

Afghan Midwifery in Remote Areas: A Pilot Project of Asynchronous Telemedicine in Rural Bamyan Province

AABRAR (Afghan Amputees for Bicycle Rehabilitation And Recreation) · Bamyan Province, Afghanistan · Funded by GIZ GmbH · January 2024 – ongoing



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BACKGROUND & PROBLEM

Afghanistan has among the world's highest maternal and neonatal mortality rates. Bamyan — a mountainous, rural province — faces compound barriers: minimal health infrastructure, impassable roads in winter, cultural restrictions on women's independent mobility, and a persistent shortage of skilled female providers since the 2021 Taliban seizure of power.

In designated "**white areas**" — communities with no clinic or functional primary care — pregnant women, adolescent girls, and newborns receive no routine care. Preventable complications go undetected; avoidable deaths result.



Mobile Midwife arriving at a remote community dwelling — Bamyan Province

"Many women in villages like mine suffer in silence. I was lucky to be found. Please reach them before it's too late."

— MS. TAMANA, PATIENT, PUNJAB DISTRICT, BAMYAN (PSEUDONYM)

OBJECTIVES

Primary: Deliver accessible, equitable Midwifery care to ~41,000 women and girls of reproductive age and ~20,000 newborns and infants across all 6 districts of Bamyan.

Secondary: Deploy asynchronous telemedicine linking field teams to a clinical supervision hub; reduce maternal and neonatal risk through timely referral and counselling; build community health knowledge among men and boys through CMA engagement.

PARTICIPANTS & SCALE

22 Mobile Midwives deployed	22 Community Midwifery Assistants
6 Districts of Bamyan covered	~90K People needing mobile care in province

Each Midwife-CMA pair assigned an exclusive catchment ("white area") by the Provincial Directorate of Public Health (DoPH), coordinated with other NGOs to prevent duplication.



Household ANC visit — Yakawlang District



Training group discussion, Bamyan

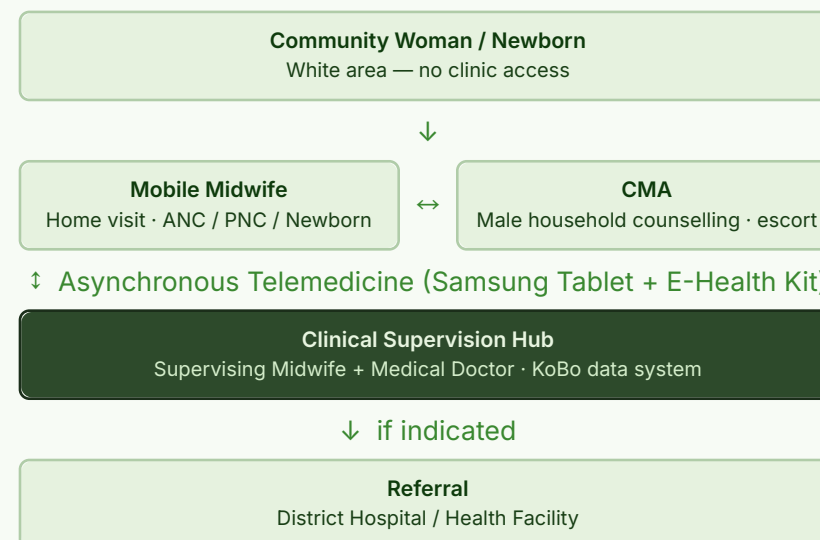
THE MAHRAM SOLUTION

Under Taliban rule, women cannot travel independently. AABRAR recruited each Midwife's *mahram* (required male escort) as a **Community Midwifery Assistant (CMA)** — trained in health communication and male-household engagement. Every field team is a Midwife-CMA pair. This converts a legal restriction into a structural asset.



Midwife-CMA team — winter field visit, Bamyan

INTERVENTION MODEL



E-HEALTH KIT — FIELD EQUIPMENT

📱 Samsung Tablet + power bank	👂 Digital stethoscope
🌡️ Digital thermometer	⚖️ Digital scale
🩺 Sphygmomanometer	🩸 Glucometer + haemometer
👶 Fetal doppler monitor	📏 MUAC tape

All data entered into KoBo System in field; reviewed by Supervising Midwife at hub for clinical decision support and programme monitoring.

CLINICAL SERVICES PROVIDED (JAN 2024 – MAR 2025)

Service	Cases
Antenatal Care (ANC)	3,012
Postnatal Care (PNC)	2,574
Newborn assessment	2,073
Counselling — women & girls (reprod. age)	13,189
Health awareness by CMA (men & boys)	86,870
Referral cases to higher care	242
Total service contacts	107,960

SCOPE OF MIDWIFE SERVICES

- **ANC**
Vital signs, fetal doppler, MUAC, pregnancy counselling, birth planning, danger-sign education, referral
- **PNC**
BP, HB, glucose, postnatal complication screening, wound care, breastfeeding, iron supplementation
- **Newborn**
Temperature, breathing, feeding assessment, vaccination schedule, neonatal danger signs
- **Adolescent girls**
Menstrual health, reproductive counselling, hygiene, UTI prevention, family planning
- **CMA (male household engagement)**
Timely decision-making, birth transport planning, health literacy, stigma reduction



Newborn assessment — mother with twins, Bamyan



Postnatal newborn check — Bamyan Province clinic

TRAINING & CAPACITY BUILDING

All 22 Midwives and CMAs received a 2-day professional refresher before deployment. In Q1 2025, a 3-day ANC/PNC training was additionally delivered — fully funded by AABRAR's CORD Fund outside the project budget.



ANC/PNC refresher training — AABRAR Bamyan office, Q1 2025

CHALLENGES & INNOVATIONS

Winter road closures, extreme terrain, and Taliban movement restrictions define the operating environment. **Asynchronous** telemedicine was chosen because reliable real-time connectivity is unavailable across most of Bamyan — teams collect data offline, synchronise at return, and receive clinical guidance before their next visit.

Initial DoPH white-area allocations under-supplied case volume. Following sustained advocacy, additional areas were assigned — expanding coverage across all 6 Bamyan districts.

CONCLUSIONS

In 15 months, 22 Midwife-CMA pairs delivered over 107,000 service contacts to communities with no alternative care pathway. The mahram-as-CMA model demonstrates that Taliban mobility restrictions can be structurally navigated without compromising women's access to female providers.

Community-based Midwifery with asynchronous telemedicine support is viable, scalable, and urgently needed across Afghanistan's white areas — where preventable maternal and neonatal death remains the norm.