SWOT analysis of program design and implementation: a case study on the reduction of maternal mortality in Afghanistan

Qudratullah Ahmadi¹, Homayoon Danesh², Vasil Makharashvili², Kathryn Mishkin², Lovemore Mupfukura², Hillary Teed² and Maggie Huff-Rousselle²,³*

¹Ministry of Higher Education, University Medical School, Kandahar, Afghanistan
²Brandeis University, Heller School for Social Policy and Management, Waltham, MA, USA
³Massachusetts College of Pharmacy, Boston, MA, USA

SUMMARY

This case study analyzes the design and implementation of the Basic Package of Health Services (BPHS) in Afghanistan by synthesizing the literature with a focus on maternal health services. The authors are a group of graduate students in the Brandeis University International Health Policy and Management Program and Sustainable International Development Program who used the experience in Afghanistan to analyze an example of successfully implementing policy; two of the authors are Afghan physicians with direct experience in implementing the BPHS. Data is drawn from a literature review, and a unique aspect of the case study is the application of the business-oriented SWOT analysis to the design and implementation of the program that successfully targeted lowering maternal mortality in Afghanistan. It provides a useful example of how SWOT analysis can be used to consider the reasons for, or likelihood of, successful or unsuccessful design and implementation of a policy or program. Copyright © 2015 John Wiley & Sons, Ltd.

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AFGHANISTAN’S HEALTH SYSTEM AND GENERAL HEALTH STATUS

Afghanistan has 34 provinces and 398 administrative districts. Districts are further divided into smaller units of villages and municipalities. Mountains cover two-thirds of Afghanistan; access to health services is particularly challenging in remote areas with difficult terrain (Saba and Bakhter, 1997). A 10-year war with the Soviet Union destroyed much of Afghanistan’s physical and institutional infrastructure. At the end of this war, the health system was characterized by rundown facilities unevenly...
distributed across the country; a shortage of skilled health providers, especially female; impaired access to health services because of difficult communications and security problems; poor information systems, and weak implementation of the newly approved national health policy (WHO, 2014). This resulted in inefficient and insufficient health coverage and service delivery.

The health system is now designed, under the BPHS, so that individuals seeking services will go to the local health post first. Complex conditions requiring more specialized attention are then transferred to the next level health facility, which offers a wider range of services. The government contracts with international and national non-governmental organizations (NGOs) such as Afghan Health and Development Services, Oxfam, Care International, and International Medical Corps (The Afghanistan Analyst, 2014) to provide the BPHS within a geographically defined area. A third party evaluator monitors providers’ performance on the basis of agreed upon national indicators.

Afghanistan is considered to be one of the least developed countries in the world. With a population of 29.8 million in 2012, it had a Human Development Index (HDI) of 0.374 and an HDI ranking of 175 out of 187 nations (UNDP, 2013a). Despite full, free coverage being stipulated in the Afghan constitution, only about 50% of the population, 70% of the districts, is covered by the BPHS (WHO, 2013a).

There are wide gaps in access to health services based on geography. There are approximately 5.3 hospital beds per 10 000 population depending on the location (WHO, 2013c). Although 77% of the population lives in rural areas and 23% lives in urban areas, the health work force in the rural areas is 16.7 workers per 10 000 people; in urban areas, where the most qualified professional staff is located, there are 36 health workers per 10 000 people (Mo PH, 2010).

MATERNAL HEALTH IN AFGHANISTAN

According to the WHO definition, “maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.” Most maternal deaths in Afghanistan occur because of hemorrhage and/or obstructed labor; both are problems that can be improved by access to appropriate health services (WHO, 2011).

In 2010, the Afghanistan Mortality Survey (AMS) was implemented by the Afghan Public Health Institute, the Ministry of Public Health (MoPH), and the Central Statistics Organization to include 22 000 households, representative of 87% of the total Afghan population. The 2010 AMS 2010 showed that the MMR in the survey area of Afghanistan was 327 deaths per 100 000 live births. The survey included little of the country’s south and southeast; if these conflict areas were considered, the AMS estimated a countrywide MMR as high as 500 deaths per 100 000 live births. However, even at a rate of 500, the 2010 MMR in Afghanistan
would be less than one-third of the 1600 deaths per 100,000 live births found in the 2002 CDC/UNICEF study (Management Sciences for Health, 2012).

