Beyond the *burqa*: addressing the causes of maternal mortality in Afghanistan

by Hernan del Valle

Priority must be given by national and international actors to rehabilitate health systems in Afghanistan in order to meet basic health needs.

Much has been written about the restrictions on access to health for women under the Taliban regime that controlled Afghanistan until 2001. Taliban edicts gave institutional standing to practices which limited women's movements in public unless accompanied by a male relative, obliged women to wear the all-enveloping *burqa* and denied women access to education, work and health care.

Several reports highlighted the impact of these measures on women's access to reproductive health (RH) services. In 1997 WHO reported that Afghanistan had one of the world's highest maternal mortality rates: 820 per 100,000 live births. This alarming level was widely attributed to Taliban gender policies.[1]

Almost two years after the demise of the regime, however, it is hard to see any improvement. It is believed that only 12% of pregnant women have access to emergency obstetric care. UNFPA estimates maternal mortality rate still to be around 820 per 100,000 live births while UNICEF estimates it to be 1,600 – the highest maternal mortality rate anywhere in the world. Almost half of the reported deaths of Afghan women of childbearing age are due to complications of pregnancy or childbirth, 87% of which are considered preventable.[2] Newborn children who have lost their mothers have a one-in-four chance of living until their first birthday, with the majority perishing in the first month of life. The infant mortality rate is also the highest in the world: 161 per 1,000.[3] Even after making allowance for the unreliability of statistics and different methodologies adopted by researchers, it is indisputable that Afghanistan has appallingly low levels of RH care.

Programmes implemented by NGOs and UN agencies have had limited impact on reducing maternal mortality. We need to move away from one-dimensional accounts that describe the problem only from the angle of gender inequality and RH access restrictions towards a broader understanding of factors contributing to the ongoing high levels of maternal mortality in Afghanistan.

Culture and women's access to health

The restrictive policies imposed by the Taliban had a tremendous impact on the way Western governments and donors framed the planning and delivery of post-Taliban RH care. There has been a marked tendency to focus on maternal mortality as a problem stemming from a deeply embedded gender inequality limiting women's choices and access to health services. Virtually every expatriate-generated report has pointed to the recurrent scarcity of qualified female staff as a major factor contributing to poor RH care in an environment in which it is not always acceptable for a male doctor to examine a female patient. In terms of health-seeking behaviours, the vast majority of women have been reported as having to obtain permission from their husbands to seek health care. Women, it is stressed, have no power to make decisions about contraception or birth spacing.

All of this is true. However, in the context of Afghanistan's reconstruction, the problem of maternal mortality is far more complex. There are three reasons why the rights-based approach put forward to overcome it has been only marginally effective.

Firstly, the demise of the Taliban regime brought to an end the centralised system that enforced restrictive gender policies across the country. Although some reports have highlighted the continued existence of restrictions imposed by regional warlords, on the whole current government policies and legislation uphold access to health and education for all. It goes without saying that a country's traditions are far more resilient and influential than its laws. So the battle for access to RH has shifted from the realm of government policies to the slippery slope of culture and traditions. Therefore, the current challenge in developing any kind of advocacy strategy to promote access to RH care is how to work around constraints linked to local politics, cultural attitudes and interpretations of Islam.

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Secondly, focusing solely on the promotion of women's rights has proved too easy an option. It remains true that pressures on women to marry at an early age and their lack of freedom to make birth-spacing decisions are significant factors influencing maternal mortality. However, in a context in which Western understanding of women's rights are arguably at odds with Afghan traditions, the effectiveness of the women's rights-based approach in improving access to RH and reducing maternal mortality needs to be called into question.

Finally, and perhaps more importantly, the issue in Afghanistan is arguably not so much one of access to

health services for women but rather an issue of absolute lack of facilities. As one Afghan woman said when interviewed: "Well, the question is not if I **would** go or if I would be **allowed** to go [to a health facility] by my husband, but rather where I **could** go. (...) We would certainly use those services if they were accessible and proven to be reliable".[4]

Access to what?

