INSTITUTE OF HEALTH SCIENCES

Curriculum for Community Midwifery Education

Human Resources Development Department
Ministry of Public Health
Islamic Republic of Afghanistan

3rd Edition
2009
Prepared for the Ministry of Public Health (MoPH) of Afghanistan as the national community midwife curriculum for use by all organizations implementing a Community Midwife Education Program.

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FOREWORD

Women’s and children’s health is one of the top priorities of the Ministry of Public Health (MoPH) in Afghanistan. The MoPH is committed to reducing the high levels of maternal and newborn mortality and morbidity by ensuring women have improved access to all aspects of maternal and newborn care provided by competent and skilled staff. Strengthening the pre-service education programs required to develop the knowledge, skills and abilities of all those who provide these health services is particularly important for making pregnancy, childbirth and postnatal care safer.

Educating midwives is at the forefront of increasing the number of skilled providers especially for the remote and rural areas of Afghanistan. As reflected in its Health and Nutrition Strategy for 2007/08–2012/13, the MoPH is strengthening human resources development, especially of female staff, through high-quality basic training and continuing education in parallel with further development of human resource planning and retention strategies. Human resource needs in a post conflict environment must be addressed through comprehensive systems. As part of this, a standardized approach to address quality improvements in midwifery education has assured effective pre-service programs. The development of the national midwifery education system has seen marked improvements in improving access to skilled care. The Community Midwifery Education program has been successfully scaled up to many provinces in Afghanistan and Community Midwives will continue to be trained for many years to come and prepared to fulfill a community-based midwifery role.

The MoPH appreciates the efforts of the reproductive health directorate and safe motherhood department, with support of their partners, in the development of policies, guidelines, and competency based training materials to improve the quality of maternal and newborn services. Following a general recommendation the Community Midwifery program will now be 2 years and linked to this a curriculum review has identified areas in need of strengthening and expansion. This updated Community Midwifery Curriculum and associated Learning Resource Package provide the educational and training framework needed to teach midwives evidence-based life-saving skills and best practices in maternal and newborn health as well as in other areas of child and reproductive health. This learning package will enable midwives to develop competency in managing the most common complications of pregnancy and childbirth.

Many partners and stakeholders from the Ministry of Health, UN agencies including Jhpiego/HSSP, AKU, WHO, UNICEF, UNFPA, IMC and other nongovernmental organizations (NGOs) worked hard to prepare this revised curriculum and are gratefully acknowledged. Special thanks are due to the Reproductive Health Task Force, particularly to the MNH Working Group members and all those who made valuable contributions to this document.

I, as the Acting Minister of Ministry of Public Health have great pleasure in endorsing two years Community Midwifery Education curriculum to be implemented in Afghanistan

Regards,

Dr. Suraya Dalil
Acting Minister of Public Health
Kabul – Afghanistan
BACKGROUND

The Basic Package of Health Services (BPHS) implemented in 2003 provides a minimum range of primary care services to which all Afghans should have equal access. After 5 years of implementation of the BPHS there have been a number of changes in the health system, including increased access to health services and expansion in the number of health facilities. The Ministry of Public Health (MoPH) believes that by continuing to focus on a Basic Package of Health Services, it will be able to concentrate its resources on reducing mortality among its most vulnerable citizens, especially women of reproductive age and children under five.

The BPHS (revised in 2009) has being updated and expanded with a greater focus on women and children and under-served areas of the country. It has been agreed that health centers (both Basic and Comprehensive) should offer basic emergency obstetric and newborn care (BEmONC\(^1\)), along with improved referral practices for pregnant women and increased birth planning activities with women and their families. This strategy is in agreement with the internationally agreed optimal strategy to reach MDGs which is to ensure that all births are attended by professional and skilled attendants operating in teams in health centres, all women with complications have access to emergency obstetric care and the unmet need for family planning is reduced. Midwives are considered to be the prototype ‘skilled birth attendant’ (WHO 2005) and midwifery services are core to public health initiatives to reduce maternal and newborn mortality. The MoPH in Afghanistan has given a special emphasis to human resources for health, and building on the success of the current Community Midwifery Education programs they wish to continue scaling up of the midwifery workforce, especially Community Midwives.

The quality of midwifery education is being ensured through the effective functioning of the National Midwifery Education Accreditation Board (NMEAB). The National Policy on Midwifery Education and the Accreditation of Midwifery Education Programs in Afghanistan (see Annex 2) was prepared in 2005 and revised in 2007. The goal of the policy is to provide the framework for appropriate and successful recruitment, education, and development of midwives in Afghanistan, and the accreditation of those institutions assigned to educate midwives. The NMEAB was established for the purpose of authorizing, supervising and monitoring all midwifery education programs in the country. Programs operating outside the board will be ordered to close by the MoPH.

The following curriculum for community midwifery education and the accompanying learning resource package have been developed from the original work in 2003. To assure the pre-service programs continue to meet the priority needs of the country this curriculum was reviewed in a workshop in Kabul in January 2009 in which all stakeholders participated.

Both the curriculum and the learning resource package have been translated into Dari and Pashto and used as the basis for community midwifery training at selected, approved sites throughout Afghanistan.

\(^1\) Basic EmONC services should include the following: parenteral antibiotics; parenteral uterotonic; parenteral anticonvulsants; manual removal of placenta; manual removal of retained products (preferably by MVA); assisted delivery by vacuum and newborn resuscitation.
ACKNOWLEDGMENTS

The Ministry of Public Health (MoPH) of Afghanistan and the Ghazanfar Institute of Health Sciences (GIHS) acknowledge the efforts, technical support, and guidance of its partners for review of the Community Midwife Program Curriculum and Learning Resource Package. Technical review and revisions were provided by personnel from the MoPH and HSSP as well as UN agencies, donors and other NGO partners.

We gratefully acknowledge the following individuals who contributed generously of their time and expertise:

Members we need to list from the following hospitals, NGOs, and other organizations contributed valuable ideas and technical support both directly and indirectly through participation in meetings and workshops:

- Dr. Arezoyee Advisor, of Human Recourse MoPH
- Ms. Pashtoon Azfar, Director of GIHS (Ghazanfar Institute of Health Science) MoPH
- Dr. Jeffery M. Smith, Safe motherhood Advisor Jhpiego USAID/REACH
- Sheena M Currie, Senior Midwifery Advisor Jhpiego
- Dr. Akmal Samsor, IPCC Officer HSSP
- Ms. Sabera Turkmani, Midwifery Education Advisor, Jhpiego-HSSP
- Ms. Farida Shah, Midwifery Advisor AKU (Aga Khan University) Kabul, Afghanistan
- Ms. Fatima Gohar, Midwifery Coordinator AKU (Aga Khan University) Kabul, Afghanistan
- Dr. Saneullah Zalmai, Academic Deputy Director GIHS, MoPH
- Naweed Ahmad Nayib, Knowledge Management Advisor, Jhpiego-HSSP

- Ministry of Public Health, Afghanistan
- Ghazanfar Institute of Health Science, Kabul Afghanistan
- Directororate of Reproductive Health, MoPH Afghanistan
- National Midwifery & Nursing Education Accreditation Board Members
- Midwifery Programs Representatives
Several reference materials were used in the development of the Curriculum and Learning Resource Package, and selected text/graphics presented in this document have been adapted/reprinted from these documents:

- **A Basic Package of Health Services.** MoPH, Kabul Afghanistan, 2005, (revised 2009)
- Bartlett, L et al (2009) *Program Evaluation of the pre-service midwifery education Program in Afghanistan*
- **Basic maternal and newborn care: a guide for skilled providers.** Jhpiego: Baltimore, MD, 2004
- **Best Practices in Maternal and Newborn Care: A Learning Resource Package for Essential and Basic Emergency Obstetric and Newborn Care (ACCESS 2008)**
- **Learning Resource Package for Managing Complications in Pregnancy and Childbirth.** JHPIEGO: Baltimore, MD, 2002
- **WHO (2007) Strengthening Midwifery Toolkit**

In addition, supplementary materials have been prepared, which contain relevant theoretical content not included in the manuals mentioned above.

All of the reference materials will be available in both Dari and Pashto.
## ACRONYMS

AADA | Agency for Assistance and Development of Afghanistan  
ACTD | Afghanistan Centre for Training and Development  
ADRA | Adventist Development and Relief Agency  
AFSOG | Afghan Society of Obstetricians and Gynecologists  
AKHS | Aga Khan  
AMA | Afghanistan Midwives Association  
AMTSL | Advanced management of third stage labor  
BASICS | Basic Support for Institutionalizing Child Survival (USAID-funded project)  
BEOC | Basic Emergency Obstetric Care  
BCC | Behavior change communication  
BHC | Basic Health Center  
BPHS | Basic Package of Health Services  
CAAC | Catchment Area Annual Census  
CAF | Care of Afghan Families  
CBHC | Community Based Health Care  
CGHN | Consultative Group on Health and Nutrition  
CHC | Comprehensive Health Center  
CHS | Community Health Supervisor  
CHW | Community Health Worker  
CME | Community Midwifery Education  
CNE | Community Nursing Education  
COMPRI-A | Communication for Behavior Change: Expanding Access to Private Sector Health Products and Services in Afghanistan (USAID-funded project)  
C-RUD | Community Focused Rational Use of Drugs  
DH | District Hospital  
DMPA | Depot Medrox Progesterone Acetate (progestin-only injectable)  
EC | European Commission  
EmOC | Emergency Obstetric Care  
EOI | Expression Of Interest  
ETS | Effective Teaching Skills  
FP | Family Planning  
GAVI | Global Alliance for Vaccines and Immunization  
GCMU | Grants and contracts management unit of MoPH  
GIHS | Ghazanfar Institute for Health Sciences  
GRR | Gender and reproductive rights  
HEFD | Health Economics and Financing Directorate  
HF | Health Facility  
HMIS | Health Management Information Systems  
HNI-TPO | HealthNet International-Trans Psychosocial Organization (NGO)  
HP | Health posts  
HRD | Human Resource Department  
HR | Human Resources  
HRM | Human Resource Management  
HSSP | Health Services Support Project  
IDM | International Day of the Midwife  
IEC | Information, Education and Communication  
I.H.S | Institute for Health Sciences  
IMCI | Integrated Management of Childhood Illnesses
IP | Infection Prevention
IPCC | Interpersonal Counseling and Communication
IR | Intermediate Result
IUD | Intrauterine Device
Jhpiego | An affiliate of Johns Hopkins University
JICA | Japan International Cooperation Agency
LRP | Learning Resource Package
MCH | Maternal and Child Health
M&E | Monitoring and Evaluation
MoHE | Ministry of Higher Education
MoPH | Ministry of Public Health
MSH | Management Sciences for Health
NGO | Non-Governmental Organization
NMEAB | National Midwifery Education Accreditation board
PBUH | Peace Be Upon Him
PC | Provincial Coordinators
PQAC | Provincial Quality Assurance Committee
PCH | Partnership Contracts for Health Services (formerly PPG)
PDQ | Partnership Defined Quality
PHCC | Provincial Health Coordination Committee
PPG | Performance-Based Partnership Grants (USAID funded BPHS health service delivery grants in Afghanistan)
PPH | Post-Partum Hemorrhage
PPHO | Provincial Public Health Officers
PMP | Performance Monitoring Plan
PY | Program Year
QA | Quality Assurance
REACH | Rural Expansion of Afghanistan’s Community-based Healthcare (USAID-funded project)
RFP | Request For Proposals
RH | Reproductive Health
RUD | Rational Use of Drugs
SBA | Skilled Birth Attendants
SBM-R | Standards-Based Management and Recognition
SC/US | Save the Children US
SMS | Short Message Service
TAG | Technical Advisory Group
TB | Tuberculosis
TB-CAP | The Tuberculosis Control Assistance Program (USAID-funded project)
Tech-Serve | Technical Support to the Central and Provincial Ministry of Public Health
TOR | Terms of Reference
TOT | Training of Trainers
UN | United Nations
UNDP | United Nations Development Program
UNFPA | United Nations Population Fund
UNICEF | United Nation’s Children Fund
USAID | United States Agency for International Development
WHO | World Health Organization
INTRODUCTION

Program Rationale

Improving maternal and newborn health remains a priority for the MoPH in Afghanistan. Maternal and neonatal mortality continues to be unacceptably high, particularly in rural areas. Developing professional, first-line midwifery care is essential for addressing maternal mortality in low-resource settings. To increase skilled attendance at birth, the MoPH developed a comprehensive approach to strengthening midwifery which included:

- Strengthening pre-service education of midwives
- Increasing the number of skilled midwives;
- Adopting a health workforce approach to planning
- Which focused on deployment of midwives to rural areas
- Improvements in the quality of midwifery care

Two midwifery programs have been developed to train the following cadre who are accepted as midwives in Afghanistan:

- **Midwife**: a fully trained midwife who graduate from one of the campuses of the IHS and is deployed to hospitals (central, provincial and district) or comprehensive health centers.
- **Community Midwife**: a fully trained midwife who graduates from one of the recognized community midwife\(^2\) education programs in Afghanistan and is deployed to basic or comprehensive health centers. She is facility-based with outreach to the community

A competency based job description for both midwife and community midwife were developed in 2003. Following successful piloting of a CME program by *HNI*, the program was standardized and endorsed by the MoPH in 2003. Rapid expansion of CME schools followed and the CME program has been successfully implemented in many provinces in Afghanistan. The standardized curriculum agreed in 2003 covered a training period of 18 months with the advantage of being able to produce skilled midwives more quickly especially for the rural areas. However in light of 5 years experience in implementation of CME programs and with consensus of stakeholders the length of the curriculum will be increased to **2 years**. This will enable further strengthening of the pre-service programs and address gaps identified in the evaluation of pre-service midwifery (HSSP 2009).