The MMR in Afghanistan varies depending on the organization reporting, and the rate of 327 is potentially unreliable because of inadequate reporting in conflict areas (Reuters, 2011). A woman’s risk of mortality is significantly dependent on location within Afghanistan: the MMR is much higher in mountainous, remote, and underserved areas, compared to the flat, secure, and urban areas of Afghanistan. For example, the highest MMR was measured in Ragh district of Badakhshan province, a remote, mountainous area, with an estimated MMR of 650. A similar ratio is likely in areas, such as Ghor and Daikondi provinces (UNDP, 2012). WHO uses an overall MMR estimate of 400 (WHO, 2013a; WHO, 2013b), and this rate is used by other international agencies. Although there are discrepancies about MMR rates, this article uses the MMR of 327 provided by the 2010 AMS. The MMR target for 2015 is 320. This should be achieved in secure and flat areas, but achieving it in mountainous, remote, and insecure areas is less certain (UNDP, 2013a).

**Challenges to maternal health**

Gender norms, social status, inadequate transportation and trained health professionals (especially female workers), user fees, and corruption in the health system have all impacted women’s health status.

Half of Afghan girls marry before the age of 15, which increases their risk of dying from pregnancy-related complications. A 15-year-old girl is five times more likely to die from pregnancy complications than a woman who is 20 years old (Reuters, 2011). Women’s household and social status impact MMR. Women who had closer relationships with their husbands reported higher household status, and a shorter delay in accessing health facilities. Statistical analysis showed that women were taken to hospitals more quickly when husbands had good social networks, helping families to borrow money and transport (Hirose et al., 2011).

When women do leave the home, they are expected to keep an appropriate distance from men, a cultural norm that is more pronounced in conservative rural areas. It is not appropriate for many women to visit male doctors and nurses for prenatal care, delivery, and postnatal care. Because of this, under the BPHS strategy, 100% of trained midwives and traditional birth attendants (TBA) are female, and 50% of community health workers (CHW) are female. Unfortunately, only 28% of the health workforce, including unqualified support staff, is female; female vaccinators, doctors, dentists, and pharmacists comprised 20% of those professions (Reuters, 2011). This gender disparity in the entire health workforce has impacted the care that women receive.

In 2011, Afghanistan had 7.26 medical professionals per 10,000 people, compared with the 23 that WHO establishes as a minimum. There were 0.08 registered medically trained midwives, 0.006 enrolled midwives, 0.15 generalist doctors, and 0.07 specialists per 1000 people (MoPH, p.3, 2011). Community midwives were those who come from rural villages and received a MoPH approved 18-month training to assist during births in rural areas. An estimated additional 3983 midwives would be needed to achieve 95% coverage of births attended by skilled birth attendants by 2015.
A general lack of faith in the quality of the healthcare system also contributes to MMR. Almost one quarter of healthcare facilities had high case fatality rates, with the majority of these in more rural areas. Inadequate transportation leads to delayed access and results in more serious complications on arrival at health centers; some people interpret the resultant higher fatality rate as an indication of poor quality at health centers (Kim et al., 2012; Hirose et al., 2011).

Access to health services is very dependent upon the ability to pay for healthcare (Trania et al., 2010). The BPHS provides free goods and services, but salaries for health personnel are often inadequate. Corruption within health centers on the part of health care professionals can be high. Corruption is a recognized issue as Transparency International (2014) ranked Afghanistan as having the third worst rate of corruption in the world, and many families continue to pay for services that were designed to be free (Hirose et al., 2011).

