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Postpartum Haemorrhage in Afghanistan: challenges and opportunities

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Country Context

- Land locked, mountainous
- Conflict since 1978
- ~ 32 million population
- ~ 55% below poverty line
- ~ 21% female literacy rate
- ~ 3,600 public and 500 private health facilities
- Health workers affected by the "3 imbalances"
  - Imbalanced gender, skills and location – disproportionately urban
- Health service delivery is contracted to NGOs at primary and secondary levels
- Highly affected by COVID-19 pandemic

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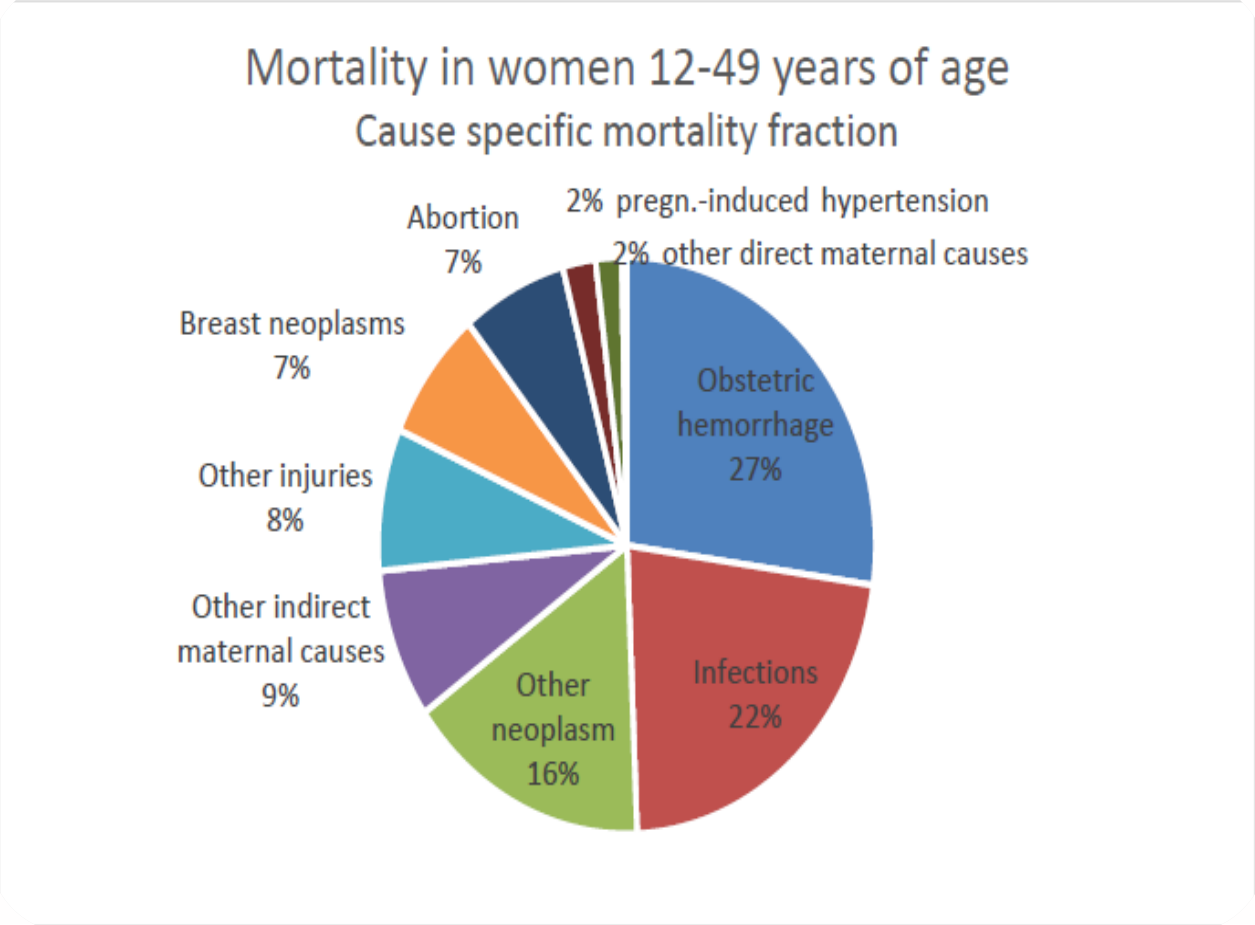
Maternal mortality in Afghanistan, Afghan Health Survey 2018



- ANC4 - 21%
- Institutional delivery – 58.8%
- MMR- 638/100,000 *(UN estimation 2017)*
- Obstetric hemorrhage is the leading cause of maternal death

➢ Coverage if services disrupted by Covid-19 *(estimations by JHU/GFF 2020)*

- Facility-based delivery- ~ 25%
- ~ 18 % increase in maternal mortality and a 14% increase in child mortality

