

Knowledge Brief

Health, Nutrition and Population Global Practice

AFGHANISTAN: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

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KEY MESSAGES:

- Afghanistan has made progress towards the MDGs, especially in education and health; however, widespread gender gaps remain and the country suffers from poverty and low human development, aggravated by years of conflict.
- Maternal mortality rate is 400 deaths per 100,000 live births in 2013, representing a decline of 67 percent from 1990.
- Fertility declined but remains high at 5.1, while contraceptive prevalence rate increased to 21%. Sixty-three percent of women sought ANC from a qualified provider and nearly 39% of births were attended by qualified providers.
- Wide gaps in access to maternal health services remain by geography and wealth quintile.
- Undernutrition is a major challenge for women of age 15-49.
- Afghanistan would need to focus on improving access to maternal, neonatal, and child health in urban and rural areas; promoting multisectorial coordination; and increasing attention to service quality.

Country Context

Afghanistan suffers from poverty and low human development aggravated by 23 years of conflict. In 2012, the population was 29 million and per capita income US\$268. Economic growth was estimated at 3.6 percent in 2013, down from 14.4 percent in 2012. The transition led to investor and consumer wariness.^{1,2}

Poverty reduction has stagnated at about 36 percent since 2007-08, while inequality increased (NRVA 2011-12). The Gini coefficient rose from 29.7 in 2007-08 to 31.6 in 2011-12. The large youth population — 47 percent is under 15 — is an opportunity to benefit from the demographic dividend through high growth and poverty reduction.^{1,2} The country ranks 175 out of 187 countries in the human development index.

Afghanistan has progressed toward the MDGs over the decade, particularly in education and health. In 2001, no girls attended formal schools and boys' enrollment was 1 million. By 2013, 9.1 million pupils were enrolled and 3.6 million were girls. However, education attainment remains low. Female literacy rate is 13 percent, one of the poorest in the world. Between 2003 and 2011, maternal and child mortality fell sharply. The U5MR and IMR dropped from 257 and 165 per 1,000 live births to 97 and 77 respectively.^{1,2}

Gender equality and women's empowerment are important determinants of reproductive health. Decades of the Taliban's retrogressive policies resulted in widespread gender gaps in health, education, access to resources, economic opportunities, and political voice and power. Afghanistan ranks 175 out of 186 countries on the Gender Inequality Index (2012).³

AFGHANISTAN: MDG 5 STATUS

MDG 5A indicators

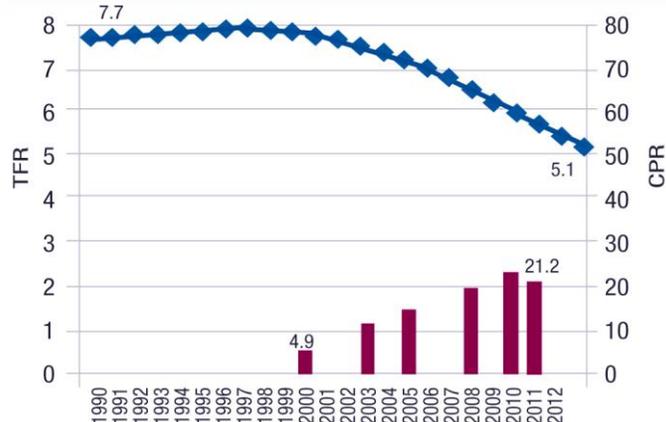
Maternal mortality ratio ([MMR]), (maternal deaths per 100,000 live births) – UN estimate	400
Births attended by skilled health personnel (percent)	38.6

MDG 5B indicators

Contraceptive prevalence rate, any method (percent)	21.2
Adolescent fertility rate (births per 1,000 women ages 15–19) – WDI	86.8
Antenatal care with health personnel (percent)	47.9

Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report, 2010 Afghanistan Mortality Survey, 2014 World Development Indicators (WDI).

FIGURE 2: TRENDS IN CONTRACEPTIVE PREVALENCE RATE (CPR) AND TOTAL FERTILITY RATE (TFR)

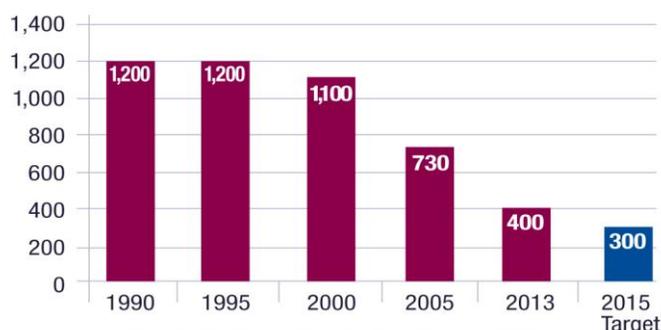


Source: World Development Indicators 2014

MDG Target 5a: Reduce the MMR by three-quarters, between 1990 and 2015

The MMR has declined from 1,200 deaths per 100,000 live births in 1990 to 400 in 2013 (figure 1). According to the latest Interagency estimates, Afghanistan is “making progress” toward achieving MDG5. The MMR declined 67 percent with an average annual decline of 4.7 percent between 1990 and 2013.⁴

FIGURE 1: MATERNAL MORTALITY RATIO 1990-2013 AND 2015 TARGET



Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report

ⁱ “Making progress” is defined as a 2%-5.5% average annual percentage decline between 1990 and 2013.