Table 1. The seven elements of the BPHS and their components

| 1. Maternal and newborn care    | a. Antenatal care  |
|                                | b. Delivery care   |
|                                | c. Postpartum care |
|                                | d. Family planning |
|                                | e. Care of the newborn |
| 2. Child health and immunization | a. Expanded program on immunization (EPI) |
|                                | b. Integrated management of childhood illnesses (IMCI) |
| 3. Public nutrition            | a. Prevention of malnutrition |
|                                | b. Assessment of malnutrition |
| 4. Communicable disease treatment and control | a. Control of tuberculosis |
|                                | b. Control of malaria |
|                                | c. Prevention of HIV and AIDS |
| 5. Mental health               | a. Mental health education and awareness |
|                                | b. Case identification, referral, and follow-up |
| 6. Disability and physical rehabilitation services | a. Disability awareness, prevention, and education |
|                                | b. Provision of physical rehabilitation services |
|                                | c. Case Identification, referral and follow-up |
| 7. Regular supply of essential drugs | List of all essential drugs needed. |

BPHS policy implementation

What was done?. The MoPH formed the Consultative Group for Health and Nutrition (CGHN) to develop effective policies for overcoming the most severe health problems facing Afghanistan, including the high MMR. In 2002, the CGHN suggested the development of the BPHS to (Table 1) address the highest priority health problems, with services and interventions that would be available to all.
Afghans. Rural areas were targeted as they suffered the most from the lack of basic health services. BPHS also gave the tools to effectively coordinate and monitor the implementation of health care activities. It worked as a roadmap that provided policy makers with a clear sense of direction that emphasized primary care as the crucial foundation of the health system (MoPH, 2010).

In 2003, the MoPH implemented the BPHS, with later revisions in 2005 and 2010. It was implemented by both the MoPH and by collaborating partners. The standardized classifications of health facilities that provide services under the plan include Health Posts, Health sub-centers, Basic Health Centers, Mobile Health Teams, Comprehensive Health Centers, and District Hospitals.

The Afghan government’s commitment to improved maternal health was strengthened through the adoption of a modified version of Millennium Development Goal (MDG) 5. Their target was a 50% reduction in the MMR by 2015 and a 75% reduction by 2020 (MoPH, 2010; WHO, 2013b). Despite financial problems and the health workforce shortage, in 2010, the Afghanistan Maternal Survey reported that the MMR had dropped to 327 per 100 000 live births. This was an impressive outcome in such a short time and met the MDG of a 50% reduction by 2015 (The World Bank, 2013).

Implementation of the BPHS brought other positive health outcomes for women in Afghanistan. While in 2002 there were only two midwifery schools in the entire country, there were 34 such schools, one in each province, in 2014. This made an enormous contribution to the improvement of maternal health. The number of medically trained midwives increased to almost 2000, compared to just 467 in 2003, representing a major step for the female health workforce. Surveys found that skilled birth attendants were attending about 22% of all births. The BPHS had provided increased quality healthcare for women. As a result of the BPHS, women had access to both trained midwives and MoPH-trained CHWs in addition to TBAs who may or may not have ever received medical training (The World Bank, 2013).

Another major achievement in maternal health that coincided with the BPHS roll-out was a widespread campaign that educated women about their reproductive health. Women were informed about the importance of birth spacing and of visiting health clinics at least three times during the pregnancy period. Women were also instructed about foods they should eat during pregnancy. The campaign was effective and women began to attend health clinics more often for antenatal care. The fertility rate was reduced from 6.4 in 2002 to 5.6 in 2010 (Carvalho et al., 2013).