\(^2\) By the end of 2008, 20 Community Midwifery Program had been established.
Also in 2003, the IHS midwifery training program in Kabul introduced a new midwifery curriculum that uses the competency-based approach to learning. The program is of two-years duration, with one semester of pre-clinical subjects and three semesters of clinical subjects however the length of the GIHS midwifery training is under discussion. This community midwife education curriculum contains essentially the same material arranged along a different timeline.

In reality, both the IHS midwifery program and the community midwife training program have the same midwifery content and the graduates of each program have the same set of essential competencies for midwifery services. The major difference is, however, that community midwives will predominantly practice at the comprehensive health centers (CHCs) and basic health centers (BHCs) with outreach in rural areas\(^3\), while the IHS-trained midwives will practice at provincial and district hospitals and some CHCs.

**Towards the Future**

In the last 5 years there have been significant improvements in the pool of women who are interested in entering the CME program related to levels of education and social and cultural acceptability.

In addition to a minimum of **10 years of schooling**\(^4\) (or successful completion of an equivalent amount of schooling through a bridging program), selection criteria for the community midwife education program include:

- Minimum age of 18 years;
- Married, preferably with children;
- Chosen by the community and willing to relocate for training; and
- Plans for deployment agreed on commencing Program\(^5\).

All candidates must pass the entrance exam. If there are candidates with less than 10 years schooling, in addition to passing the entrance exam, the school, in collaboration with the Ministry of Education (MOE) must provide a program to enhance the academic skills of the student to ensure equivalency of 10 years schooling\(^6\).

Graduates of the community midwife program will fit the definition of a midwife adopted by the International Confederation of Midwives (ICM), the Confederation of Gynaecologists and Obstetricians (FIGO), and the World Health Organization (WHO), as described in Textbox 1. The Job Description for a Community Midwife approved by the MoPH is included in Annex 1.

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\(^3\) In the Basic Package of Health Services for Afghanistan (2009), community midwives are assigned to basic health centers and comprehensive health centers; however, they will have the midwifery skills required to work, if necessary, at district hospitals.

\(^4\) In the next curriculum review minimum of 12 years education should be considered

\(^5\) Refer to CME Admission Guidelines

\(^6\) This additional schooling must be completed within Year 1 of the CME
A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

ICM 2005

In May 2005, the Afghan Midwives Association (AMA) was established to strengthen and professionalize midwifery. Graduates from the accredited midwifery schools are encouraged to become members of the AMA. The AMA continues to grow and is making significant contributions to improving the health of women and newborns in Afghanistan as well as strengthening midwifery education and practice.

7 The definition of a midwife was adopted by the International Confederation of Midwives (ICM) and the International Confederation of Gynaecologists and Obstetricians (FIGO) in 1972 and 1973 respectively, and later adopted by the World Health Organization (WHO). It was amended by the ICM in 1990; the amendment was ratified by FIGO in 1991 and by the WHO in 1992. A further amendment to the definition was developed by the ICM in 2005.
Program Philosophy

The curriculum outlined in this document presupposes that both practice and education will be firmly community based. This is of the utmost importance. In the community the student midwife will be in contact with the people for whom she will provide services and also those with whom she needs to collaborate in her practice, for example, local leaders, women’s groups, schools, and so forth. This will enable the future midwife to grasp the realities of her client’s lives as they impact on the provision of reproductive health care.

Fundamental to the professional practice of midwives is the professional ethos that underpins all that a midwife does and how they function within society. Critical to this ethos is the relationship the midwife has to women, which by general consensus, is one of partnership, working within the framework of reproductive rights as outlined in ICPD Declaration of 1994. Therefore, midwives see their professional duty and thus their primary function as acting at all times to ensure the well being of the childbearing woman and her baby. To do this, midwives believe women should be empowered to assume responsibility for their health and that of their families. A core value being that midwives have confidence in and respect for women and their capabilities in childbirth.

The community midwife program embraces the following educational philosophy.

The program:

- acknowledges the uniqueness of the individual, whether student, client/patient or teacher;

- promotes equal rights regardless of sex, race, religion, age, or nationality;

- is committed to a life cycle perspective of reproductive health with a special focus on women’s health;

- includes a woman-centered approach which aims to promote safe motherhood; and

- increases the students’ awareness of family health issues and sexuality within a framework of gender sensitivity.

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8 Adapted from ICM 2002
9 Adapted from Strengthening Midwifery Toolkit (WHO 2006)
Program Aim

The aim of the community midwife program is to enable students to:

- become safe, competent practitioners, able to promote safe motherhood and reproductive health;
- be caring, sensitive midwives who work alongside women and their families to educate, advise, facilitate choice, and respond to individual needs;
- develop the ability to work well within a multi-disciplinary team to promote safe motherhood and reproductive health;
- make a positive contribution to the reduction of maternal and infant mortality and morbidity by recognizing life-threatening conditions early and taking timely and skilled action;
- reflect on their practice to promote learning from experience that will enhance their future care of women and their families;
- recognize that learning is a life-long process and take every opportunity to keep up-to-date with research-based practice, using different forms of continuing professional education; and
- develop into midwives who value their profession and contribute to the development of the profession by advocating change, where necessary, and by improving the care given to women and their families.

Key Midwifery Concepts

Key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families will be reflected in the educational approach and include: partnership with women to promote self-care and the health of mothers, infants and families; respect for human dignity and for women as persons with full human rights; advocacy for women so that their voices are heard; cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies; and a focus on health promotion and disease prevention.
Ongoing Needs

Much has been done to strengthen the pre-service education of midwives in Afghanistan however some gaps related to professionalizing midwifery remain.

One area is to continue to strengthen midwifery as outlined in the *Islamabad Declaration*[^10] (2007) by further developing career frameworks, work environments and regulatory frameworks to ensure efficient, effective, and safe health systems. A process for regulating the practice of the different categories of health professionals, including midwives is not yet in place in Afghanistan. Regulation of health care seeks to ensure that health care fulfills technical, operational, and social requirements. The objectives of regulation are to guarantee efficiency, quality, and equity of health care and to protect individuals and society from undesirable outcomes or effects of the functioning of the health system and its elements. As midwifery and nursing education continues to improve and expand a regulatory framework is urgently needed. It is recommended to establish a national health professional council as well as a program for professional updating.

Additionally the community midwife, needs to work within an “enabling environment,” that is, to be supported by a fully functioning health system and linked to a referral system for the management of obstetric and neonatal complications. It therefore follows that developing a competency-based curriculum for midwives that embraces the wider concepts of reproductive health is only part of what is required to building an appropriate professional cadre of midwives in order to achieve reproductive health for all.

[^10]: Islamabad Declaration on Strengthening Nursing and Midwifery March 2007, WHO. ICN, ICM and Gov of Pakistan
PROGRAM CONSIDERATIONS

Before implementing a community midwife education program, consideration must be given to the learning process, the learning environment, the preparation of teachers and classrooms, selection of clinical sites, the availability of learning resources, and the preparation of a simulated practice environment, as well as taking into account certain scheduling issues, as outlined below. In addition programs must comply with the national accreditation program for midwifery education which has established standards for the education of midwives. There are national standards in five areas: classroom and practical instruction, clinical instruction and practice, school infrastructure and materials, school management, and clinical areas where student midwives undertake clinical experience. These explicit and mutually agreed-upon standards enable schools to improve the quality of education.

The Learning Process

As midwives may be the sole health-care providers for most Afghan women for some time to come, especially in rural areas, it is clear that any significant and sustainable improvement in maternal and newborn health will require that midwives be highly competent in a broad range of skills and able to work independently and with confidence.

Community midwives must have the knowledge and skills essential to the provision of safe and effective pregnancy, childbirth, and newborn care. It is necessary, therefore, that they participate in a learning process that facilitates the development of:

- problem solving, critical thinking, and decision-making skills,
- appropriate professional behaviors and interpersonal communication skills, and
- competency in a range of essential clinical skills for basic maternal and newborn care and for the management of common complications in pregnancy and childbirth.

In addition, the learning process must be supported by:

- training programs that provide appropriate managerial and technical support,
- skilled classroom and clinical teachers, and
- teaching and learning materials that reflect the most recent evidence-based information.
The Learning Environment

The learning environment should:

- be supported by enough funds to maintain quality
- incorporate an educational philosophy that encourages the development of problem-solving and critical thinking and emphasizes behaviors that respect and respond to a patient’s/client’s perceived needs,
- include relevant educational materials that reflect an adult learning approach,
- involve teachers who are adequately prepared to use competency-based learning methods and clinically competent to teach and serve as role models for learners according to the essential midwifery competencies (see Textbox 2 and Annex 3),
- involve competent clinical preceptors who are able to use competency-based assessment tools,
- facilitate comprehensive, supervised clinical learning experiences that will enable the development of essential skills for maternal and newborn care and for the management of common complications in pregnancy and childbirth, and
- include evaluation methods that assess knowledge, skills, and attitudes.

Preparation of Teachers

Ongoing in-service training and capacity building of teachers is necessary to help ensure that the classroom and clinical teachers are:

- current in their knowledge of care during pregnancy and childbirth,
- proficient in the skills they will teach,
- able to use competency-based learning methods and methods of assessment,
- capable of serving as role models for learners and colleagues, and
- interested in being teachers.
Preparation of Classroom Facilities

Classrooms should be available for interactive presentations (e.g., illustrated lectures) and group activities. Seating in classrooms should be comfortable and lighting and ventilation adequate. At a minimum, a writing surface should be provided for each learner, and a chalkboard and/or flipchart, chalk and/or felt pens, and an overhead projector and/or LCD should be available in each classroom. If possible, classrooms should be within easy access of the clinical sites used for the program.

Selection of Clinical Sites

Practice in the clinical setting is essential for developing healthcare delivery skills. Clinical practice helps prepare students for the roles and responsibilities they will hold in their profession, and gives them opportunities to become competent, gain confidence and with further experience become proficient.

Clinical sites should be assessed and selected based on the following criteria:

- **Patient/client mix and volume.** Are there sufficient patients/clients in sufficient numbers for learners to gain the clinical experience needed? There should be an opportunity for each student to undertake a minimum 25 competent deliveries each, through the training.

- **Equipment, supplies, and drugs.** Does the facility have the necessary equipment, supplies, and drugs, in sufficient quantities, to support the learning process?

- **Quality of care.** Does the care in the principle clinical learning facilities adhere to the national standards and guidelines and the content of the program?

- **Staff.** Are staff members at the site willing to accept learners and participate in the learning process? Do they use up-to-date, evidence-based practices for pregnancy, childbirth, and newborn care? Do their practices reflect the knowledge and skills described in this learning resource package (there may be a need to update their knowledge and skills)? Do they use correct infection prevention practices?

- **Transportation.** Is the site within easy access for learners and teachers? Do special transportation arrangements need to be made?

- **Other training activities.** Are there other training activities at the site that would make it difficult for learners to gain the clinical experience they need?

Practical components must also include community based experiences. If the situation allows, these can be close to the student’s homes and/or intended place of work on graduation.
Availability of Learning Resources

Learners need to have access to reference materials and other learning resources for the duration of the training program. Ideally, these materials and resources should be made available at a single location, and include reference manuals and other relevant printed materials; anatomic models such as a childbirth simulator, pelvic and fetal models, and a newborn resuscitation model; and supplies and equipment for practicing with the models such as gloves, drapes, etc. There should be a video cassette player or DVD/LCD player and monitor for viewing educational videos/DVDs.

Preparation of a Simulated Practice Environment – “Skills Lab”

A simulated practice environment provides students with a safe environment where they can work together in small groups, watch technical videos, and practice skills with anatomic models. If a room dedicated to simulated practice is not available, a classroom or a room at a clinical practice site should be set up for this purpose.

The simulated practice environment must have the necessary supplies and equipment for the desired practice sessions. The room should be set up before learners arrive and there should be enough space and enough light for them to practice with models or participate in other planned activities. The following resources should be available:

- anatomic models,
- medical supplies such as a newborn resuscitation bag and mask, cloth sheets or drapes, cotton/gauze swabs, syringes and needles, and infection prevention supplies,
- learning materials such as the reference manuals, learning guides, and checklists,
- chairs, tables, and a place for handwashing or simulated handwashing, video cassette player and monitor or DVD/LCD, flip chart stand, paper and markers, and
- Medical supplies such as a newborn resuscitation bag and mask, cloth sheets or drapes, cotton/gauze swabs, syringes and needles, and infection prevention supplies.
Scheduling Considerations

The number of learners in the program will need to be considered when scheduling classroom and clinical activities. For example, while it is possible to hold lectures for large groups of learners, clinical teaching in simulated situations and at clinical sites should be undertaken with small groups of learners. (i.e. 1:12 for small group/skills lab and 1:4 for skills practice with patients).

A schedule of activities should be developed for a particular period of time (e.g., blocks of time spent in the classroom and at clinical sites) and indicate clearly:

- where and when classroom sessions will be held and the teacher(s) responsible for the session,
- where and when simulated clinical skills learning will take place, the responsible teachers, and the small group composition of learners,
- where and when clinical practice will take place, the teachers responsible, the small group composition of learners, and the transportation arrangements to and from the clinical site, and
- where and when examinations will take place and the teacher(s) responsible.

Student Teacher/Preceptor Ratio

The ratio of students to teachers has a direct impact on the quality of learning and the ability of students to gain the knowledge and skills required. Ratios that are recommended are:

**Classroom:** 1 teacher for a maximum of 50 students

**Small group learning or discussion:** 1 teacher for 12 students

**Simulated practice:** 1 teacher to 12 students who are working on models, or in a simulated setting

**Clinical practice:** 1 teacher or clinical preceptor for 4 students who are providing patient care.
Monitoring Program Implementation

A coordinator will be appointed for each program and will conduct the day-to-day monitoring of the program\textsuperscript{11}. Program management will be based on predetermined and agreed upon educational and programmatic standards. The monitoring of the programs will be a process of assessing whether the program is achieving the determined standards, and supporting them to do that.

