of 56 union councils (the smallest administrative unit), we selected three union councils that were Predominantly rural population, served by the LHW Programmed, and had functioning first level government health facilities. From each union council we randomly selected two villages. In each selected village, IDIs with a local LHW and a currently pregnant woman were

conducted. The currently pregnant woman was selected randomly from a list of currently pregnant women, which was prepared with assistance of the local LHW. A FGD with women who had a child aged 5 years or younger was conducted in each village. Six to eight women who were identified by the local LHW participated in each FGD.

The interview was taking place from March – May 2018 in heart province in Afghanistan.

The location was in Herat maternal hospital, Afghan Apollo hospital and laqman Hakim hospital.

Herat Maternity Hospital is one of the largest women's hospital in Afghanistan,

with 90 –100 births daily.

Afghan Apollo hospital: private clinic providing obstetric services as well as internal medicine and surgery.

Laqman Hakim hospital.: Loghman Hakim, non-governmental organization and provides mainly reproductive health services.

Sample design- simple Purposive sampling

Inclusion criteria: pregnant ladies/ recent delivered (within 5 hours) and doctors/ care givers.

Exclusion criteria: Non pregnant, C-S, PNC

RESULTS

Result:

The materiality morbidity of pregnant women and new born babies were the hardest case in Herat, Afghanistan. The poorest economic and lack of interest was the main obstacle to attend monthly visit to doctors. It rises of lack security in urban area and as well transportation to communicate it well.

Even if public antenatal care exists in Afghanistan and the government recommends routine check-ups, My research study confirmed underuse of these resources. My study identified numerous reasons why women may not utilize these accessible and available services. Participants reported several obstacles, including their own personal views and beliefs, family decisions, financial reasons, as well as transportation difficulties. The National Reproductive Health Strategy 2006–2015 document states that more than 60% of families in Afghanistan who did seek help encountered barriers either because of costs or poor quality offered at the only accessible health care facility "Health care knowledge and ability to seek care decline with remoteness and low literacy rate. Decisions to seek care are also influenced by the family's perception of accessibility. Families do not seek care because of lack of transportation, insecure travelling conditions and inability to afford either transport or care."

Amongst all top problem, but It has done lots of working by government and international agencies to tackle with issues and holding programs to grow up the quality of knowledge to reduce the morbidity and mortality of pregnant women.

The research which was taken by UNICEF is supported my research thesis the morbidity of and mortality of mothers and new born babies is declined.

Table 3

Antenatal care coverage: at least one visit - Percentage								
Last update: December 2017								
			Total	Place of residence		Household wealt		
ISO Code	Countries and areas	Year(s) of data collection		Urban	Rural	Poorest	Second	Middle
AFG	Afghanistan	2015	59	72	55	50	50	54
AFG	Afghanistan	2013-2014	63	84	58	-	-	-
AFG	Afghanistan	2011-2012	51	78	46	-	-	-
AFG	Afghanistan	2010-2011	48	77	41	26	38	42
AFG	Afghanistan	2010	60	85	54	44	58	60
AFG	Afghanistan	2008	36	-	-	-	-	-
AFG	Afghanistan	2003	16	38	8	-	-	-

Source: UNICEF Global databases 2016 based on MICS, DHS and other national household surveys.

Table 4

Antenatal care coverage: at least four visits - Percentage											
Last update: December 2017											
ISO Code	Countries and areas	Year(s) of data collection	Total	Place of residence		Household wealth quintile					Source
				Urban	Rural	Poorest	Second	Middle	Fourth	Richest	
AFG	Afghanistan	2015	18	32	14	11	11	14	20	34	DHS KIR(Prelim)_2015
AFG	Afghanistan	2013-2014	23	-	-	-	-	-	-	-	Living Conditions Survey_2013-2014
AFG	Afghanistan	2010-2011	15	33	11	6	8	11	17	32	MICS_2010-2011
AFG	Afghanistan	2010	16	34	12	-	-	-	-	-	DHS_2010

Afghanistan was still one of the worst countries which the level of morbidity was in high level. Based on report the Antenatal care in Afghanistan was not professional[7]. Moreover, multiple

[7] UNICEF manual report

obstacles were identified, including lack of knowledge regarding the importance of antenatal care among the women and their families, financial difficulties, traditional birds and transportation problems in Afghanistan. Despite These serious concerns, there were lacks of Maternal Hospitals in Herat city and there were not enough professional staffs to prevent well from morbidity of

Mothers and new born babies in Hospitals.

The World Health Organization (WHO) said; Afghan mothers' and children's mortality remains among the highest in the region.

Several factors affect the health system's capacity to reduce the risks that pregnant women face – access to and use of maternal and reproductive health services was still limited and the quality of services was lowed as a result of service delivery capacity, particularly in difficult-to-reach rural areas, the WHO reported.