How was it done?. Under the BPHS services were offered through six types of health facilities. Communities in the rural areas received primary health services through health posts, which were equipped with a male and a female CHW. CHWs were typically semi-literate women and men hired from the rural areas and trained by the MoPH. Some received training at the midwifery schools. They provided limited curative care, but also distributed condoms and oral contraceptives. Female CHWs coached pregnant women on birth preparedness, informed them about danger signs to watch for during pregnancy, and facilitated urgent referrals when delivery complications occurred. The catchment area of each CHW was 1000–1500 individuals or 100–150 Afghan families MoPH, 2010).
Basic Health Centers (BHCs) offered services to communities of 15,000–30,000, depending on the density of the population. In addition to outpatient services, BHCs also offered non-permanent contraceptive methods, routine immunizations, antenatal care, delivery and postpartum care, as well as referral in case of delivery complications. At minimum, a BHC had a nurse, a medically trained midwife, and two vaccinators. If required, up to two additional health workers were added to make sure well-defined tasks were performed (MoPH, 2010).

Comprehensive Health Centers (CHC) offered more complex services, including limited inpatient services. The catchment area of each CHC covered a population of 30,000–60,000 individuals. In addition to assisting normal deliveries, CHCs also took complicated delivery cases. CHCs had a larger staff, including male and female doctors and nurses, midwives, a psychological counselor, a pharmacist, and a laboratory technician (MoPH, 2010). The male-to-female ratio was strictly considered for both health centers and health posts because male providers impeded women patients from being treated.

Different numbers of these three types of health centers and posts operated inside each Afghanistan district. However, one hospital was established in each district and provided the most complex services. It treated comprehensive emergency obstetric cases, including cesarean section. Only rarely would a district hospital need to refer a complicated obstetric case to a provincial hospital (MoPH, 2010).

The MoPH also developed training programs to increase the number of trained midwives. Midwifery institutes were built in the capitals of all 34 provinces. Increasing the number of midwives assisted in reducing MMR throughout the country. Breaking down cultural barriers, female midwives worked effectively to reach target populations. They informed women about different methods of contraception as well as assisting in normal deliveries. Three different midwife categories were established: (i) medically trained midwives underwent university medical training; (ii) community midwives had undergone a MoPH-approved 18-month/24-month certificate training; and (iii) TBAs had never received MoPH medical training.

Why was it done? Five main indicators associated with the decreased MMR in Afghanistan: the TFR, contraceptive use, antenatal care, the use of Skilled Birth Attendants (SBA) during delivery, and emergency obstetric care. SBAs could be midwives or TBAs (Rasooly et al., 2013). When examining the success that Afghanistan achieved with each of these indicators, it is important to ask: why were the policy interventions of the past 10 years necessary and why were they successful? Both the design of the policy and its implementation warrant attention.

After defeating the Taliban regime in 2002, Afghanistan had the world’s second highest MMR after Sierra-Leone. Cultural norms and lifestyle characteristics contributed to the MMR, including: (i) women married and delivered their first child at a young age; (ii) women did not receive emergency obstetrical care; (iii) the majority of women delivered at home; (iv) women did not deliver in health facilities even if they had access to them; (v) women used contraception at very low rates; (vi) women had high fertility rates; and, (vii) there was a low level of female education (Egmond et al., 2004). Research has shown that increasing contraceptive use can prevent both maternal and infant deaths (Rahmani et al., 2013). These
Contextual factors were complex and beyond the normal purview of health services delivery. Success was achieved in part because the MoPH used the knowledge of international experts but adapted their ideas into the Afghanistan’s cultural and social reality.

A 2004 study showed that 95% of women in the country wanted to be educated (Egmond et al., 2004). This was a significant because it showed that women were motivated to learn. The BPHS included a newly redesigned CHW program involving community and religious leaders, especially mullahs. “Meeting with religious and other community leaders, including health committees, CHWs and couples was important for achieving trust and confirming acceptance of innovations” (Huber et al., 2010). CHWs were effective in communicating with men and women. Because women were motivated to receive more education, they successfully internalized the information and skills about health behaviors from CHWs.

CHWs also maintained educational campaigns that taught women the risks of having children at early and later ages, a significant problem in the country. Women who already had five to six children often still wanted to have more (Egmond et al., 2004). The BPHS made contraceptives more widely available which contributed to a reduction in the fertility rate. Appropriate handling of these social and cultural factors in Afghanistan was critical to the successful implementation of the BPHS policy.

