Reproductive Health in Post-conflict Afghanistan

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

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Sexual and Reproductive Health Status: 2002/2003 Assessments*

Maternal health	
Maternal mortality ratio	1600 per 100,000
Antenatal care by skilled worker	8% (rural)
Skilled birth attendance	14% (Urban 35%, rural 7%)
Family Planning	
Total fertility rate	6.7
Crude birth rate	48 per 1000
Contraceptive prevalence rate	8.5%

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- Outdated policies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

	2003	2006
Skilled birth attendance	7%	19%
Use of antenatal care	8%	32%
Heard of modern contraceptives	28%	33%
Use of modern contraceptives	5.3%	16%

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?