Fertility

Fertility has been slowly declining but remains high. Between 1990 and 2012, the total fertility rate (TFR) declined from 7.7 to 5.1 (figure 2).¹

The contraceptive prevalence rate (CPR) has been increasing over the past 14 years. The CPR (any method) increased from 4.9 percent in 2000 to 21.2 percent in 2011 (figure 2).¹ Modern methods are the main choice of contraceptives and are used by 19.9 percent of currently married women. Injectables (7.2 percent), the pill (6 percent), and LAM (4 percent) are the most commonly used form of modern methods. Traditional methods are used by 1.9 percent of currently married women.⁵

Birth intervals of less than 24 months are considered too short: 37.4 percent of children are born within 24 months of the previous birth. The median number of months since the preceding birth is 26.7 months.⁵

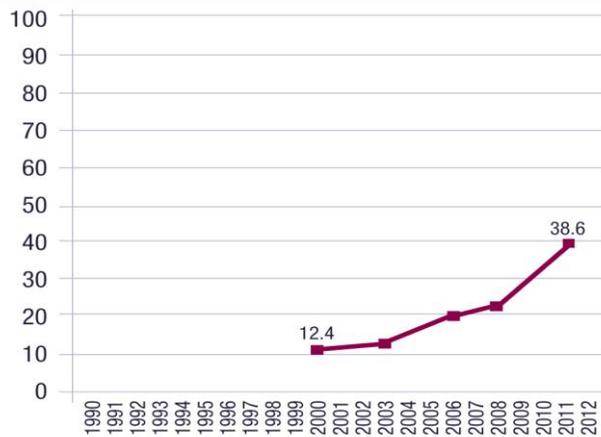
The median age at first marriage among women aged 25-49 is 17.7 years and the median age at first birth among the same cohort is 20 years. Early childbearing affects maternal health outcomes. The share of women age 15-19 that have begun childbearing is 12.1 percent.⁵ The adolescent fertility rate is high at 86.8 births per 1,000 women age 15–19.¹

Pregnancy Outcomes

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2010, 63.4 percent of women sought ANC from a qualified provider. About 16 percent of women received the recommended four or more ANC visits; 89.5 percent of women had their blood pressure measured (one of the components in the package of ANC services). The top reasons for not seeking ANC are: lack of money (50 percent), distance to a facility (49 percent), transport problems (48 percent), no need for services (41 percent), and not customary (22 percent).⁵

Skilled birth attendance (SBA) is critical for reducing maternal deaths. SBA by qualified providers increased from 12.4 percent in 2000 to 38.6 percent in 2011 (figure 3).¹ The majority of births are delivered at home, with institutional delivery accounting for only 32.4 percent of all births (27.3 percent in public sector facilities and 5.1 percent in private sector facilities). The leading reasons for not delivering in a health facility are lack of money, distance and transport (about 50 percent each). Other important reasons are: not necessary (35.2 percent) and not customary (19 percent).

FIGURE 3: TRENDS IN SKILLED BIRTH ATTENDANCE



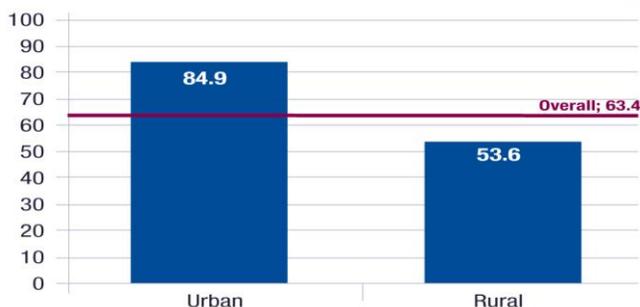
Source: World Development Indicators 2014

Postnatal care is another important component for maternal health, especially for managing post-delivery complications. It is recommended that postnatal care for mothers occur within the first two days of delivery. Of women, 23.4 percent sought this type of care from a qualified provider within the first two days of delivery.⁵

Equity in Access to Maternal Health Services

Inequity in access to maternal health services is a barrier toward MDG 5. While utilization of antenatal care has been increasing, wide disparities remain. Women in urban areas were more likely to seek antenatal care (84.9 percent) from a qualified provider than their rural counterparts (53.6 percent) (figure 4).⁵