**SWOT analysis**

A SWOT analysis of the Afghanistan BPHS, in relation to maternal health, is illuminating in terms of understanding why the design and implementation of the BPHS were successful in reducing the MMR, and how the policy might be replicated and scaled up in other contexts. A SWOT analysis—Strengths, Weaknesses, Opportunities and Threats—identifies internal strengths and weaknesses within a program or organization, and external opportunities and threats within the operating context (Harvard Business School, 2006a; Harvard Business School, 2006b).

Strengths were the specific MoPH capabilities that allowed the MoPH to perform well to reduce maternal mortality and child mortality. The MoPH gained experience implementing several analysis and quality improvement tools, including: the Fully Functional Service Delivery Point (FFSDP), Quality Assurance, Partnership Defined Quality (PDQ), and Quality Improvement (MoPH, p. 9, 2011). These tools promoted collective and cooperative action on the part of the health community. The FFSDP approach promoted teamwork among health providers, improved the management of the various health systems, and advanced preventative health practices (Management Sciences for Health, 2012). The PDQ improved “the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process” (CORE Group, 2014). In addition to these collective community-based programs, the MoPH also implemented measures to ensure overall quality of care. The MoPH developed extensive measures to maintain the quality of pharmaceuticals and medical commodities (MoPH, p. 4, 2011).
Another strength was that certain regulatory bodies were being used which assured quality and accountability. The MoPH used various technical departments including the Riyasat-Qawaneen wa Barrasi, or the Directorship of Laws and Assessment, and independent associations, including the Afghanistan Midwifery and Nursing Education Accreditation Board. Riyasat-Qawaneen wa Barrasi evaluated the implementation of laws and regulations within the health system and the MoPH. It was responsible for drafting public health laws to be approved by parliament. The Midwifery Education Policy was implemented in 2005 (WHO, 2011). As a result, the Community Midwifery Education program, an 18-month training program, was established to expand the network of qualified rural female health workers (UNICEF, 2009). This certification program improved the quality of care provided to women in rural areas. The National Midwifery Education Accreditation Board was created, and standards and accreditation became mandatory (WHO, 2011).

Weaknesses were the characteristics that prevented the MoPH from performing well to improve maternal health. Although data collection systems existed in Afghanistan, there were issues with the quality of information gathered because of poor monitoring systems. Ownership over and responsibility for programs and quality improvement measures remained undefined, and quality assurance suffered as a result. Partner organizations had differing conceptions about their own responsibility to monitor and evaluate programs and projects (MoPH, p. 5, 2011). Additionally, there was inadequate coordination between partners; both donors and implementing stakeholders, when health care quality improvement and assurance measures were introduced. Coordination challenges were because of issues with following program timeframes for regular reporting of performance and clinical data, and establishing protocols for the classification, recording, and presentation of medical data (MoPH, p. 24, 2011).

Another weakness was that health staff skills were insufficient for implementing data collection. Hospital administrators and managers were inadequately trained to monitor success, and the MoPH provided an insufficient amount of training courses for them. Primary and secondary care hospitals and specialists were targeted to provide information regarding quality of care. Tertiary hospitals were not well integrated into the monitoring system. No standardized training manual to train staff on monitoring techniques existed (MoPH, p. 24, 2011). This reduced the quality of data collection and affected the utilization of the data and feedback provided. Although the MoPH developed extensive measures to improve quality of pharmaceuticals, there continued to be “inadequate checks and controls on the production, importation and safety of pharmaceuticals” (MoPH, p. 10, 2011).

In addition, quality of care per site was monitored differently depending on the geographic location of the site (MoPH, p. 11, 2011). Standardized monitoring and evaluation training materials were not distributed evenly across the country, resulting in uneven data collection and information deficiencies for some regions.