Where possible, the coordinator should be an experienced midwife who is thoroughly familiar with the community midwife program. In particular, she will be responsible for ensuring that midwifery teachers are adequately prepared; that appropriate classroom facilities, simulated practice laboratories, and clinical practice sites (e.g., hospital and clinic facilities) are available; and that the required learning resources are accessible to students.

The coordinator will also be responsible for scheduling classroom, simulated practice, and supervised practice sessions, as outlined in the program calendar for the community midwife program, and ensuring that the assigned teachers conduct the sessions according to the schedule. Additionally, in consultation with the designated teachers, the coordinator will be responsible for ensuring that the assigned teachers record the progress of each student, according to the rules and regulations of the IHS and through the use of the students’ Clinical Experience Log Book.

To enable the coordinator to carry out her responsibilities, she should not be expected to assume substantial teaching responsibilities; however, she must ensure, through regular supervisory visits to classrooms, simulated laboratories, and clinical sites, that learning activities are being conducted as planned.

The coordinators from the implementing NGO will be responsible for reporting progress, on a regular basis, to the coordinator at the regional IHS, national GIHS in Kabul, and if applicable to the donor supporting the program. Standard reporting forms and methodologies will be used for this purpose.

\textsuperscript{11} Job Descriptions for course coordinators, teachers and clinical preceptors have been standardised and may be used by implementing NGOs who can adapt as necessary.
PROGRAM CONTENT AND STRUCTURE

Progression of the Program

The community midwife education program covers a 2 year period of time and is divided into three phases. Phase 1 covers management of normal pregnancy, labor, postnatal and newborn care. Phase 2 builds the student’s skills in the management of complications of pregnancy and childbirth. Phase 3 addresses other reproductive health topics, with a focus on Family Planning as well as management of service provision and professional issues.

Learning Modules

A series of learning modules is included in Phases 1 through 3, containing the theoretical content and clinical skills considered to be necessary to prepare midwives capable of providing comprehensive maternal, newborn, and infant care. The focus on clinical practice is reflected in the overall theory: practice ratio of 45%: 55%. The 35 modules are divided between the three 32-week phases of the training program, as follows.

The first phase covers a range of pre-clinical subjects aimed at providing learners with knowledge and skills relevant to the basic sciences, in preparation for the clinical content. The remaining part of the first phase is, as well as phases two and three, are dedicated to the development of clinical skills for midwifery, including those for essential maternal and newborn care, the management of complications in pregnancy and childbirth, and for the provision of other related services for women and/or mothers and their infants.

The essential competencies to be achieved by the end of the training program are included in Textbox 2. Further detail of the knowledge and skills required to achieve these competencies is included in Annex 3 and this detail provides the framework for the content and teaching learning approaches used.

Each module is self-contained and includes a learning outline and a multiple-choice knowledge assessment questionnaire, which is to be administered on completion of the module. In addition, where applicable, skills checklists, role plays, case studies, and clinical simulations are included (for details, see the Learning Resource Package).

Modular learning allows students to progressively build skills one at a time. By focusing on the individual knowledge and skills needed to deal with a particular clinical problem the students give the time and attention needed to understand management of the problem. Once this problem is understood, they then move on to the next clinical situation or problem. During this time they continue to work in the hospital and/or health center to apply their new knowledge and skills in the clinical environment.
Textbox 2: Essential Competencies for Basic Midwifery Practice

There are seven essential competencies for the midwife as follows.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency in Social, Epidemiologic &amp; Cultural Context of Maternal and Newborn Health</td>
<td>The midwife/community midwife should have knowledge about the socio-cultural determinants and epidemiological context of maternal and newborn health and ethics that form the basis of appropriate care</td>
</tr>
<tr>
<td>Competency in Pre-pregnancy Care and Family Planning</td>
<td>The midwife/community midwife should provide high quality, culturally sensitive health education and family planning services in order to promote healthy family life, planned pregnancies and positive parenting</td>
</tr>
<tr>
<td>Competency in Care and Counselling During Pregnancy</td>
<td>The midwife/community midwife should provide high quality antenatal care to maximise the woman’s health during pregnancy, detect early and treat any complications which may arise and refer if specialist attention is required</td>
</tr>
<tr>
<td>Competency in care during labour and birth</td>
<td>The midwife/community midwife should provide high quality, culturally sensitive care during labour, conduct a clean, safe delivery, give immediate care to the newborn and manage emergencies effectively to prevent maternal and neonatal mortality and morbidity.</td>
</tr>
<tr>
<td>Competency in Postpartum Care of Women</td>
<td>The midwife/community midwife should provide comprehensive, high quality, culturally sensitive postpartum care for women</td>
</tr>
<tr>
<td>Competency in Postnatal Newborn Care and Care of the young child</td>
<td>The midwife/community midwife provides high quality postnatal care for the newborn and surveillance and preventive care for young children.</td>
</tr>
<tr>
<td>Competency in promoting health in the community</td>
<td>The midwife/community midwife participates in the promotion of health and wellness in the community and serves as a link between the community and the health system.</td>
</tr>
</tbody>
</table>

12 Adapted from ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY PRACTICE, 2002 International Confederation of Midwives
Program Calendar

Phase 1: Fundamentals of Midwifery Care in Normal Pregnancy and Childbirth. (32 weeks)

Phase 1 includes Modules 1 through 15 of the program. The first 9 of these modules provide an introduction to a range of topics that underpin midwifery training and practice. Many of these topics will be elaborated on in later modules so as to relate specific theoretical content to the learning of particular clinical skills. For example, Module 6 introduces learners to basic anatomy and physiology and Module 7 provides an introduction to the physiologic adaptations and changes that take place during pregnancy. This basic and/or introductory information is then expanded on in later modules; for instance, at the beginning of Module 11, which covers normal childbirth care, the physiology of labor is included. In addition, Phase 1 includes modules on normal antenatal and postpartum care and newborn care.

Module 15 is English language which is incorporated throughout all three phases of the training program, at least twice weekly during the weeks prior to the blocks spent in supervised clinical practice. English language skills are considered essential to move towards international equivalency in midwifery education and also increase the students ability to access technical documents such as on the Internet as well as in books and journals. Training in computing skills is also recommended but is not compulsory and can be made available if the schools resources include computers and technical support.

The program calendar (see Annex 4) reflects the structure of the training program for each of the three phases. In Phase 1, Modules 1 through 15 are covered during the first 32 weeks and include classroom activities (e.g., interactive presentations and discussions, role plays, case studies, etc.), simulated practice of clinical skills, and short periods of supervised practice at clinical sites. For example, the module covering antenatal care is spread over 3 weeks and includes classroom and skills learning activities integrated with periods of supervised practice in antenatal clinics.

Weeks 18 through 29 of Phase 1 are spent in supervised practice at various clinical sites. During this period, learners should be rotated through the sites so as to enable them to practice the full range of skills learned during Phase 1. When scheduling periods of supervised practice, it will be important to avoid overcrowding clinical sites by assigning only small groups of learners to each of the sites used for the training program. In addition, it will be important to ensure that learners are provided consistent and appropriate clinical supervision while at clinical sites.

On the last day of Week 29 a comprehensive knowledge assessment is included, based on a selection of the questions from the knowledge assessment questionnaires for Modules 1 through 15. The aim of this comprehensive knowledge assessment is to enable teachers to determine student progress and identify ongoing individual learning needs.

A break of three weeks is scheduled at the end of Phase 1, although these three weeks can be worked in at other times, providing that learning is not disrupted unnecessarily.
**Phase 2** covers the second 32 weeks of the training program and is structured in much the same way as Phase 1. Classroom activities, simulated practice of clinical skills, and short periods of supervised practice at clinical sites are scheduled covering Modules 16 through 26. Weeks 17 to 29 are then spent in supervised practice at various clinical sites and/or simulated practice, based on individual needs. At clinical sites, emphasis should, where possible, be placed on detecting and managing complications of pregnancy and childbirth. Learners should be rotated through the clinical sites to provide opportunities to practice the range of skills learned thus far.

Once again, a comprehensive knowledge assessment is included on the last day of Week 29, in this instance based on a selection of questions from the knowledge assessment questionnaires included in Modules 16 to 26.

As is the case with Phase 1, a break of three weeks is scheduled at the end of Phase 2 and these three weeks can also be worked in at other times, providing that learning is not disrupted unnecessarily.

**Phase 3** covers the third and final 32 week phase of the training program and differs slightly in structure from Phases 1 and 2. Weeks 1 to 9, for example, cover the remaining 9 modules in the program and include classroom activities, simulated practice of clinical skills, and time for supervised practice at clinical sites. Weeks 10 through 16 include review of the clinical modules included in Phases 1 and 2 of the program and will involve classroom activities, simulated practice of clinical skills, based on the individual needs of learners, and supervised practice at clinical sites. Weeks 17 through 30 are then spent entirely in supervised clinical practice during which learners should be assigned to clinical sites based on individual needs. For example, learners who need to develop further their competency in the skills for antenatal care should be assigned to an antenatal clinic for at least part of this clinical block. Towards the end of Phase 3 it is suggested if security and other factors permit that students are placed in the facility where they will work on graduation for 2-3 weeks to enable them to experience semi-autonomous community based practice in a supported manner. During this time they should plan to attend home births and participate in the regular service delivery of the facility (Guidelines to be developed).

Throughout the program teachers should continuously track the development of the clinical skills required. Most of these skills will be addressed in real clinical scenarios with patients. There may be some more rare events, however, that will not be able to be assessed with patients. These should be noted by the teachers and should be assessed using anatomic models and clinical simulations during the final weeks of the third phase. The ultimate goal is that, by the end of the program, all skills that are the objectives of the program will be assessed to competency in either real or simulated clinical settings.

The final comprehensive knowledge assessment is scheduled for the first day of Week 31 and is based on a selection of questions from the knowledge assessment questionnaires for Modules 1 through 35. Once again, this comprehensive knowledge assessment will enable teachers to assess the progress of learners and address individual learning needs during the final weeks of the program.
During Week 31 of Phase 3 final assessments of skills competency should be completed and, during Week 32, any remaining details relevant to completion of the program should be addressed.

**Key References**

The following selected texts/graphics have been identified as key references for student midwives and are identified within the Learning Resource Package:

- Best Practices in Maternal and Newborn Care: A Learning Resource Package for Essential and Basic Emergency Obstetric and Newborn Care (ACCESS 2008)
- Essential Package of Health Services (MoPH 2005)
- International Confederation of Midwives – several publications

In addition, supplementary materials have been prepared, which contain relevant theoretical content not included in the manuals mentioned above.

All of the reference materials will be available in both Dari and Pashto.
MODULE OUTLINES

Phase 1: Introductory Topics and Normal Pregnancy and Childbirth Care (32 weeks)

Module 1: Orientation
- Introduction to the training program
- Overview of materials
- How to use library
- Student responsibilities on the program (study skills)
- Visits to health facilities

Module 2: The Role of the Community Midwife
- The midwife in the community (Job Description)
- Introduction to professional behaviors and midwifery ethics (ICM Code of Ethics)
- Maternal and newborn health in Afghanistan (maternal & newborn mortality and morbidity)
- Social and cultural context of health in Afghanistan
- Safe motherhood and midwifery
- The sexual and reproductive rights of women

Module 3: Health Care in Afghanistan
- Provision and access to Maternal and Newborn Health
- Basic Package of Health Services
- Essential Package of Hospital Services
- Orientation to relevant policies
- Referral systems

Module 4: Interpersonal Communication Counseling & Behavior Change Communication
- Health Education – overview, methods, midwives as health educators, IEC, community mobilisation
- Interpersonal communication and counselling (IPCC) and the basics of IPCC
- Counselling – role of counselling, techniques, rights of clients
- Communication and gender
- Confidentiality

Module 5: Basic Nutrition
- General nutrition
- Nutritional problems in Afghanistan and how to address these
- Nutritional needs during pregnancy
- Nutritional needs of the newborn and small child
Module 6: Basic Anatomy and Physiology

- Overview of all systems
- Male and female reproductive systems in detail (integrate sexuality)
- CV system; respiratory system; alimentary tract and liver; endocrine system
- Vital signs (temperature, pulse, respiration, and blood pressure)

Module 7: Changes and Adaptations in Pregnancy

- Physiologic changes in the reproductive system
- Changes in other systems (cardiovascular, urinary, endocrine)
- Detecting and diagnosing pregnancy
- Auscultation of heart, lungs and bowel

Module 8: Foundations of Basic Maternal and Newborn Care

- General principles of basic care - hygiene
- Overview of key skills for basic care (problem solving, infection prevention practices, record keeping)
- Principles of medication and vaccine administration (including preparation and routes of administration) and giving injections (include vaccinations)
- Pre and post operative care, wound care

Module 9: Infection Prevention

- Personal and communal hygiene
- Infection prevention practices for health care providers

Module 10: Antenatal Care

- Focused antenatal care (FANC)
- The basic antenatal visit (assessment, including history, physical examination, pelvic examination, confirmation of pregnancy, and calculation of EDC; care provision, including birth planning, preventive measures, and health education and counseling)
- Birth preparedness and complication readiness including place for birth, funds, transportation and social support, danger signs
- Promotion of women’s empowerment and decision making
- Common discomforts in pregnancy
- Special needs, including anemia, HIV, and gender-based violence

Module 11: Childbirth Care

- Normal labor and childbirth, including the physiology and mechanism of labor; diagnosis and confirmation of labor
- Introduction to childbirth care
- Basic care during labor and childbirth, including best practices such as use of the partograph, clean and safe childbirth, active management of third stage, and episiotomy and repair
- Repair perineal and vaginal lacerations
- Common discomforts
- Special needs
Module 12: Newborn Care

- Introduction to newborn care
- Basic care of the newborn, including thermal protection, newborn resuscitation, Apgar scoring, eye care, early and exclusive breastfeeding, physical examination, and newborn immunization
- Counseling danger signs