DISCUSSION

Questionnaires

Two semi-structured questionnaires designed specifically for this study were used, one for patients and one for health care providers (Appendix: I and II). Patients were asked about education, parity, present or previous pregnancy complications, help-seeking behavior, obstacles to receiving antenatal or obstetric care, sources of information regarding pregnancy, expectations and satisfaction regarding care, and how they had been received by health care providers. Doctors, midwives, and birth attendants were asked if they were familiar with national guidelines for antenatal care, if they adhered to these guidelines (or why not), their own views on the quality of care they were able to provide, and personal attitudes towards patients. They were also asked about areas needing improvement and personal views on reasons for treatment delay.

Questionnaire I

Patient Questionnaire

•Age

•Years of education

•Number of previous pregnancies. Any complications?

•Have you attended antenatal check-ups regularly in this pregnancy, or only when you felt the need for it?

•Who has carried out your check-ups?

•Any obstacles to attending check-ups?

•Who has provided information regarding pregnancy and childbirth? (Health professionals, friends, relatives, media, etc.)

•Have you found the information sufficient and satisfactory?

•Do you feel confident you will receive the care you need in your pregnancy?

•How do you feel about the care you receive here? (in this clinic)

•What are your experiences with the attitudes and behavior of the health personnel?

Questionnaire II

Health Care Provider Questionnaire (i.e., doctors, midwives, traditional birth attendants)

•Do you know if there are national guidelines for antenatal care?

•Do you follow these guidelines?

•If not – why not?

•What do you think of the quality of the care you are able to provide (in this clinic)?

•How do you evaluate the attitude of health personnel towards the patients (in this clinic)?

•What is needed to further improve ante-and perinatal care?

•What are the reasons that some pregnant women seek help too late?

12. Expected Benefits & Outcome

The current research guided well about the situation of antenatal care in

Afghanistan (Herat province) It will address what are the main issues that we had still in high level of morbidity of Mothers and Babies in Afghanistan. Moreover, what was expected for pregnant women to have better situation for all them. In addition, what was indeed necessary to be include the system of the antenatal clinics. Regular contact with a doctor, nurse or midwife during pregnancy allows women to receive services vital to their health and that of their future children as it was also recommended by the World Health Organization (WHO) to have a minimum of four antenatal care visits. Antenatal care can help women prepare for delivery and understand warning signs during pregnancy and childbirth. Therefore proper IEC material could be developed. ANC services can help the women receive proper micronutrient supplementation, Treatment of hypertension to prevent Ecclampsia, immunization against tetanus, HIV testing, in addition to medications to prevent mother-to-child transmission of HIV in cases of HIV-positive

pregnant women. Further insights of the results will be shared with Officials of Ministry of Public Health to formulate appropriate strategies to overcome the problems encountered by both care givers and care seekers.

13. References:

1. Transitional Islamic Government of Afghanistan: Ministry of Health, Reproductive Health Task Force. National Standards for Reproductive Health Services in Afghanistan: Antenatal Care Services. 2003.http://pdf.usaid.gov/pdf_docs/PNADF234.pdf.
2. Van Egmond K, Bosmans M, Naeem AJ, Claeys P, Verstraelen H, Temmerman M. Reproductive health in Afghanistan: results of a knowledge, attitudes and practices survey among Afghan women in Kabul. Disasters. 2004;28:269–282. doi: 10.1111/j.0361-3666.2004.00258.x. [PubMed] [Cross Ref]
3. Amowitz LL, Reis C, Iacopino V. Maternal mortality in Heart Province, Afghanistan, in 2002. An indicator of women's human rights. JAMA. 2002;288:1284–1291. doi: 10.1001/jama.288.10.1284. [PubMed] [Cross Ref]
4. Kaartinen L, Divan. Mother and child health care in Kabul, Afghanistan with focus on the mother: women's own perspective. Acta Obstetr Gynecol Scand. 2002;81:491–501. doi: 10.1034/j.1600-0412.2002.810604.x. [PubMed] [Cross Ref]
5. Williams JL, McCarthy B. Observations from a maternal and infant hospital in Kabul, Afghanistan – 2003. J Midwifery Womens Health. 2005;50:e31–e35. doi: 10.1016/j.jmwh.2005.02.009. [PubMed] [Cross Ref]
6. Malterud K. Shared understanding of the qualitative research process: guidelines for the qualitative researcher. Fam Pract. 1993;10:201–216. doi: 10.1093/fampra/10.2.201. [PubMed] [Cross Ref]
7. Malterud K. Qualitative research: standards, challenges, and guidelines. Lancet. 2001;358:483–488. doi: 10.1016/S0140-6736(01)05627-6. [PubMed] [Cross Ref]
8. Reproductive Health Task Force, Ministry of Health, Islamic Republic of Afghanistan. National Reproductive Health Strategy 2006–2009. 2006.http://moph.gov.af/Content/Media/Documents/National-RH-Strategy-2006-092912201016403425 9.pdf.
9. Koblinsky M, Matthews Z, Hussein J, Mavalankar D, Mridha MK, Achadi E, Padmanabhan P, van Leberghe W. on behalf of The Lancet Maternal Survival Series steering group. Maternal