Another significant weakness was the level of corruption within the healthcare system. Transparency International (2014) ranks Afghanistan’s corruption as being the third worst in the world, 175th out of 177 countries, giving Afghanistan a corruption score of eight out of 100, with lower scores indicating high corruption.
The most common form of corruption serves to fill the gap in labor reimbursement for health workers, as official salaries are often inadequate. Without corruption, there would be a higher absence of the workforce; reports reveal that one-third of population believes that corruption is necessary (Rahmani & Brekke, 2013).

Opportunities were the external “trends, forces, events, or ideas” (Harvard Business School, 2006a) that the MoPH capitalized on in order to improve the status of maternal health in Afghanistan. Perhaps the greatest opportunity for the MoPH was the availability of donor funding to advance such efforts throughout the country. USAID, the World Bank, and the European Commission were the most dominant financial contributors to the MoPH and the BPHS specifically (MoPH, p. 2, 2011). For example, in FY 2012, USAID spent a total of $75.3 million on maternal health and another $32.6 million on family planning and reproductive health (USAID, 2012). These substantial investments presented an enormous opportunity for the MoPH because they would not have been able to afford to improve maternal health services otherwise.

Another critical opportunity for the BPHS policy implementation was access to quality national and international experts as well as a high level of commitment and knowledge from Afghanistan’s health sector leadership. The 2011–2015 National Strategy for Improving Quality in Healthcare lists more than 50 local and foreign professionals who contributed to the overall health systems strengthening efforts, including implementation of the BPHS. These individuals were aware of the problems underlying Afghanistan’s high MMR. Local experts provided a strong orientation and continued intellectual capital to the foreign experts as they partnered together to implement the BPHS policy (MoPH, p. 5, 2011).

The fact that Afghanistan had one of the highest maternal mortality rates in the world was also an opportunity in the implementation of this policy. Because the health system was largely destroyed following decades of war, the focus in 2002 was on rebuilding. Starting from a foundational point, it was more likely that targeted outcomes to reduce MMR would have a measurable impact quickly because the rate was so high. The BPHS provided increased opportunities for midwife training in Afghanistan and the majority of medically trained midwives report being satisfied with the MoPH training (Turkmani et al., 2013).

Threats were the possible events or forces outside of MoPH’s control that they had to plan for or decide how to mitigate. The threat of donor dependency is and was problematic for Afghanistan’s MoPH as it implemented the BPHS. Health services were and continue to be primarily delivered by national and international NGOs, overseen by the MoPH. This financial dependence threat stems from Afghanistan’s poor economic status and related low level of health spending. The high dependence on external aid naturally raises important questions regarding long-term sustainability.

In addition to donor dependency threatening the sustainability of achievements, the dependence also made it difficult for the BPHS to achieve coordinated health outcomes. “Different NGOs funded by different donors are obligated to meet slightly different terms and conditions and operate with different flexibilities in applying funds. It is highly likely, therefore, that the services these NGOs deliver have some variation in terms of quality” (MoPH, p. 2, 2011).
Political insecurity was another threat to Afghanistan’s implementation of the BPHS. Following nearly thirty years of war, after the Taliban were overthrown in 2002, violent attacks still occurred frequently. Afghanistan’s volatile political environment had a negative influence on its health systems strengthening efforts, particularly the rollout of the BPHS.

Financial insecurity and lack of infrastructure also impacted health status. Individual financial insecurity and lack of general transportation infrastructure reduced the probability that women could travel and deliver with the assistance of a medically trained birth attendant (Rahmani & Brekke, 2013; Trania et al., 2010). As a result, health conditions varied greatly depending on physical location. Badakhshan, for example, a province where 70% of the population falls below the poverty line, had one of the highest MMRs in the country (Agence Française de Développement, p. 3, 2011).

Cultural barriers including those related to education, contraception, and marriage age also threatened the status of maternal health in Afghanistan. Rasooly et al. (2013) found that fertility rates varied significantly by education; rates among well-educated women were nearly half what they were among illiterate women. This meant that women with more education had fewer children, and it is widely established that the number of births that a woman experiences affects the chance that she will die from a maternal cause. In addition, the use of contraception and an increased marriage age contributed to lower fertility rates (Rasooly et al., 2013). Women’s lack of access to education and contraceptives because of cultural barriers threaten the country’s ability to substantially reduce MMR.