Module 13: Postpartum Care

- Physiologic and psychological changes in the puerperium
- Introduction to postpartum care
- Basic postpartum visit (complication readiness and dangers signs)
- Common discomforts
- Special needs, including malaria, anemia, HIV, gender-based violence

Module 14: Pharmacology

- Principles of safe drug administration
- Principles of drug interactions, side effects and contraindications (e.g. toxicity)
- Calculations
- Principles of prescribing and recording relating to midwifery practice
- Drugs for Reproductive Health per essential drug list in Afghanistan

Module 15: \(^{13}\) English language (repeated each Phase)

- Understand medial terms in common use

\(^{13}\) English Language should continue through the program in each Phase
Phase 2: Complications of Pregnancy and Childbirth (32 weeks)

Module 16: Vaginal Bleeding in Pregnancy and Labor

- Understanding bleeding in pregnancy and labor
- Detecting and managing vaginal bleeding in early pregnancy
- Detecting and managing vaginal bleeding in later pregnancy and labor
- Rapid initial assessment and management of shock, including taking blood samples, starting an IV, and bladder catheterization
- Blood transfusion
- Cardio-pulmonary resuscitation
- Manual vacuum aspiration (MVA)
- Post abortion Care

Module 17: Vaginal Bleeding After Childbirth

- Understanding bleeding after childbirth
- Detecting and managing vaginal bleeding after childbirth
- Manual removal of placenta
- Vaginal and cervical inspection
- Repair of 3rd degree and cervical tears
- Prevention of PPH programs (use of Misoprostol)

Module 18: Headaches, Blurred Vision, Convulsions or Loss of Consciousness, Elevated Blood Pressure

- Understanding pre-eclampsia and eclampsia
- Detecting and managing pre-eclampsia and eclampsia
- Anticonvulsive and antihypertensive drug administration

Module 19: Unsatisfactory Progress in Labor

- Understanding obstructed labor
- Detecting and managing unsatisfactory progress in labor
- Vacuum extraction
- Safe Caesarean Section

Module 20: Malpositions and Malpresentations

- Understanding malpositions and malpresentations
- Detecting and managing malpositions and malpresentations
- Breech delivery

Module 21: Shoulder Dystocia

- Understanding shoulder dystocia
- Detecting and managing shoulder dystocia
Module 22: Labor With an Overdistended or Scarred Uterus

- Detecting and managing labor with an overdistended uterus
- Managing labor with a scarred uterus

Module 23: Fetal Distress in Labor and Prolapsed Cord

- Understanding fetal distress in labor
- Detecting and managing fetal distress in labor
- Understanding prolapsed cord
- Detecting and managing prolapsed cord
- Detecting and managing intrauterine fetal death

Module 24: Fever During Pregnancy and Labor and After Childbirth

- Understanding fever during pregnancy and labor and after childbirth
- Detecting and managing fever during pregnancy and labor and after childbirth (including administration of antibiotics)
- Preventing, detecting and managing Malaria in pregnancy and postpartum

Module 25: Other Complications in Pregnancy and Childbirth

- Detecting and managing abdominal pain in early pregnancy
- Detecting and managing abdominal pain in later pregnancy and after childbirth
- Detecting and managing difficulty in breathing in pregnancy
- Detecting and managing loss of fetal movements
- Detecting and managing premature rupture of membranes
- Detecting and managing preterm labour
- Detecting and managing pre-existing medical problems (severe anaemia, diabetes, cardiac and/or respiratory conditions, essential hypertension, renal disease)

Module 26: Managing Newborn Problems

- Assessment of the newborn with a problem
- Managing breathing difficulties, sepsis (major infections) convulsions or spasms, jaundice, diarrhea, and vomiting, congenital malformations
- Measuring body temperature in the newborn
- Low birth weight (LBW); feeding LBW; Kangaroo Mother Care
- Support for perinatal loss
Phase 3: Family Planning and Other RH Topics (32 weeks)

Module 27: Family Planning

- Family planning in the context of Afghanistan (policies)
- Women’s decision making in reproductive choices and male involvement
- Family planning counseling
- Modern methods of family planning (natural methods, condom (male & female) cervical cap, oral contraceptive pills, DMPA, and IUD, Emergency Contraception, permanent
- PPFP – LAM and PP IUCD
- IUD insertion and removal
- Advantages and disadvantages including effectiveness each method and side effects

Module 28: Other Reproductive Health Topics

- Traditional practices harmful to reproductive health (child marriage and teenage pregnancy)
- Obstetric fistula
- Infertility
- Cervical and breast cancer
- Other RH problems - DUB
- Menopause

Module 29: STIs and HIV/AIDS

- Recognition/screening and management STIs
- Prevention & education HIV/AIDS

Module 30: Mental Health

- Interpersonal relationships
- Mental health promotion
- Mental health prevention
- Mental health assessment
- Psychosocial problems/stresses (gender based violence)
- Psychosocial management (counselling)
- Mild Mental Health Disorders (mild-moderate post partum depression, anxiety disorders, unexplained somatic complaints): primarily psycho-social management
- Severe Mental Illness (puerperal psychosis, severe depression, bipolar disorder, schizophrenia): bio-psycho-social management (including family support)

Module 31: Care of the Young Child

- Growth monitoring
- Nutrition of the young child, including weaning practices
- Immunization
- Detecting and managing common health problems in the first year of life (5 major killers) - IMCI
Module 32: Supervision and Partnership

- Roles and interactions of Community Midwives, CHWs, CHSs and TBAs
- Partnering with CHWs, TBAs, and community leaders for Safe Motherhood
- Supervision skills for Community Midwives
- Reporting and documentation
- Preparing a community profile

Module 33: Professional Issues in Midwifery

- Ethics in midwifery practice
- Continuing education for midwives
- Preparing to begin fulltime work as a community midwife at a designated facility
- Role of the midwife internationally
- Role of professional associations
- Evidence based practice and introduction to research
- Islam and health

Module 34: Health Service management

- Primary health care – access and equity
- Teamwork and managing a health team
- Leadership
- Effective and efficient use of resources (drug supply & management)
- Overview human resources; conflict resolution
- Quality in health care – performance improvement approaches

Module 35: Basic epidemiology & surveillance

- Basic epidemiology & surveillance
- Maternal death review

Note:

1. Islamiyat at the program’s discretion in Phase 1 – 3
2. Additional classes in literacy and numeracy as required can be added however these are additional activities and do not replace other subjects.
LEARNING APPROACH

Mastery Learning

The mastery learning approach assumes that all learners can master (learn) the required knowledge, attitudes, or skills provided there is sufficient time and appropriate learning methods are used. The goal of mastery learning is that 100 percent of the learners will "master" the knowledge and skills on which the training is based. Mastery learning is used extensively in inservice training where the number of learners, who may be practicing clinicians, is often low. While the principles of mastery learning can be applied in preservice education, the larger number of learners presents some challenges.

Although some learners are able to acquire new knowledge or new skills immediately, others may require additional time or alternative learning methods before they are able to demonstrate mastery. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken, or visual means. Effective learning strategies, such as mastery learning, take these differences into account and use a variety of teaching methods.

The mastery learning approach also enables the learner to have a self-directed learning experience. This is achieved by having the teacher serve as facilitator and by changing the concept of testing and how test results are used. Moreover, the philosophy underlying the mastery learning approach is one of continual assessment of learning where the teacher regularly informs learners of their progress in learning new information and skills.

With the mastery learning approach, assessment of learning is:

- Competency-based, which means assessment is keyed to the learning objectives and emphasizes acquiring the essential skills and attitudinal concepts needed to perform a job, not just to acquiring new knowledge.
- Dynamic, because it enables learners to review continual feedback on how successful they are in meeting the course objectives.
- Less stressful, because from the outset learners, both individually and as a group, know what they are expected to learn, know where to find the information, and have ample opportunity for discussion with the teacher.

Mastery learning is based on principles of adult learning. This means that learning is participatory, relevant, and practical. It builds on what the learner already knows or has experienced and provides opportunities for practicing skills. Other key features of mastery learning are that it:

- uses behavior modeling,
- is competency-based, and
- Incorporates humanistic learning techniques.
Behavior Modeling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modeling to be successful, however, the teacher must clearly demonstrate the skill or activity so that learners have a clear picture of the performance expected of them.

Behavior modeling, or observational learning, takes place in three stages. In the first stage, **skill acquisition**, the learner sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the learner attempts to perform the procedure, usually with supervision. Next, the learner practices until **skill competency** is achieved and s/he feels confident performing the procedure. The final stage, **skill proficiency**, occurs with repeated practice over time.

<table>
<thead>
<tr>
<th>Skill Acquisition</th>
<th>Knows the steps and their sequence (if necessary) to perform the required skill or activity but <strong>needs assistance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skill competency</td>
<td>Knows the steps and their sequence (if necessary) and <strong>can perform</strong> the required skill</td>
</tr>
<tr>
<td>Skill Proficiency</td>
<td>Knows the steps and their sequence (if necessary) and <strong>effectively performs</strong> the required skill or activity</td>
</tr>
</tbody>
</table>
Competency-Based Training

Competency-based training (CBT) is learning by doing. It focuses on the specific knowledge, attitudes, and skills needed to carry out the procedure or activity. How the learner performs (i.e., a combination of knowledge, attitudes, and, most important, skills) is emphasized rather than just the information learned. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

To successfully accomplish CBT, the clinical skill or activity to be taught must be broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. The process is called standardization. Once a procedure, such as active management of the third stage of labor, has been standardized, competency-based learning guides and evaluation checklists can be developed to make learning the necessary steps or tasks easier and evaluating the learner’s performance more objective.

An essential component of CBT is coaching, in which the classroom or clinical teacher first explains a skill or activity and then demonstrates it using an anatomic model or other training aid, such as videotape. Once the procedure has been demonstrated and discussed, the teacher then observes and interacts with learners to guide them in learning the skill or activity, monitoring their progress and helping them overcome problems.

The coaching process ensures that the learner receives feedback regarding performance:

- **Before practice.** The teacher and learners meet briefly before each practice session to review the skill/activity, including the steps/tasks that will be emphasized during the session.

- **During practice.** The teacher observes, coaches, and provides feedback to the learner as s/he performs the steps/tasks outlined in the learning guide.

- **After practice.** Immediately after practice, the teacher uses the learning guide to discuss the strengths of the learner’s performance and also offer specific suggestions for improvement.
Humanistic Training Techniques

The use of more humane (humanistic) techniques also contributes to better clinical learning. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids. Working with models initially, rather than with patients/clients, allows learners to learn and practice new skills in a simulated setting rather than with patients/clients. This reduces stress for the learner as well as risk of injury and discomfort to the patient/client. Thus, effective use of models (humanistic approach) is an important factor in improving the quality of clinical training and, ultimately, service provision.

Before a learner performs a clinical procedure with a patient/client, two learning activities should occur:

- The clinical teacher should demonstrate the required skills and patient/client interactions several times using an anatomic model and appropriate videotape.

- Under the guidance of the teacher, the learner should practice the required skills and patient/client interactions using the model and actual instruments and/or equipment in a setting that is as similar as possible to the real situation.

Only when skill competency has been demonstrated should learners have their first contact with a patient/client. This often presents challenges in a preservice education setting when there are large numbers of learners. Before any learner provides services to a patient/client, however, it is essential that the learner demonstrate skill competence in a simulated setting.

When mastery learning, which is based on adult learning principles and behavior modeling, is integrated with CBT, the result is a powerful and extremely effective method for providing clinical training. And, when humanistic training techniques, such as using anatomic models and other learning aids, are incorporated, training time and costs can be reduced significantly.
Assessing Competence

As described in Humanistic Training Techniques (above), learners should first practice a new clinical skill using anatomic models. For interpersonal and decision-making skills, other methodologies are used. These include role plays, case studies, and clinical simulations. Once learners have had adequate practice, including coaching and feedback from their teacher, and before practicing a skill with patients/clients, they are assessed using one of these methodologies.

Ideally, learners will then continue to practice these skills with patients/clients until they are able to demonstrate competency in the clinical setting. This final assessment of competency with patients/clients is necessary before they can perform a skill without supervision. Ongoing practice and assessment with patients/clients may not, however, be possible for all of the skills needed to provide high quality care during pregnancy and childbirth.

A realistic guideline to follow is that most, if not all, skills associated with normal maternal and newborn care should be assessed with patients/clients, while skills that are rarely required should be assessed using other methodologies. Nonetheless, if there are opportunities to practice these rare skills and be assessed with a patient/client, they should be taken.
LEARNING METHODS

A variety of learning methods, which complement the learning approach described in the previous section, is included in the learning resource package. A description of each learning method is provided below.

Illustrated Lectures/ Interactive Presentations

Lectures should be used to present information about specific topics. The lecture content should be based on, but not necessarily limited to, the information in the recommended reference manual/text book/other written materials.

There are two important activities that should be undertaken in preparation for each lecture or interactive presentation. First, the learners should be directed to read relevant sections of the resource manual (and other resource materials, if and when used) before each lecture. Second, the teacher should prepare for lectures by becoming thoroughly familiar with the technical content of a particular lecture.

During lectures, the teacher should direct questions to learners and also encourage them to ask questions at any point during the lecture. Another strategy that encourages interaction involves stopping at predetermined points during the lecture to discuss issues/information of particular importance.

Case Studies

The purpose of the case studies included in the learning resource package is to help learners practice clinical decision-making skills. The case studies can be completed in small groups or individually, in the classroom, at the clinical site, or as take-home assignments.

The case studies follow the clinical decision-making framework presented under Foundation Topics. Each case study has a key that contains the expected responses. The teacher should be thoroughly familiar with these responses before introducing the case studies to learners. Although the key contains the “likely” responses, other responses provided by learners during the discussion may be equally acceptable. The technical content of the case studies is taken from the recommended reference manual/text book/other written materials.
Role Plays

The purpose of the role plays included in the learning resource package is to help learners practice interpersonal communication skills. Each role play requires the participation of two or three learners, while the remaining learners are asked to observe the role play. Following completion of the role play, the teacher uses the questions provided to guide discussion.