Survival 3. Going to scale with professional skilled care. Lancet. 2006;368:1377–86. doi: 10.1016/S0140-6736(06)69382-3.[PubMed] [Cross Ref]

10. D'Olivera A, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. Lancet. 2002;359:1681–85. doi: 10.1016/S0140-6736(02)08592-6. [PubMed] [Cross Ref]
11. Harvey S, Ayala GF, Bermeo PH. Reframing authoritative knowledge about childbirth in Ecuador. 104th annual meeting of the American Anthropological Association. 2005.
12. Kabakian-Khasholian T, Campbell O, Shediac-Rizkallah M. Women's experiences of maternity care: satisfaction or passivity? Soc Sci Med. 2000;51:103–13. doi: 10.1016/S0277-9536(99)00443-8. [PubMed] [Cross Ref]
13. Malqvist M, Hoa DTP, Thomson S. Causes and determinants of inequity in maternal and child health care in Vietnam. BMC Public Health. 2012;12:641. doi: 10.1186/1471-2458-12-641. [PMC free article] [PubMed] [Cross Ref]
14. Cockcroft A, Khan A, Ansari N, Omer K, Hamel C, Andersson N. Does contracting of health care in Afghanistan work? Public and service-users' perceptions and experience. BMC Health Serv Res. 2011;11(Suppl 2):S11. doi: 10.1186/1472-6963-11-S2-S11. [PMC free article] [PubMed] [Cross Ref]
15. Thorson A, Johansson E. Equality or equity in health care access: a qualitative study of doctors' explanations to a longer doctor's delay among female TB patients in Vietnam. Health Policy. 2004;68:37–46. doi: 10.1016/j.healthpol.2003.07.010. [PubMed] [Cross Ref]
16. United Nations Children's Fund. *State of the world's children*. New York: UNICEF; 2007.
17. United Nations Children's Fund. *State of the world's children*. New York: UNICEF; 2008.
18. United Nations. *Manual X: indirect techniques of demographic estimation*. New York:
19. UN Department of Economic and Social Information and Policy Analysis; 1983 (Population Studies No. 81).
20. Turner AG, Magnani RJ, Shuaib M. A not quite as quick but much cleaner alternative to the Expanded Programme on Immunization (EPI) cluster survey design. *Int J Epidemiol* 1996; 25: 198-203 doi: 10.1093/ije/25.1.198 pmid: 8666490.

21. Brass W, Coale AJ. Methods of analysis and estimation. In: Brass W, ed. *The demography of tropical Africa.* Princeton: Princeton University Press; 1968.
22. United Nations. *QFIVE: United Nations Program for Child Mortality Estimation*. New York: Department of Economic and Social Information and Policy Analysis; 1990 (Population Studies No. 107).
23. Chu S, Hill R, Graham S. *National demographic and Family Guidance survey of the settled population of Afghanistan. Vol. 1: Demography and knowledge, attitudes and practices of Family Guidance*. Washington: United States Agency for International Development; 1975.
24. Trussell J, Brown E. A close look at the demography of Afghanistan. *Demography* 1979; 16: 137-56 doi: 10.2307/2061085 pmid: 428605.
25. Hobbs F. *Afghanistan: a demographic profile*. Washington: Center for International Research, US Bureau of the Census; 1988.
26. CIET International. 1997 Afghanistan Multiple Indicator Baseline Survey. Kabul: CIET; 1997.
27. Central Statistics Office & United Nations Children's Fund. Moving beyond two decades of war: progress of provinces: Multiple Indicator Cluster Survey 2003. Kabul: CSO, UNICEF; 2003.
28. Boss LP, Brink E, Dondero T. Infant mortality and childhood nutritional status among refugees in Pakistan. *Int J Epidemiol* 1987; 16: 556-60 doi: 10.1093/ije/16.4.556 pmid: 3440665.
29. Smith A. *Diarrhoea morbidity, mortality and treatment practices*. Peshawar: United Nations High Commissioner for Refugees; 1989.
30. Tangermann RH, Pamuk E. *Evaluation of infant mortality and childhood nutritional status among Afghan refugees in Pakistan, 1990*. Peshawar: United Nations High Commissioner for Refugees; 1990.
31. United Nations. *Demographic yearbook*. New York: UN Department of Economic and Social Information and Policy Analysis; 1994.
32. United Nations Children's Fund. 2000 Multiple Indicator Cluster Survey (MICS2): situational analysis of women and children in east of Afghanistan. Kabul: UNICEF; 2001

33.

Kaartinen L, Divan. Mother and child health care in Kabul, Afghanistan with focus on the mother: women's own perspective. Acta Obstetr Gynecol Scand. 2002;81:491–501. doi: 10.1034/j.1600-0412.2002.810604.x. [PubMed] [Cross Ref]

submission of research proposal :

- Submitted to Dr Rashmi Rathore , Associate Professor Department of Public Health Maulana Azad University .
- rashmi.rathore@jsph.in under cc to harish.meghwani@jsph.in