Comprehensive PPH Reduction Approach in Afghanistan

PROMOTION OF COMPREHENSIVE PACKAGE OF INTERVENTIONS TO PREVENT AND MANAGE PPH

EDUCATION: Birth planning/complication readiness; Promotion of ANC; encouragement of facility birth with SBA

Facility Birth:

- Quality respectful care during labor and birth
- Routine administration of uterotonic immediately after birth (oxytocin preferred, if not, misoprostol)
- Uterotonic availability and quality
- Proper management of PPH including introduction of UBT
- Postpartum care for PPH

Early care seeking:

- **Transport**
- **Blood donor**
- **Support person**

Home Birth:

- Education about PPH detection
- Education about use of misoprostol
- Advanced distribution of misoprostol for self administration after birth
- Education about what to do for continued bleeding

Community based prevention of Postpartum Hemorrhage

- Advanced distribution of misoprostol for self-administration piloted through Community Health Workers in 2004 – but with smaller scale up attempts
- Gradual scale up is planned under the MoPH investment case supported by GFF

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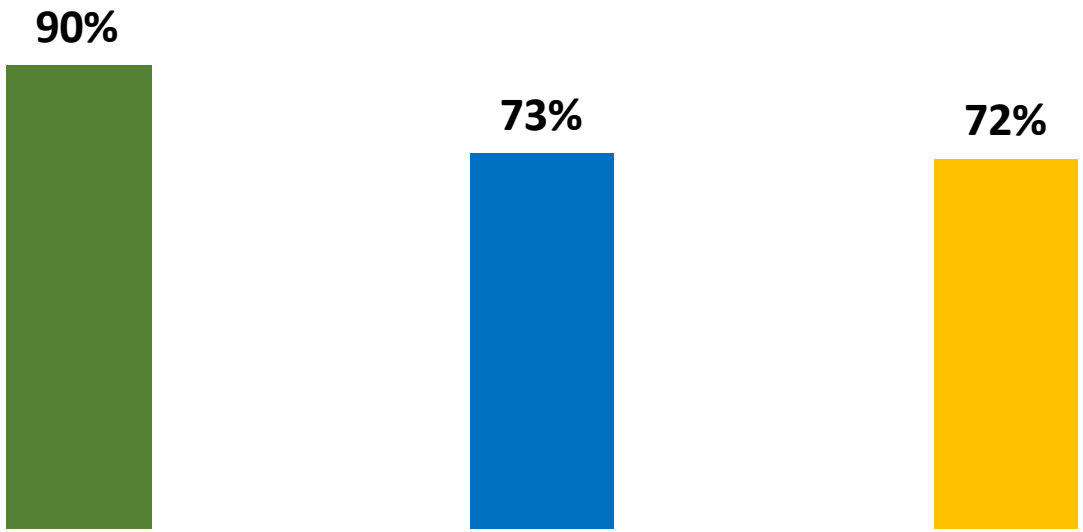
A strong national level foundation

- Call to Action to end preventable maternal deaths (2015)
- Position paper: to improve prevention and management of PPH (2016)
- National RMNCAH Strategy 2017–2021
  - *Uterotonics*
  - *Evidence based guidelines*
  - *Scope of Practice*
- National package of competency based performance improvement learning, tools & job aids
- Tranexamic acid (TXA) was included in the PPH protocol (2018)

Facility based Prevention of Postpartum Hemorrhage (QoC 2016)

TO REDUCE RISK OF POSTPARTUM HEMMORHAGE, ALL WOMEN SHOULD RECEIVE ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR (AMTSL) WITH IV OR IM OXYTOCIN IMMEDIATELY AFTER BIRTH.



Percent of facilities with uterotonic drugs in the delivery room

Percent of SBA who know that AMTSL includes uterotonic administration immediately after delivery

Percent of women who received a uterotonic immediately after delivery

28%
of women who give birth at facilities do not receive a uterotonic immediately after delivery

58%
are not checked for postpartum bleeding or counseled on PPH danger signs before discharge

QoC: Management of Postpartum Hemorrhage

- Gaps in PPH management practices of SBAs exist. For instance, uterotonics were not used in all PPH cases and dosage varied and did not adhere to the national guidelines (QoC 2016/17 report).
- Less than half of the public and private hospitals had guidelines for EmONC in 2016/17
- Management of main maternal and newborn complications is poor
- Lack of national quality enhancement agenda and approaches

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What is required to improve quality and coverage of PPH considering the COVID-19 outbreak?

- Strong leadership and governance
- Standardized national quality improvement approach
- Measuring metrics (e.g. Balanced Score Cards), integrated patient records
- Functional MNDSR system and decentralised decision making

Cont.