Each role play has a key that contains the likely answers to the discussion questions. The teacher should be familiar with the answer key before using the role plays. Although the key contains “likely” answers, other answers provided by learners during the discussion may be equally acceptable.

Skills Practice Sessions

Skills practice sessions provide learners with opportunities to observe and practice clinical skills, usually in a simulated setting. The outline for each skills practice session includes the purpose of the particular session, instructions for the teacher, and the resources needed to conduct the session, such as models, supplies, equipment, learning guides, and checklists. Before conducting a skills practice session, the teacher should review the session and ensure that s/he can perform the relevant skill or activity proficiently. It will also be important to ensure that the necessary resources are available and that an appropriate site has been reserved. Although the ideal site for conducting skills practice sessions may be a learning resource center or clinical laboratory, a classroom may also be used providing that the models and other resources for the session can be conveniently placed for demonstration and practice.

The first step in a skills practice session requires that learners review the relevant checklist, which contains the individual steps or tasks, in sequence (if necessary), required to perform a skill or activity in a standardized way. The checklists are designed to help learn the correct steps and the sequence in which they should be performed (skill acquisition), and measure progressive learning in small steps as the learner gains confidence and skill (skill competency).

Next, the teacher demonstrates the steps/tasks, several times if necessary, for the particular skill or activity and then has learners work in pairs or small groups to practice the steps/tasks and observe each other’s performance, using the relevant checklist. The teacher should be available throughout the session to observe the performance of learners and provide guidance. Learners should be able to perform all of the steps/tasks in the checklist before the teacher assesses skill competency, in the simulated setting, using the relevant checklist (see Skill Assessments with Models under Assessment Methods). Supervised practice should then be undertaken at a clinical site before the teacher assesses skill competency with patients/clients, using the same checklist.

The time required to practice and achieve competency may vary from hours to weeks or months, depending on the complexity of the skill, the individual abilities of learners, and access to skills practice sessions. Therefore, numerous practice
sessions will usually be required to ensure achievement of competency before moving into a clinical practice area.

Clinical Simulations

A clinical simulation is an activity in which the learner is presented with a carefully planned, realistic recreation of an actual clinical situation. The learner interacts with persons and things in the environment, applies previous knowledge and skills to respond to a problem, and receives feedback about those responses without having to be concerned about real-life consequences. The purpose of clinical simulations is to facilitate the development of clinical decision-making skills.

The clinical simulations included in the learning resource package provide learners with the opportunity to develop the skills they need to address rare or life-threatening situations. Clinical simulation may, in fact, be the only opportunity learners have to experience some rare situations and therefore may also be the only way that a teacher can assess learners’ abilities to manage these situations.

Clinical simulations should be as realistic as possible. This means that the models, equipment, and supplies needed for managing the particular complication involved in the simulation should be available to the learner.

Learners will need time and repeated practice to achieve competency in the management of the complex situations presented in the simulations. They should be provided with as many opportunities to participate in simulations as possible. The same simulation can be used repeatedly until the situation presented is mastered.
ASSESSMENT METHODS

A variety of assessment methods, which complement both the learning approach and the learning methods described in the previous two sections, are included in the learning resource package. Each assessment method is described below.

Case Studies

Case studies serve as an important learning method, as described earlier. In addition, they provide an opportunity for the teacher to assess the development of clinical decision-making skills, using the case study keys as a guide. Assessment can be conducted on an individual basis or in small groups.

Role Plays

Role plays also serve as both a learning method and a method of assessment. Using the role play keys as a guide, the teacher can assess learners’ understanding and development of appropriate interpersonal communication skills. Opportunities will arise during role plays for the teacher to assess the skills of the learners involved, whereas the discussions following role plays will enable the teacher to assess the attitudes and values of all learners in the context of their role as health care providers.

Clinical Simulations

As with case studies and role plays, clinical simulations serve both as a learning method and a method of assessment. Throughout the simulations, the teacher has the opportunity to assess clinical decision-making skills as well as knowledge relevant to a specific topic.

Written Tests

Each module includes a multiple-choice test, or knowledge assessment questionnaire, intended to assess factual recall at the end of the module. The items on the questionnaire are linked to the learning objectives for the module; each questionnaire has an answer sheet for learners and an answer key for teachers. Students who fail their first attempt should be given individual guidance to help them learn the required information before completing the test again.

14 Please read in conjunction with Assessment Policy.
Skill Assessments with Models and Patients/ Clients

Skill assessments with models and patients/clients are conducted using skill checklists. The checklists focus on the key steps or tasks and enable assessment and documentation of the learner’s overall performance of a particular skill or activity. If a checklist is too long and /or detailed, it may distract the teacher from objectively assessing the learner’s overall performance.

Using checklists in competency-based training:

- ensures that learners have mastered the clinical skills or activities, first with models and then, where possible, with patients/clients,
- ensures that all learners have their skills measured according to the same standard, and
- forms the basis for follow-up observations and evaluations.

When using checklists, it is important that the scoring is completed correctly, as follows:

**Satisfactory:** Performs the step or task according to the standard procedure or guidelines.

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines.

**Not Observed:** Step, task, or skill not performed by learner during evaluation by teacher.

As described in Skills Practice Sessions under Learning Methods, learners should be able to perform all of the steps/tasks for a particular skill before the teacher assesses skill competency, in a simulated setting, using the relevant checklist. Supervised practice should then be undertaken at a clinical site before the teacher assesses skill competency with patients/clients, using the same checklist. It should be noted, however, that there may not be opportunities for all learners to practice the full range of skills required for the management of complications at a clinical site; therefore, competency should be assessed in a simulated setting.

It is important to keep in mind, however, that it will probably not be possible for learners to practice some of the additional skills with patients at a clinical site. For example, obstetric complications are not common; therefore, patients who experience complications may not be available, making it impossible for learners to undertake supervised practice in certain skills, or for skill competency to be assessed at a clinical site. For these skills, practice and assessment of competency should take place in a simulated setting. The following table provides guidelines for final assessment of skills competency.
## Guidelines for Final Assessment of Competency

<table>
<thead>
<tr>
<th>Skills for which <em>final assessment may</em> be completed using case studies, role plays, or clinical simulations (patients should be used whenever possible)</th>
<th>Skills for which <em>final assessment must</em> be completed with patients (skills should be learned to competency with models, case studies, role plays, or clinical simulations first)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTENATAL CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Antenatal history taking and examination</td>
<td></td>
</tr>
<tr>
<td>Antenatal care, including preparation of birth plan</td>
<td></td>
</tr>
<tr>
<td>Management of severe pre-eclampsia/eclampsia</td>
<td></td>
</tr>
<tr>
<td>Management of shock</td>
<td></td>
</tr>
<tr>
<td>Postabortion care including uterine evacuation with MVA</td>
<td></td>
</tr>
<tr>
<td><strong>LABOR AND CHILDBIRTH CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Vacuum extraction childbirth</td>
<td>Initial assessment in labor</td>
</tr>
<tr>
<td>Breech delivery</td>
<td>Use of the partograph</td>
</tr>
<tr>
<td>Management of prolapsed cord</td>
<td>Ongoing assessment and care throughout labor</td>
</tr>
<tr>
<td>Management of shoulder dystocia</td>
<td>Clean and safe childbirth, including active management of the third stage of labor</td>
</tr>
<tr>
<td></td>
<td>Episiotomy and perineal repair</td>
</tr>
<tr>
<td><strong>POSTPARTUM AND NEWBORN CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Postpartum history taking and examination</td>
<td></td>
</tr>
<tr>
<td>Bimanual compression of the uterus</td>
<td>Postpartum care, including breastfeeding support</td>
</tr>
<tr>
<td>Compression of the abdominal aorta</td>
<td>Family planning counseling and assessment</td>
</tr>
<tr>
<td></td>
<td>Management of vaginal bleeding after childbirth</td>
</tr>
<tr>
<td></td>
<td>Manual removal of the placenta</td>
</tr>
<tr>
<td>Inspection and repairs of cervical tears</td>
<td>Inspection and repair of perineal and vaginal,</td>
</tr>
<tr>
<td>Counseling and Post placental insertion of IUD</td>
<td>Care of woman after caesarean section</td>
</tr>
<tr>
<td><strong>NEWBORN CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and management of newborn with acute infection, low birth weight/prematurity and birth asphyxia</td>
<td>Immediate newborn care, including warmth, cord care, and eye care</td>
</tr>
<tr>
<td></td>
<td>Newborn resuscitation</td>
</tr>
<tr>
<td></td>
<td>Newborn examination</td>
</tr>
<tr>
<td></td>
<td>Newborn immunization</td>
</tr>
<tr>
<td><strong>REPRODUCTIVE HEALTH CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Counseling assessment for and insertion/removal of intrauterine contraceptive device</td>
<td></td>
</tr>
<tr>
<td>Counseling and management of patient with symptoms of sexually transmitted infection</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 1: JOB DESCRIPTION
Community Midwife Job Description

The community midwife works in the country’s provincial and district health centres (comprehensive and basic) to predominantly deliver reproductive health care services to women. She assumes responsibility and accountability for her practice, applying up to date knowledge and skills in caring for each woman and family. She works as a member of a team that includes doctors (including ob/gyn specialists), midwives, nurses, paramedicals and community health workers.

The responsibilities of the community midwife are to:

1. Give the necessary supervision, care and advise to women during pregnancy, labour and the postpartum period
2. Conduct deliveries on her own and care for the newborn infant
3. Manage complications in pregnancy and childbirth, in accordance with the principles of basic emergency obstetric care
4. Provide primary care to women of reproductive age, in accordance with the Basic Package of Health Services (BPHS)
5. Supervise the provision of primary health care within the community by female community health workers
6. Counsel and educate women, the family and the community, in relevant areas of health including preparation for parenthood and childbirth
7. Provide all non-surgical methods of family planning, and counselling for surgical methods
8. Obtain specialised assistance as necessary (consultation or referral)
9. Share knowledge, skill and expertise with midwifery, medical and nursing students, and nursing and resident staff, in management of pregnancy and childbirth, acting as a clinical preceptor
10. Perform limited, select administrative duties such as patient charting, recording and reporting of data; clinic and/or facility management (as required); or coordination of specific educational or outreach programs
11. Participate in research, professional organizations and related committees; and in continuing education opportunities
12. Follow established health centre policies, procedures and objectives; continuous quality improvement initiatives; safety, environmental, and infection prevention standards
13. Participate in provision of 24-hour, 7-day maternity service, which may require evening, night or on-call duty

The required competencies in order to successfully perform the above services include:

15 Adapted from World Health Organization, Competencies for Midwifery Practice (Adapted from the Provisional Competencies for Basic Midwifery Practice Prepared by the International Confederation of Midwives, 1999).
Competency 1: Community midwives have the requisite knowledge and skills from the social sciences, the public health sector and ethics that form the basis of high quality, culturally relevant, appropriate care for women, their newborns, and their families.

Competency 2: Community midwives provide high quality, culturally sensitive health education and family planning services in the community in order to promote healthy family life, planned pregnancies and positive parenting.

- Provide information and counselling on family planning.
- Provide all methods of non-surgical family planning services (clinical and non-clinical).
- Provide counselling and referral information for surgical methods of contraception.

Competency 3: Community midwives provide high quality antenatal care to maximize the woman’s health during pregnancy, detect early and manage/refer any complications.

- Diagnose pregnancy and perform antenatal history and examination.
- Provide early detection and referral of non-emergent complications.
- Provide tetanus toxoid immunization, iron and folic acid and other antenatal preventive measures according to the BPHS
- Advise on development of birth plan, and promote the concept of birth preparedness and complication readiness
- Counsel on prenatal self care, including nutrition, hygiene, breastfeeding and danger signs in pregnancy and childbirth
- Detect and manage/refer obstetric emergencies, according to the principles of basic emergency obstetric care

Competency 4: Community midwives provide high quality, culturally sensitive care during labour; conduct a clean, safe delivery; give care to the newborn, and manage/refer emergencies effectively to prevent maternal and neonatal mortality and morbidity.

- Perform history and exam of the labouring woman and diagnose labour
- Manage labour, using the partograph
- Assist the woman in clean, safe and humanistic childbirth
- Conduct active management of the third stage of labour for reduction of post partum haemorrhage
- Diagnose (using the partograph) and manage/refer women with prolonged second stage labour, and diagnose and refer women with other labour abnormalities
- Treat postpartum haemorrhage (including manual removal of placenta and injection oxytocics). Stabilize and refer required cases.
- Detect and manage (or refer) obstetric emergencies, according to the principles of basic emergency obstetric care
- Refer complications of labor and birth when necessary
**Competency 5:** Community midwives provide comprehensive, high quality, culturally sensitive postnatal care for women.
- Provide immediate postpartum care, including history, examination and counselling
- Provide postpartum assessment(s) of mother and infant
- Offer postpartum family planning counselling and services
- Counsel on breastfeeding and provide nutritional support to woman
- Detect and manage obstetric emergencies, according to the principles of basic emergency obstetric care
- Refer postpartum complications when necessary

**Competency 6:** Community midwives provide high quality care for the newborn infant and surveillance and preventive care for young children.
- Provide immediate newborn care with a focus on airway, warmth and breastfeeding
- Provide emergency measures for newborn resuscitation
- Provide routine newborn care, including physical examination, care of the umbilical cord, immunization, etc.
- Provide emergency care for newborns (including hypothermia, infections of eye or cord stump, etc.) and infants, according to principles of IMCI
- Encourage exclusive breastfeeding and provide nutrition counselling to mothers on introduction of appropriate weaning foods
- Provide basic care for infants including history and examination; care provision including care for ARI and CDD; preventative care including immunization and growth monitoring; and counselling to parents on infant and child care and danger signs
- Monitor newborn and child growth and development; identify malnourished children and refer for management
- Provide preventative care, including immunization, to young children
- Identify and refer conditions or complications beyond the scope of practice

**Competency 7:** Community midwives participate in the promotion of health and wellness in the community and serve as a link between the community and the health system.
- Support community health workers in their provision of community based health care by participating in, and providing technical guidance as required, during periodic CHW meetings
- Provide supportive clinical supervision and technical information to CHWs regarding maternal and newborn health
- Support CHW and TBA with respect to referral cases brought to the facility
- Work with CHW and community leaders to promote the concept of birth preparedness and complication readiness related to pregnancy, delivery and newborn care
- Partner with TBAs to bring them and their services into the health system
ANNEX 2: NATIONAL POLICY ON MIDWIFERY EDUCATION AND ACCREDITATION
Policy (Updated version)

Midwifery Education and the Accreditation of Midwifery Education Programs in Afghanistan

BACKGROUND

In 2002 an estimated 467 midwives were in Afghanistan\(^\text{16}\). Midwifery schools had essentially been closed from 1996 – 2002 and the human resource need was critical, especially given the high maternal mortality and the mal-distributions of these few midwives. Even those few midwives were inadequately prepared for work and varied greatly with respect to their formal training. Results to date on the national testing and certification exams show that the majority of midwives do not meet minimum levels of competency\(^\text{17}\).