SUGGESTIONS FOR FUTURE POLICY DESIGN AND IMPLEMENTATION IMPROVEMENTS

The MoPH should strengthen its ownership of all health information gathered in order to better use that information to make decisions to improve the quality of the entire health system. Although data collection systems exist in Afghanistan, there were complications with the quality of information gathered because of poor monitoring mechanisms. For information or data systems to achieve desired results, a regulatory and policy environment should be in place (Gladwin et al., 2003). This would enable standardization of quality of care monitoring which makes it easy to compare between health facilities and use best practices for improvement in other areas. Consolidating information would also allow the MoPH to determine which specific regions require more support. The MMR of all provinces would be further reduced as a result.

Financing services and goods should also be a priority for the MoPH. First, the government of Afghanistan must fully finance training in monitoring and evaluation, particularly for the key people who will be collecting the data. This will ensure that data is used systematically to inform decision making at all levels. Financing should also be targeted for access to reliable power sources, internet connectivity, procurement of computers and other equipment, appropriate software, and adequate technical support. Evidence from developing countries has shown that if these components

of the information system are poorly financed, it will lead to failure of the system to achieve the intended outcome (Gladwin et al., 2003).

Efforts should be made to further reduce the shortage of medically trained midwives and female CHWs, especially in remote areas. Because of the various threats to maternal health in Afghanistan, women may not deliver with a medically trained midwife at a health care facility, and may be more likely to deliver with untrained TBAs. There is need for the MoPH to intensify their policy to train existing TBAs so that they can better manage normal deliveries, recognize complications earlier, and refer women for obstetric care accordingly. The collaboration between CHWs, TBAs, and formal health facilities can bring valuable benefits to community-based public health interventions and increase women’s presence in the public sphere (Walraven et al., 2005). “Overwhelmingly, women interviewed expressed enthusiasm about having their daughters and female relatives attend school and become midwives” (Turkmani et al., 2013). Increasing contraceptive use to 60% over five years could also potentially prevent an estimated 11 653 maternal deaths and 317 084 infant deaths (Rahmani et al., 2013).

The education of rural female populations should be prioritized. Rasooly et al. (2013) found that Afghan women with more education had fewer children. In another cross sectional study to find determinants of skilled birth attendant utilization in Afghanistan, literacy was strongly associated with their use (Mayhew et al., 2008). This is consistent with other studies done in other low and middle-income countries. It is therefore crucial for the government of Afghanistan to implement additional educational policies targeting the rural populations, especially women, to increase education levels. This will help to stimulate demand for maternal health services because a number of studies have shown that level of education is associated with health-seeking behavior. There is also a need to increase provision of maternal health education through the use of CHWs and other culturally acceptable methods.

CONCLUSION

The implementation of the Afghanistan MoPH’s BPHS significantly assisted in the reduction of maternal mortality rates. As a result of robust policy implementation, accessible, low cost, good quality health care was expanded to all Afghans through health posts, basic health centers, comprehensive health centers and district hospitals, health worker development, and health education. Afghanistan’s reported MMR was reduced from 1600 deaths per 100,000 live births in 2002, before the policy implementation, to 327 per 100,000 live births in 2010 (Management Sciences for Health, 2012). Through SWOT analysis, the strengths, weaknesses, opportunities, and threats of this policy implementation were evaluated in this article to determine what facilitated the implementation of this successful policy as it relates to the decline in MMR. Recommendations to further reduce maternal mortality in Afghanistan include strengthening and expanding women’s educational opportunities in rural areas, improving the quality of data information systems, promoting additional monitoring and evaluation of MoPH services, and increasing the number of trained
midwives in rural areas. Afghanistan presents a valuable case study of a successful program designed to reduce the maternal mortality rate, but also a case study on how health policy can be carefully sculpted and implemented in other contexts.

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