- Competent and responsive multidisciplinary care teams
- Emergency preparedness (e.g. triage, referral)
- Adherence to clinical protocols (PPH, infection prevention etc.)
- PPH essential commodities
- Enabling environments (woman centred care)
- Community participation/engagement
- Bring services closer to home and motivate families to seek care for normal birth and complications (e.g community distribution of misoprostol by CHWs for prevention of PPH)

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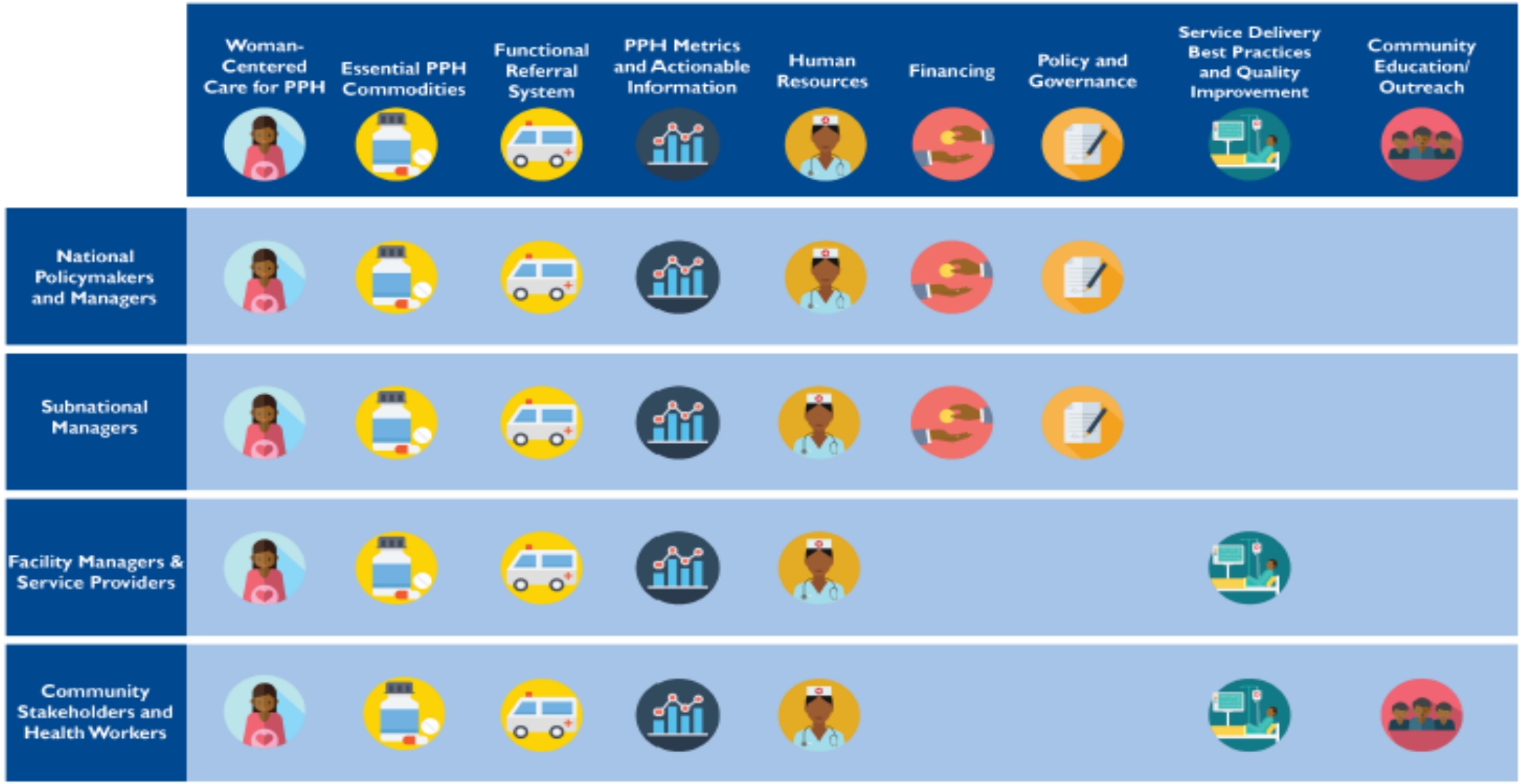
Applying the PPH framework (MCSP 2018)



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Unfinished Agenda…

Urgent effort is needed to ***prioritize*** and tackle the immediate causes of death (e.g. PPH) for many women and ***foster coordination*** (e.g on and off budget resources) with a ***shared accountability,*** while achieving in longer-term ***collective responses*** and ***impacts*** to strengthen the health system and working on the social determinants that lie outside the health sector with a ***multisectoral approach***.