In response to this shortage, there has been substantial effort to educate midwives for work at both hospital and health center levels. In 2002 there were nurse-midwifery programs at 6 of the country’s campuses of the Institute of Health Sciences (IHS), and one community midwife program in Nangarhar province. Now there are 4 IHS midwifery programs and 30 community midwifery programs and a new skill-focused curriculum for the education of midwives. This rapid expansion raises the concern that programs may potentially not understand nor abide by MoPH recommendations for the standardized formation of qualified midwives.

GOAL

The **goal** of this policy is to establish the framework for appropriate and successful recruitment, education and deployment of midwives in the country, and the accreditation of those institutions assigned to educate these midwives.

\(^{16}\) Health Resources Assessment Survey, MSH, 2002
\(^{17}\) Human Resource Directorate, Summary of Testing and Certification Program, 2005
DEFINITIONS:

According to the World Health Organization (WHO), International Confederation of Midwives (ICM) and International Federation of Gynaecology and Obstetrics (FIGO):

A **midwife** is a person who, having been regularly admitted to a midwifery educational programme duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.


Based on this definition, and given the situation in Afghanistan, the following cadre, and only the following cadre, are accepted in Afghanistan:

- **Midwife**: a fully trained midwife who graduates from one of the campuses of the Institute of Health Sciences and is deployed to hospitals (central, provincial and district) or comprehensive health centers.

- **Community Midwife**: a fully trained midwife who graduates from one of the recognized community midwife education programs in Afghanistan and is deployed to basic or comprehensive health centers\(^\text{18}\). She is facility-based with outreach to the community.

Job descriptions for both midwife and community midwife have been approved and are in effect at this time.

RECRUITMENT

Candidates for midwifery and community midwife programs will be recruited based on geographic need and commitment to work in designated posts. They will be recruited predominantly from the provinces and rural areas and, to the extent possible, will have a deployment post designated at the time of recruitment. In the IHS midwifery program 75% of candidates will have a designated post-graduation work station determined prior to admission; for the community midwife programs 90% of candidates will have a designated post-graduation work station determined prior to admission. Recruitment is done in collaboration with national, provincial and local health authorities and communities, under the direction of the General Directorate of Human Resources.

\(^{18}\) Given the shortage of midwives who are able and willing to be deployed to provinces throughout the country, community midwives may be hired to posts at provincial and district hospitals until 2008.
ADMISSION

Admission of students to the IHS midwifery and CME programs will be according to the national admission policy and criteria. All students will meet the admission criteria outlined in the educational standards. Students and their families are required to sign educational contracts at the outset of the course which defines their rights and obligations.

EDUCATION

Midwifery education is based upon the concepts of competency-based education. The educational programs and the clinical sites where students receive clinical instruction and practice must ensure that students develop the lifesaving knowledge, skills and attitudes required of them as professionals.

Programs will be conducted according to the national educational standards (see Appendix 1). Student progression and graduation is based upon attainment of key clinical competencies. Academic policies contained within the standards will be followed by all programs. Education is conducted with the understanding that new graduates leave the program ready to work and should not need substantial additional training once they have taken up their posts.

All IHS midwifery programs are required to follow the national curriculum for midwifery education as well as use the approved learning resources and references linked to that curriculum. Likewise, all community midwife education programs are required to follow the national curriculum for community midwife education as well as use the approved learning resources and references linked to that curriculum. Until 2008 midwives who graduate from accredited schools will not be required to sit for the national licensing examination. They will only be required to register with the MoPH. Midwives who graduate from pre-existing, non- accredited schools, however, would be required to sit for the national exam and pass it in order to be licensed to practice as a midwife.

DEPLOYMENT

All programs are required to gather prescribed demographic and academic data on their students and maintain appropriate records. Deployment should be planned from the time of student recruitment and done in close collaboration with national and/or provincial health authorities. Records on deployment are to be maintained by the program implementers, the GIHS and the General Directorate of Human Resources.

PROGRAM ESTABLISHMENT, MONITORING and ACCREDITATION

A National Midwifery Education Accreditation Board is established for the purpose of authorizing, supervising and monitoring all midwifery and community midwife education programs in the country. Programs operating outside the authority of this Board will be ordered to close by the MoPH.

This Board will consist of representatives of the following institutions:
- MoPH Department of Nursing & Midwifery (1)
- MoPH Human Resources General Directorate (1)
- MoPH Reproductive Health Directorate (1)
- Institute of Health Sciences/Kabul or Regional (1)
- Afghan Midwives Association (1)
- NGO Representatives (2)
- International Representatives (Donor and/or UN Agency) (2)

The Chair will be a MoPH representative and will be nominated by the Board members. The Board will ensure the uniform and appropriate implementation of the Midwifery Education Accreditation Program. The Board will be supported by a secretariat for administrative purposes. Each school will be assessed a fee for their mandatory participation in the accreditation process.

New programs may only be established with the authority of this Board, and upon successful demonstration that they have achieved a minimum acceptable level of quality prior to initiating instruction. Donors will be requested to support only accredited programs, and to approach the Board prior to allocating funds for any new or existing programs.

Current existing programs should have an accreditation assessment and make every effort to achieve accreditation prior to graduating their first group of graduates.

All programs will be monitored and assessed using the national educational standards for midwifery education. Standards based educational management (SBEM) is a system for the assessment, monitoring and quality improvement and accreditation of midwifery programs in Afghanistan. Though SBEM is primarily used to measure progress in the accreditation process, it also serves as a clear and explicit statement of the manner in which educational programs should be conducted. It states the standards for desired performance and provides guidance toward achieving those standards. The standards describe desired performance in five specific areas: Classroom and Practical Instruction; Clinical Instruction and Practice; School Infrastructure, Curriculum and Training Materials; School Management; and clinical areas where student midwives undertake clinical experience. These standards are attached in Appendix 1 and the accreditation tools are attached as Appendix 2.

All programs will be given a reasonable amount of time and support for the implementation of these standards. Thereafter, they will be accredited based upon their compliance with those standards. Accreditation is granted when a program achieves 85% of the standards in each area. The following thresholds will be used for accreditation and additional action:

<table>
<thead>
<tr>
<th>Program Status</th>
<th>% achievement of standards</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Accreditation</td>
<td>≥85%</td>
<td>Renewal every 2 years</td>
</tr>
<tr>
<td>Provisional Accreditation</td>
<td>75 – 84%</td>
<td>Reassessment in 1 year</td>
</tr>
<tr>
<td>Probation</td>
<td>65 – 74%</td>
<td>Reassessment in 6 months</td>
</tr>
<tr>
<td>Suspension</td>
<td>&lt;65%</td>
<td>Close in 3 months</td>
</tr>
</tbody>
</table>

Accredited programs will be reassessed every 2 years or sooner if there is evidence of deteriorating quality.

All programs are required to reserve an appropriate amount of budget to fund the visits and activities of the Accreditation Board related to the process of accreditation of their program.

The Board will be supported by a secretariat and the finances and operation of the Board will be conducted in a transparent manner.

*This policy will be reviewed every 3 years.*
APPENDIX 1: EDUCATIONAL STANDARDS FOR MIDWIFERY EDUCATION

Classroom and Practical Instruction

1. Classroom instructors have the requisite qualifications
2. Classroom instructors come to class prepared
3. Classroom instructors are teaching according to the curriculum and related learning resource materials
4. Classroom instructors introduce their classes effectively
5. Classroom instructors use effective presentation and questioning techniques
6. Classroom instructors summarize before ending a presentation or class
7. Classroom instructors facilitate group activities effectively
8. Classroom instructors plan and administer knowledge assessments
9. Knowledge assessments and exams are administered fairly
10. Results of knowledge assessments and exams are recorded and reported properly
11. Instructors use the skills learning lab effectively for demonstrating clinical skills
12. Instructors use the skills learning lab effectively for student practice of clinical skills
13. Instructors use the skills learning lab effectively for assessing student achievement of clinical skill competence
14. Teaching is routinely monitored for effectiveness

Clinical Instruction and Practice

15. The number of clinical practice sites meet the requirements of the curriculum
16. The variety of clinical sites meets the requirements of the curriculum
17. The infrastructure of the clinical practice area is conducive to clinical practice
18. Clinical volume at the clinical practice sites is adequate for student learning
19. The school has an agreement with the clinical practice sites that allows students’ learning,
20. The clinical practice sites are prepared for student teaching
21. Schedules have been developed to distribute students across clinical practice areas evenly
22. Transportation is assured to and from clinical practice sites
23. Students are provided meals while on duty in clinical practice facilities
24. Clinical preceptors have the necessary teaching materials to effectively guide students in clinical practice
25. Clinical preceptors have been appropriately selected
26. Students are prepared for clinical practice prior to their departure for clinical practice site.
27. Students are prepared for clinical practice upon their arrival at clinical practice site.
28. Students and preceptors use appropriate learning and assessment tools
29. Clinical preceptors begin practice sessions by providing clear instructions
30. Clinical preceptors monitor student performance and give feedback
31. Clinical preceptors meet with students at the end of a clinical practice session
32. Clinical preceptors or the school develops and implements structured practical examinations

School Infrastructure, Curriculum and Training Materials

33. The school has the basic infrastructure to function effectively
34. The school facilities are clean.
35. The school compound is safe and secure.
36. Classrooms are comfortable and properly equipped for teaching.
37. The learning lab is properly equipped for practical learning sessions.
38. The learning lab is accessible for independent practice.
39. The learning lab’s anatomic models are in a functional state.
40. The library is appropriately equipped and organized.
41. The library has appropriate reference materials.
42. The library is open to students on demand.
43. The hostel (dormitory) is adequately furnished and suitable for women with small children.
44. Nutritious meals are provided to students.

School Management

45. Student composition reflects national Human Resources (HR) policies for midwifery or community midwifery education.
46. Class size is consistent with national HR policy and local capacity.
47. School has developed and implemented effective student recruitment and admission strategies.
48. School academic policies exist and are applied.
49. School has a clear academic calendar.
50. Written job descriptions exist for all staff at the school.
51. A salary structure exists to pay school staff, and staff are paid on time.
52. The curriculum is available to administrators and faculty.
53. Master copies of the learning resource materials and teaching transparencies exist for duplication.
54. A staff performance evaluation system exists.
55. Student academic performance standards exist and are known by students and teachers.
56. Student performance results are documented centrally and in a confidential manner.
57. Graduation requirements are explicit and are met before any student can graduate.
58. School administrators and teaching staff meet regularly.
59. A teaching coordinator visits clinical practice sites and meets with clinical preceptors.

Clinical areas where students midwife under take clinical experience:

60. The provider receives the pregnant woman in labor in a cordial manner.
61. The provider uses the partograph to monitor labor and make adjustments to the birth plan.
62. The provider adequately performs active management of the third stage of labor.
63. The provider properly conducts a rapid initial assessment and provides immediate newborn care.
64. The provider adequately performs immediate post partum care.
65. The provider properly disposes the used instruments and medical waste after assisting the birth.
66. The provider properly performs the general management of PPH.
67. The provider uses recommended counseling technics.
68. The provider ensures that all women and their husbands/companions are prepared for a complication arising.
69. The provider asks about and records danger signs that the women may have or has had.
ANNEX 3: ESSENTIAL COMPETENCIES FOR MIDWIVES/ COMMUNITY MIDWIVES IN AFGHANISTAN
There are seven essential competencies for the midwife/community midwife as follows.

1. Competency in social, epidemiologic and cultural context of maternal and newborn health

The midwife/community midwife should have knowledge about the socio-cultural determinants and epidemiological context of maternal and newborn health and ethics that form the basis of appropriate care.

Knowledge is required on:

1. Demography and epidemiology of the local community, including vital statistics of births and deaths, and indicators for health and disease
2. Direct and indirect causes of maternal, prenatal and neonatal mortality and morbidity, and strategies for reducing them
3. Social determinants for health such as income, water, sanitation, housing, food security, level of literacy and education, environmental hazards, access to health facilities, local culture and beliefs, including religious beliefs, gender roles and traditional practices
4. National and local health services including policies, plans and legal framework that regulates provision of and access to essential health package for MNCH at each level in the context of the continuum of care
5. The role of the midwife internationally and within Afghanistan
6. Communication/counseling techniques to enhance health promotion / disease prevention
7. Advocacy and empowerment strategies for women.
8. Referral system to higher health facility levels including transport mechanisms
9. The role and function of relevant national programmes
10. Ethical principles and appropriate attitudes that promote equitable access, respect of and inclusion of the patient in decision making and maintain confidentiality
11. Principles of good management including effective teamwork with other health care professionals and the community.

