Reproductive Health in Post-conflict Afghanistan

Case study on sexual and reproductive health services during recovery after twenty years of war

conducted by Iain Aitken

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Sexual and Reproductive Health Status: 2002/2003 Assessments*

<table>
<thead>
<tr>
<th>Maternal health</th>
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<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>1600 per 100,000</td>
</tr>
<tr>
<td>Antenatal care by skilled worker</td>
<td>8% (rural)</td>
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<tr>
<td>Skilled birth attendance</td>
<td>14% (Urban 35%, rural 7%)</td>
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<table>
<thead>
<tr>
<th>Family Planning</th>
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<tbody>
<tr>
<td>Total fertility rate</td>
<td>6.7</td>
</tr>
<tr>
<td>Crude birth rate</td>
<td>48 per 1000</td>
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<tr>
<td>Contraceptive prevalence rate</td>
<td>8.5%</td>
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Gender based violence and rape known to be widespread, but grossly under-reported

*Afghan National Health Resources Assessment; UNICEF/CDC study; UNICEF MICS study
Reproductive Health service challenges

- Outdated policies

- Depleted infrastructure and human capacities
  - Lack of adequate equipment at primary care centers
  - Only 24% of hospitals provided cesarean section

- Lack of female health workers
  - Only 21% health centers with female worker
  - Only 467 midwives in whole country

Response

Policy development:

- Basic Package of Health Services
  - Priority on maternal and child health.

- National Reproductive Health Strategy,
  - National standards and guidelines

- Performance-based contracting to NGOs for implementation of BPHS

- Health Management Information System to monitor implementation of the BPHS
Response

Human Resources:

– Promote skilled birth attendance;
  • Stop training of TBAs

– New Cadre: Community Midwives
  • 60% rural health centres have MW (2009)

– Volunteer Community Health Workers,
  • 22,000, >50% female (2009)
  • Now provide 66% of public sector contraceptives

Rural Reproductive health services

<table>
<thead>
<tr>
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<th>2003</th>
<th>2006</th>
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<tbody>
<tr>
<td>Skilled birth attendance</td>
<td>7%</td>
<td>19%</td>
</tr>
<tr>
<td>Use of antenatal care</td>
<td>8%</td>
<td>32%</td>
</tr>
<tr>
<td>Heard of modern contraceptives</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td>Use of modern contraceptives</td>
<td>5.3%</td>
<td>16%</td>
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</table>
Observations

• Immediate post-conflict period is a great opportunity for establishing new policies and strategies.

• Early identification of the high maternal mortality rate and lack of female staff and midwives important for advocacy.

• NGOs able to provide services to a whole province, but took time (6 years), support and capacity building.

• Once established, Afghan NGOs performed better than international NGOs.

• Difficult to distinguish effects on NGO performance of different amounts of capacity-building and performance-based bonuses provided by different donors.

Reflections

• Importance of Granada Consensus:
  – Health Systems approach crucial:
    • human resources,
    • health information,
    • government and leadership, etc.
  – MISP not sufficient in reestablishment of services (EmOC, SGBV?)

• Progress takes long time

• Impact on outcomes?