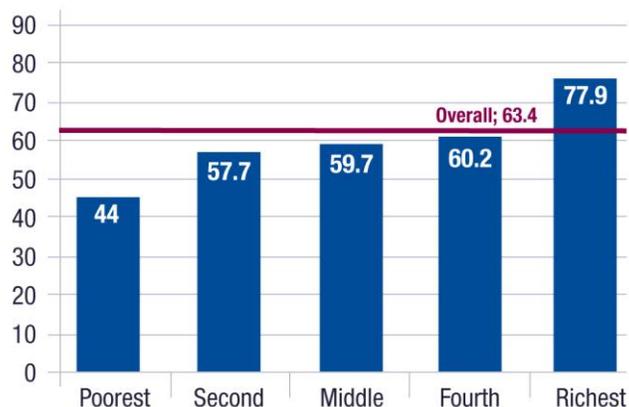
FIGURE 4: ANTENATAL CARE BY RESIDENCE



Source: 2010 Afghanistan Mortality Survey

There is also a large gap between wealth quintiles in receiving antenatal care: 77.9 percent of women in the richest quintile received ANC from a qualified provider, compared to 44 percent of women in the poorest (figure 5).⁵

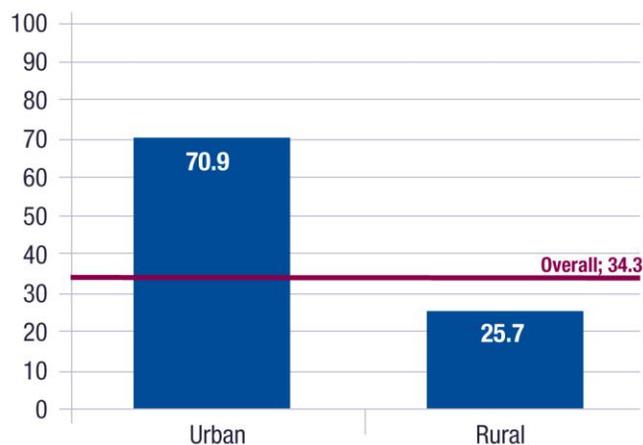
FIGURE 5: ANTENATAL CARE BY WEALTH QUINTILE



Source: 2010 Afghanistan Mortality Survey

Similar disparities are also found in skilled birth attendance: 70.9 percent of urban women are assisted during delivery by a qualified provider but only 25.7 percent of rural women (figure 6).⁵

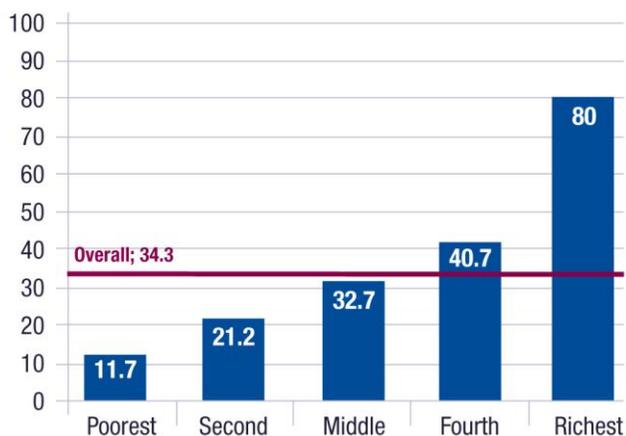
FIGURE 6: SKILLED BIRTH ATTENDANCE BY RESIDENCE



Source: 2010 Afghanistan Mortality Survey

Considerable variations in SBA are also seen among wealth quintiles. Women in the richest quintile were almost seven times more likely than women in the poorest quintile to have SBA. Only 11.7 percent of women in the poorest quintile received SBA compared with 80 percent in the richest quintile (figure 7).⁵

FIGURE 7: SKILLED BIRTH ATTENDANCE BY WEALTH QUINTILE



Source: 2010 Afghanistan Mortality Survey

Nutrition

Undernutrition is another major challenge facing women of age 15-49 in Afghanistan. Vit-D deficiency is widespread. Almost 95% of Afghan woman are Vit-D deficient. Fifteen percent of women of age 15-49 are suffering from Iron Deficiency Anemia. Besides micronutrient deficiency, some 8% of Afghan woman are of shorter stature (less than 145 cm) and overall BMI for this age category is 22.6%.



Key Strategies to Improve Maternal and Reproductive Health Outcomes

Improve access to maternal, neonatal, and child health (MNCH) in urban and rural areas by strengthening urban health with a focus on MNCH; institutionalizing Community Midwifery Education; ensuring twenty-four hour EmOC services at the basic health services (BHS) level; and strengthening the use of mobile technology for SRH services.

Promote multisectoral coordination to improve MNCH by introducing a National Intersectoral High Commission on Health led by the Ministry of Health; implementing multisectoral national campaigns to promote public awareness and advocacy on MNCH; strengthening routine data collection systems to monitor nutrition; and increasing involvement of the private sector to strengthen family planning.

Increasing attention to service quality by adopting guidelines for preeclampsia management at all levels; and expanding and strengthening maternal death investigation.

References:

- 1 World Bank. World Development Indicators 2013: Accessed 9 April 2014
- 2 Afghanistan:Country Program Snapshot. March 2014, the World Bank
- 3 UNDP. 2013 Human Development Report Gender Inequality Index
- 4 WHO, UNICEF, UNFPA and The World Bank. 2014. Trends in Maternal Mortality: 1990 to 2013: World Health Organization
- 5 Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India], and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO.

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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