Essential skills:

1. Compile a community health profile
2. Responsible practice and accountability to client and health sector for clinical decisions or actions
3. Recognize the signs and symptoms of complications and the need for consultation with other medical staff and/or referral and takes appropriate and timely action
4. Behave in a courteous, respectful, non-judgmental and culturally appropriate manner with all clients, regardless of status, ethnic origin or religious beliefs
5. Ensure equitable access to services according to need
6. Promote involvement of whole community with emphasis on men and women of reproductive age: to make informed choices on all aspects of their care and encouragement to take responsibility for their own health

7. Use appropriate communication and counseling techniques/skills and provide health education relevant for the local community and information about available health services.

8. Work in liaison with individuals, families and communities and other key stakeholders to promote and advocate for safe maternal and newborn health

9. Ensure collaboration with other health workers for effective team work in the provision of high quality health services to women and their families

10. Monitoring and evaluation, record keeping and report writing including maternal death audit
2. Competency in pre-pregnancy care and family planning

The midwife/community midwife should provide high quality, culturally sensitive health education and family planning services in order to promote healthy family life, planned pregnancies and positive parenting.

Knowledge of:

1. Female and male anatomy and physiology with a focus on anatomy and physiology related to sexuality, fertility and reproduction
2. Cultural beliefs and practices surrounding sexuality, sexual practices and childbearing
3. Relevant components of a health and family history
4. Health education content targeted at reproductive health, sexually transmitted infections, HIV/AIDS, nutrition and promotion of general health and well-being
5. Methods for child spacing and family planning namely: natural methods, barrier, steroidal, mechanical, chemical and surgical methods of contraception
6. Advantages and disadvantages of different methods of child spacing and family planning and details for their effective use
7. Policies and legislation on family planning including factors involved in decision-making related to unplanned or unwanted pregnancies
8. Signs and symptoms, screening methods and appropriate treatment of urinary tract infection and common sexually transmitted infections including HIV
9. Factors affecting women’s health (reproductive roles, poverty)
10. Mental health
11. Infertility – causes, recognition, investigations and treatment
12. Common gynaecological problems including DIB; carcinoma’s (cervix, uterus, ovaries, breasts)

Essential skills:

1. Obtain a relevant and comprehensive health and gyn-obstetric history and knowledge on the socio-economic, family and cultural woman’s context in a sensitive and friendly manner, assuring confidentiality for the woman
2. Perform a general physical examination of the woman and identify, and appreciate the significance of any abnormal findings.
3. Request and/or perform and interpret accurately common laboratory tests such as full blood picture and microscopy.
4. Correlate all data obtained from the history, physical examination and any laboratory tests and interpret the findings in preparation for giving appropriate information and care to the woman e.g. anemia, TT
5. Record all findings from history, physical examination and tests as well as advice, counseling, treatment and recommendations for follow-up.
6. Provide a full range of family planning counseling and services including the insertion of an intrauterine contraceptive device and implants, in accordance with the woman’s choice, and appropriate referral for surgical methods.

7. Record the contraceptive methods provided and give appropriate advice and care for any adverse side effects and advice on follow-up.

8. Appropriate counseling and interpersonal communication skills including health education when giving information and advice.

9. Perform breast examination

10. Identify abnormalities of the reproductive organs including breasts and arrange for referrals

11. Psycho-social counseling

12. Counsel women who have not achieved a pregnancy and refer
3. Competency in care and counseling during pregnancy

The midwife/community midwife should provide high quality antenatal care to maximize a woman’s health during pregnancy, detect early and treat any problem and/or complications which may arise and refer if specialist attention is required.

Knowledge of:

1. The biology of human reproduction, e.g. the neuro-hormonal regulation of human reproduction
2. Psychological adaptation to pregnancy
3. Signs and symptoms of pregnancy including physiological changes and advice on the minor disorders, which may result from some of them.
4. Examinations and tests for confirmation of pregnancy.
5. Dating pregnancy by menstrual history, size of uterus by palpation and ultrasound if necessary (and available).
6. Medical complications and their effect on pregnancy, e.g. severe anemia, diabetes, cardiac or respiratory conditions, essential hypertension, renal disease.
7. How to take a comprehensive and relevant history of the current pregnancy, the woman’s health, her obstetric and medical history and her family health history.
8. Components of a general physical examination to assess the well-being of the mother and the significance of the findings.
9. Components of a general physical examination to assess the well-being of the fetus including fundal height, fetal activity and heart rate and, in the latter weeks, the lie, presentation, position and descent of the fetus and the significance of the findings.
10. Screening tests in pregnancy, including the interpretation of findings, e.g. hemoglobin, urinanalysis for protein, tests for syphilis, e.g. rapid plasma reagin (RPR), HIV testing and counseling, screening for TB
11. Nutritional requirements of the pregnant woman and her fetus.
12. Health education and counseling regarding hygiene, nutrition, sexuality including safer sex, risks of HIV and contraception, lifestyle
13. The importance of birth planning and emergency preparedness including place for birth, funds, transportation and social support
14. Infant feeding, including the advantages of exclusive breast-feeding
15. Education of women and their families about danger signs during pregnancy and the need to seek immediate help from a skilled health worker.
16. Recognition and management of serious conditions in pregnancy which require immediate attention: e.g. pre-eclampsia and eclampsia, vaginal bleeding, preterm labour, preterm rupture of the membranes, severe anemia, abortion, ectopic or multiple pregnancy, malpresentations at term, e.g. breech and shoulder.
17. Measures for prevention of malaria in pregnancy
18. Basic Pharmacology of drugs commonly used in maternal and newborn health

**Essential skills:**

1. Take an initial and ongoing history at each ANC visit, record findings of history, examinations, tests and give advice and instructions for follow-up.

2. Calculate the estimated date of delivery from the date of the woman’s last menstrual period, if known; otherwise assess gestational age from onset of fetal movements and assessment of fundal height or by using ultrasound.

3. Perform a full general physical examination and explain the findings to the woman.

4. Assess maternal vital signs including temperature, blood pressure and pulse.

5. Perform and interpret screening tests in pregnancy, e.g. hemoglobin, urinanalysis for protein, tests for syphilis, HIV, screening for TB.

6. Assess maternal nutrition and give appropriate advice on nutritional requirements in pregnancy and how to achieve them.

7. Perform an abdominal examination, including measurement of the fundal height and comparison with gestational age to assess fetal growth and stage of pregnancy; in the latter weeks of pregnancy, identify the lie, presentation, position and descent of fetus and auscultate the fetal heart.

8. Correlate all data obtained from the history, examination of the woman and results of any laboratory tests and interpret the findings in preparation for giving appropriate information, advice and care to the woman.

9. Educate and counsel women about health issues; e.g. nutrition, hygiene, exercise, dangers of smoking and taking unprescribed drugs, safer sex and risks of HIV.


11. Educate women and families about the need to seek immediate help from a skilled health worker if danger signs develop: severe headache, visual disturbances, epigastric pain, vaginal bleeding, abdominal pain associated with episodes of fainting, severe vomiting, preterm rupture of the membranes, fever, and offensive or irritating vaginal discharge.

12. Diagnose complications and risk conditions for early management in pregnancy for referral to more specialized care such as:
   - Elevated blood pressure and proteinuria, and/or severe headaches, visual changes and epigastric pain associated with elevated blood pressure
   - High fever
   - Heavy vaginal bleeding in early pregnancy or after 22 weeks
   - Abdominal pain associated with episodes of fainting in early pregnancy, with or without vaginal bleeding
   - Multi-fetal pregnancy
   - Mal-presentation at term, e.g. breech, shoulder
   - Preterm rupture of the membranes
   - Suspected oligo- or polyhydramnios
   - Intrauterine fetal death

13. Perform Evacuation of the Uterus (MVA) and provide post abortion care
4. Competency in care during labour and birth

The midwife/community midwife should provide high quality, culturally sensitive care during labour, conduct a clean, safe delivery, give immediate care to the newborn and manage emergencies effectively to prevent maternal and neonatal mortality and morbidity.

Knowledge of:

1. Onset, physiology and mechanisms of labour.
2. Anatomy of fetal skull, including main diameters and landmarks.
3. Cultural issues concerning labour and birth.
4. Assessment of progress in labour and use of the partograph.
5. Measures to assess fetal well-being in labour.
6. Measures to ensure maternal well-being in labour, hygiene and bladder care, hydration and nutrition, mobility and positions of the woman’s choice, emotional support, massage.
7. Universal precautions to prevent infections.
8. Diagnosis and management of the second stage of labour including delivery of the baby.
9. Indications and technique for making and repairing an episiotomy, including the technique for local anaesthesia of the perineum.
10. Immediate care of the newborn, procedures for maintaining warmth: clearing of airways and assessing breathing, methods of resuscitation, cord care, early initiation of exclusive breastfeeding
11. Use, action and indications of uterotonics.
12. Management of the third stage of labour including active management of the third stage of labour.
13. Reasons and method for examination and safe disposal of the placenta and membranes.
14. Technique for examination of the perineum, vulva and lower vagina for tears and grading of perineal tears.
15. Methods of suturing second and third degree perineal and vaginal tears as well as cervical tears
16. Measures to assess the woman’s condition after birth
17. Complications in labour and management of complications requiring emergency care and/or referral, e.g. intra-partum hemorrhage, multi-fetal pregnancy, malpresentations, fetal distress including the risk associated with premature rupture of membranes (PROM) and meconium-stained liquor cord prolapses, prolonged or obstructed labour, shoulder dystocia, retained placenta, postpartum hemorrhage, severe vaginal and cervical tears, Serious infections.
19. Cardio-pulmonary resuscitation
Essential skills:

1. Take full history of pregnancy and labour including the review of maternal pregnancy records.
2. Perform a general physical examination to assess the woman’s condition.
3. Perform an abdominal examination to confirm the period of gestation, identify the lie, presentation, position and descent of the fetus, and auscultate the fetal heart.
4. Assess the frequency, duration and strength of uterine contractions.
5. Perform a vaginal examination to determine cervical effacement and dilatation, confirm whether or not the membranes have ruptured, identify the presenting part and position of the fetus, the moulding, the station and level of the head and rule out CPD.
6. Accurately record the progress of labour and monitor maternal and fetal condition regularly throughout labour using the partograph, identifying deviations from normal and taking timely, appropriate action.
7. Provide emotional support for the woman and her family, ensuring that the woman has a companion of her choice to stay with her throughout labour, and keep her fully informed of progress, involving her in all decisions related to her care and encourage her to adopt the positions of her choice.
8. Keep the woman in optimum condition during labour, maintaining adequate hydration and nutrition, ensuring that the bladder is emptied regularly, promoting high standards of infection prevention and appreciate the importance of pain relief.
9. Recognize the signs and symptoms of the second stage of labour and provide constant care, observation and support, allowing non-directive pushing, providing support of the perineum and avoid interference with the normal mechanism of labour.
10. Make an episiotomy where indicated, and use local anesthesia to the perineum prior to repair.
11. Provide immediate care for the newborn, including drying, clearing airways, ensuring that breathing is established, and skin-to-skin contact with mother and covering to provide warmth.
12. Correctly conduct management of the third stage of labour including the active management of the third stage of labour.
13. After delivery of the placenta and membranes, ensure that the uterus is well contracted by rubbing up a contraction and expelling clots, if necessary, and check that vaginal bleeding is minimal.
14. Examine the vulva, perineum and lower vagina for lacerations, repair second and third degree tears.
15. Estimate and record all blood loss as accurately as possible.
16. Examine the placenta and membranes for completeness and normality and dispose of them safely as appropriate.
17. Monitor the mother’s condition, ensuring that vital signs and vaginal bleeding are within normal limits and that the uterus remains well contracted.
18. Manage postpartum hemorrhage urgently, if it occurs, by massaging the uterus, administration of oxytocin, emptying the bladder, establishing an intravenous infusion and, if still bleeding, bimanual compression and preparation for referral.

19. Repair cervical tears

20. Perform urinary catheterizations using an aseptic technique to prevent the introduction of infection.

21. Monitor the condition of the newborn, ensuring that breathing and colour are normal, warmth is maintained and that there is no bleeding from the umbilical cord

22. Resuscitate the asphyxiated newborn and give appropriate care before referral

23. Keep mother and baby together to promote attachment and support early initiation (within one hour) of exclusive breastfeeding

24. Record all details of the birth, care given to the mother and baby and advice about follow-up

25. Diagnose and safely deliver breech presentation

26. Manage cord presentation or prolapses correctly

27. Perform Vacuum extraction when indicated

28. Manage shoulder dystocia correctly

29. Perform manual removal of the placenta and membranes correctly

30. Insert intravenous line when indicated, draw blood for tests

31. Provide pre and post operative care for women undergoing Caesarean Section

32. Prescribe and administer certain drugs, e.g. magnesium sulphate, diazepam, antibiotics and analgesics

33. Arrange for and undertake timely referral and transfer of women with serious complications to a higher level health facility, taking appropriate drugs and equipment and accompanying them on the journey in order to continue giving emergency care, as required
5. Competency of care for women in postpartum period

The midwife/community midwife should provide comprehensive, high quality, culturally sensitive postpartum care for women.

Knowledge of:

1. Physiological and psychological changes in the puerperium.
2. The physiology of lactation, the initiation and management of breastfeeding and the recognition and management of common problems, which may occur.
3. Recognition, monitoring and management of the psychological and emotional changes, which may occur in the puerperium.
4. Parent-infant attachment and factors, which promote and hinder it.
5. The risks of infection and measures taken to prevent infection in mother and newborn after childbirth.
6. Health education and counseling on self-care, adequate sleep, rest, good nutrition, personal hygiene including perineal care and care of the newborn infant.
7. Procedure and reasons for postnatal examinations of the mother during the first 12-24 hours, within one week and at six weeks after the birth, or sooner if required.
8. Diagnosis and treatment of anemia after childbirth.
9. Diagnosis, management and referral of complications e.g. infection and disorders of the reproductive and/or urinary tract breast infections, thrombo-embolic disorders, eclampsia, secondary postpartum haemorrhage and psychiatric disorders.
10. The grief process following stillbirth or neonatal death, or the birth of an abnormal child, counselling, comforting and supporting the mother and her family.
11. Medical conditions, which may complicate the puerperium, e.g. cardiac, lung and renal diseases, hypertensive disorders and diabetes.
12. Special support for adolescents, women living with violence, mental health problems
13. Family planning and birth spacing methods appropriate in the postpartum period.

Essential skills:

1. Take full history of pregnancy, birth and the earlier postpartum period, identifying factors which will influence the care and advice given.
2. Perform a systematic postpartum examination of the mother identifying any actual or potential problems.
3. Provide appropriate and timely treatment for any complications detected during the postpartum examination i.e. detection and treatment of anemia; breastfeeding problems
4. Facilitate and support the early initiation and maintenance of exclusive breastfeeding.
5. Use universal precautions for the prevention of infection to prevent the spread of infection after childbirth
6. Educate and counsel the woman on care for herself and for her baby.
7. Facilitate psychosocial family and community based supportive measures.
8. Emergency treatment of uncomplicated PPH
9. Emergency care of a woman during and after an eclamptic fit, including preparation for referral.
11. Counsel, comfort and support the mother and father if the baby is stillborn, born with abnormalities or dies in the neonatal period.
12. Counsel the woman on family planning and safer sex and provide appropriate family planning services in accordance with the woman’s choice including information on advantages and disadvantages of the chosen method.
13. Record the contraceptive method provided and give appropriate advice and care for any adverse side effects and advice on follow-up.
14. Keep accurate records on postnatal care (including home based records) and make arrangements for follow-up or referral, as appropriate.
6. Competency: care of the newborn and young children

The midwife/community midwife should provide high quality care for the newborn infant and surveillance and preventive care for young children.

Knowledge of:

1. Physiological changes at birth.
2. Assessment of the newborn using Apgar score.
3. Neonatal resuscitation
4. Parent/infant attachment.
5. Procedure for examination of the newborn at birth and subsequently.
6. Traditional practices as they relate to newborn care.
7. Essential elements of daily care of the newborn, e.g. warmth, skin care, prevention of infection: care of the umbilical cord, observation for signs of infection, jaundice, frequency and character of stools, feeding and signs of thriving and failure to thrive.
8. Prevention of hypothermia and how to keep the baby warm
9. Programme for immunizations and vaccinations during the first five years.
10. Common disorders of the newborn, e.g. skin rashes, minor vomiting, minor infections, minor feeding problems and physiological jaundice.
11. Serious disorders of the newborn, e.g. major infections, respiratory difficulties, congenital malformations, neonatal convulsions.
12. Low birth weight babies, e.g. preterm and small-for-gestational age including management of the very low birth weight infant - Kangaroo mother care for low birth weight babies
13. Growth and development monitoring
14. Nutrition for newborns and young infants including management of breastfeeding
15. Factors linked to malnutrition and the recognition and management of malnutrition
16. Recognize and manage common health problems in the young child according to the Integrated Management of Childhood Illness (IMCI) guidelines.
17. Birth registration
18. Follow-up of the newborn using correct records.

Essential skills:

1. Assess the condition of the newborn at birth (using Apgar score)
2. Clear airways at birth, to facilitate breathing if required.
3. Use bag and mask correctly to resuscitate the asphyxiated newborn.
4. Dry the newborn at birth, place in skin-to-skin contact on the mother’s abdomen or chest and cover to keep the baby warm. If skin-to-skin contact is not possible, place the baby on a clean, warm surface and wrap warmly.
5. Clamp and cut the umbilical cord, taking appropriate measures to prevent infection.
6. Label the newborn for correct identification
7. Examine the newborn systematically from head to feet to detect any congenital malformations, birth injuries or signs of infection.
8. Administration of Vitamin K1 and eye drops/ointment, BCG
9. Assist the new mother to initiate exclusive breastfeeding within one hour,
10. Educate the mother and her family about all aspects of infant feeding, especially the importance of exclusive breast feeding for the first six months of life and introduction of appropriate weaning foods
11. Teach the mother about the general care and hygiene of the baby, e.g. skin, eyes and cord to prevent infection
12. Monitor newborn and child growth and development; identify malnourished children and refer for management
13. Recognize minor and serious disorders in the newborn and treat appropriately, including arranging for referral, if necessary.
14. Give appropriate care including kangaroo mother care to the low birthweight baby, and arrange for referral if potentially serious complications arise, or very low birth weight.
15. Educate the parents about the signs of potentially serious conditions in the newborn and the need to seek immediate help from a skilled health worker.
16. Give immunizations correctly at the optimum time (Hep B at one week) and advise the parents of any possible adverse effects and when to return for further immunizations.
17. Keep full and accurate records
18. Manage bereavement and loss in the event of neonatal death
19. Emergency management of life-threatening conditions, e.g. the administration of appropriate drugs, monitoring the condition of the baby, and preparing the mother and newborn for referral.
20. Provide basic care for infants including history and examination; care provision including care for ARI and CDD; preventative care including immunization and growth monitoring; and counselling to parents on infant and child care and danger signs
21. Identify and refer conditions or complications beyond the scope of practice
7. Competency in promoting health in the community

The midwife/community midwife participates in the promotion of health and wellness in the community and serves as a link between the community and the health system.

Knowledge of:

2. Supportive supervision
3. Quality concepts in health care
4. Approaches to community mobilisation
5. Behaviour Change and Communication

Essential skills:

1. Support community health workers in their provision of community based health care by participating in, and providing technical guidance as required, (i.e., during periodic CHW meetings)
2. Support CHW/TBA with respect to referral cases brought to the facility
3. Work with community health workers and community leaders to promote the concept of birth preparedness and complication readiness related to pregnancy, delivery and newborn care
ANNEX 4: PROGRAM CALENDAR
# Community Midwifery Training Program Calendar

## Phase 1 (32 Weeks)

<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
<th>WEEK 3</th>
<th>WEEK 4</th>
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<tbody>
<tr>
<td>Module 1: Orientation (3 days) – classroom/training facilities</td>
<td>Module 2: The Role of the Community Midwife (continued) (2 day) – classroom/community visits</td>
<td>Module 4: Health Education and Communication (2 days) – Classroom cont.</td>
<td>Module 6: Basic Anatomy and Physiology (6 days) – classroom</td>
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<tr>
<td>Module 2: The Role of the Community Midwife (3 days) – classroom/community visits</td>
<td>Module 3: Health Care in Afghanistan (2 days) – Classroom</td>
<td>Module 5: Basic Nutrition (4 days) – classroom/community</td>
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<td>ESL*</td>
<td>Module 4: Health Education and Communication (2 days) – Classroom</td>
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<tr>
<th>WEEK 5</th>
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<tr>
<td>Module 6: Basic Anatomy and Physiology (3 days) – classroom</td>
<td>Module 8: Foundations of Basic Maternal and Newborn Care (6 days) – classroom</td>
<td>Module 9: Infection Prevention (3 day) – classroom/health facilities</td>
<td>Module 10: Antenatal Care (continued) (6 days) – classroom/supervised practice in antenatal clinics</td>
</tr>
<tr>
<td>Module 7: Changes and Adaptations in Pregnancy (3 days) – classroom</td>
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<td>Module 10: Antenatal Care (3 days) – classroom/simulated practice</td>
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<th>WEEK 9</th>
<th>WEEK 10</th>
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<tbody>
<tr>
<td>Module 10: Antenatal Care (continued) (6 days) – classroom/supervised practice in antenatal clinics</td>
<td>Module 10: Antenatal Care (continued) (3 days) – classroom/supervised practice in antenatal clinics</td>
<td>Module 11: Childbirth Care (continued) (6 day) – supervised practice on labor and delivery wards</td>
<td>Module 11: Childbirth Care (continued) (6 day) – supervised practice on labor and delivery wards</td>
</tr>
<tr>
<td>Module 11: Childbirth Care (3 days) – classroom/simulated practice</td>
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*Module 15 - English language classes will be held at least twice weekly - 3 hours recommended per week and should continue through all 3 Phases

**Note:**

1. Islamiat at the program discretion in Phase 1 – 3
2. Additional classes in literacy and numeracy however these are additional activities and do not replace other subjects.
3. Computing at programs’ discretion and according to resources
# Community Midwife Training Program Calendar

## Phase 1 (32 Weeks)

<table>
<thead>
<tr>
<th>WEEK 13</th>
<th>WEEK 14</th>
<th>WEEK 15</th>
<th>WEEK 16</th>
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<tbody>
<tr>
<td><strong>Module 11: Childbirth Care (continued) (3 day)</strong> – supervised practice on labor and delivery wards</td>
<td><strong>Module 12: Newborn Care (continued) (6 day)</strong> classroom/simulated practice/supervised practice on postpartum m wards</td>
<td><strong>Module 13: Postpartum Care (6 days)</strong> classroom/simulated practice</td>
<td><strong>Module 13: Postpartum Care (continued) (6 days)</strong> classroom/simulated practice/supervised practice on postpartum wards</td>
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</tbody>
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<tr>
<th>WEEK 17</th>
<th>WEEK 18</th>
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</thead>
<tbody>
<tr>
<td><strong>Module 14: Pharmacology (6 days)</strong> Classroom</td>
<td>Supervised practice in antenatal clinics, labor ward/delivery room, postpartum wards, focusing on normal pregnancy, childbirth, postpartum, and newborn care</td>
<td>Supervised practice in antenatal clinics, labor ward/delivery room, postpartum wards, focusing on normal pregnancy, childbirth, postpartum, and newborn care</td>
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<tr>
<th>WEEK 29</th>
<th>WEEK 30</th>
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<th>WEEK 32</th>
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</thead>
<tbody>
<tr>
<td>Revision as requested and skills practice Modules 1-14 Comprehensive Knowledge Assessment: Modules 2 – 15</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
</tr>
</tbody>
</table>
# Community Midwife Training Program Calendar
## Phase 2 (32 Weeks)

<table>
<thead>
<tr>
<th>WEEK 1</th>
<th>WEEK 2</th>
<th>WEEK 3</th>
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*ESL

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<tr>
<th>WEEK 5</th>
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<tr>
<th>WEEK 9</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Module 21: Shoulder Dystocia (2 days) – classroom/supervised practice on wards</td>
<td>Module 23: Fetal Distress in Labor and Prolapsed Cord (3 days) – classroom/supervised practice on wards</td>
</tr>
</tbody>
</table>

*Module 15 English language classes will be held twice weekly from Week 1 through Week 13 - 3 hours recommended per week*
## COMMUNITY MIDWIFE TRAINING PROGRAM CALENDAR
### PHASE 2 (32 WEEKS)

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<thead>
<tr>
<th>WEEK 13</th>
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<tbody>
<tr>
<td>Supervised practice in antenatal clinics, labor ward/delivery room, postpartum wards, and revision/skills practice as needed. Comprehensive Knowledge Assessment: Modules 16-26</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
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<td>WEEK 1</td>
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<tr>
<td>* ESL</td>
<td></td>
<td>Module 29: STIs and HIV/AIDS (2 days) – classroom/simulated practice</td>
<td>Module 30: Mental Health (3 days) – classroom/simulated practice/supervised practice</td>
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<tr>
<th>WEEK 5</th>
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<tr>
<td>Module 30: Mental Health (3 days) – classroom/simulated practice/supervised practice</td>
<td>Module 31: Care of the Young Child (6 days) – classroom/simulated practice/supervised practice in clinics</td>
<td>Module 32: Supervision and Partnership (3 days) – classroom/simulated practice in clinics</td>
<td>Module 34: Health Services Management (6 days) – classroom</td>
</tr>
<tr>
<td>Module 31: Care of the Young Child (3 days) - classroom/supervised practice in clinics</td>
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<td>Module 33: Professional Issues in Midwifery (3 days) – Classroom</td>
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* Module 15 English language classes will be held twice weekly from Week 1 through Week 18 - 3 hours recommended per week.
# Community Midwife Training Program Calendar

## Phase 3 (32 Weeks)

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<tbody>
<tr>
<td></td>
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<td></td>
<td><strong>Review of Module 22:</strong> Labor with an Over distended Uterus and Labor with a Scarred Uterus - classroom/supervised practice on wards</td>
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<tr>
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<td></td>
<td>Review of Module 23: Fetal Distress in Labor and Prolapsed Cord - classroom/supervised practice on wards</td>
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<tr>
<td><strong>Review of Module 24:</strong> Fever During pregnancy and Labor and After Childbirth - classroom/simulated practice/supervised practice on wards</td>
<td><strong>Review of:</strong> Module 26: Managing Newborn Problems classroom/simulated practice/supervised practice on wards – 3 days</td>
<td>Supervised practice in antenatal clinics, labor ward/delivery room, postpartum wards, focusing on normal pregnancy, childbirth, postpartum, and newborn care, and management of complications</td>
<td>Supervised practice in antenatal clinics, labor ward/delivery room, postpartum wards, focusing on normal pregnancy, childbirth, postpartum, and newborn care, and management of complications</td>
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## Curriculum for Community Midwifery Education

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<tr>
<td>Supervised practice in antenatal clinics, labor ward/delivery room,</td>
<td>Supervised practice in antenatal clinics, labor ward/delivery room,</td>
<td>Final Assessments (OSCE’s)</td>
<td>Completion of program</td>
</tr>
<tr>
<td>postpartum wards, focusing on normal pregnancy, childbirth, postpartum,</td>
<td>postpartum wards, focusing on normal pregnancy, childbirth, postpartum,</td>
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* Consider 2 weeks community based experience at health centre in last weeks
This publication was made possible through support provided by the Office of Health and Nutrition, Bureau for Global Health, U.S. Agency for International Development, under the terms of Contract No. 306-A-00-06-00523 (HSSP). The opinions expressed herein are those of the contributors and do not necessarily reflect the views of the U.S. Agency for International Development.