Since 1979, Afghanistan's roads, irrigation systems, educational facilities, health infrastructure and human capital have been destroyed. Of the millions of Afghans who fled the country during the conflict, more than two million have returned from Pakistan and Iran since February 2002. A high percentage of the returnees are residing in temporary settlements around Kabul, where they lack access to housing, employment, health services and education. In addition, there are nearly 240,000 officially recognised IDPs living in camps who receive assistance from the international community.

For the vast majority of rural Afghans, health facilities remain inaccessible, under-staffed and under-equipped. Roads and transport are rarely available, and pregnant women often have to travel several hours by donkey to seek health care. It is not surprising that almost all of them deliver at home without qualified assistance. RH programming in post-Taliban Afghanistan has focused mainly on training and capacity building of female traditional birth attendants (TBAs). RH interventions have often been limited to the safe environment of prenatal consultations and health education initiatives covering topics such as breastfeeding, family planning, nutrition, immunisation and sexually transmitted diseases.

This approach has been relatively cheap and easy to implement. It also proved to be an easy way to kill two birds with one stone: not only do these initiatives satisfy donors' gender yearnings but they also fit into the fashionable category of 'quick impact' projects. However, experience has repeatedly shown that 'quick' is not necessarily 'better'. 'Impact' remains hard to determine. Numerous studies in different countries have demonstrated that these projects, even when well-planned and implemented, are likely to have a negligible impact on maternal mortality rates unless complemented by larger-scale programmes providing quality obstetric services, postnatal care and improved infrastructure.

Access for whom?

The wide variety of ills generated by displacement is well known. The need for legal and physical protection and the hardships caused by the loss of livelihoods and support networks have been extensively reviewed by existing literature. However, experience has shown that, compared to the general population, IDPs living in camps assisted by the international community can sometimes be better off than the general population when it comes to access to health care, including RH.

The camp setting allows UN agencies and NGOs to work with a population which is concentrated in a limited geographical space and therefore easily accessible. Since RH programmes do not require separate facilities, it is feasible to integrate RH into the general health service provision if the human and material resources are available. The 'limited' environment provided by the camp could also make it relatively easier to effectively involve the population both in the planning and implementation phases. TBAs living in the camp could be identified and trained, and health education initiatives would have better chances of achieving continuity and higher levels of coverage. The camp setting could also facilitate prenatal visits by qualified outreach workers and post-partum follow-up.

However, even if all these systems were effectively put in place, the critical question of adequate referral options would remain unanswered. Even if transport to a nearby clinic were made available, the lack of staff and equipment would make it impossible to handle complicated births. For that reason, a limited focus on RH for IDPs in camps makes little sense if the goal is to reduce maternal mortality. In Afghanistan the challenge is to improve services at a hospital level and to ensure that quality obstetric care is available to both IDPs and the general population.

Tackling maternal mortality outside the camps

It is now widely acknowledged that commitment to the reconstruction of Afghanistan has been half-hearted. The amount of funds initially pledged was small compared to other humanitarian crises and they have not always been disbursed as promised. Moreover, commitment to support the Afghan administration in providing security in large areas of the country has also been ambiguous.[5]

Due to resource limitations and the impact of Afghanistan's brain drain, the fledgling Afghan Ministry of Health (MoH) is not able to undertake comprehensive planning and centralised implementation of nationwide initiatives. In the current reconstruction phase, its capacities have been further limited by donor prioritisation

of projects implemented by NGOs and international agencies. This situation has created considerable problems in terms of management and coordination of aid flows and harmonisation of agency mandates and agendas. It has encouraged an *ad hoc* approach. Strategies have not yielded anticipated results.

If maternal mortality is to be reduced in Afghanistan, at least four conditions need to be met.

1. RH must be recognised as an integral part of general health which cannot be divorced from the general well-being of women, men and children. RH must be incorporated into a comprehensive public health plan aimed at achieving free access to basic health care for the majority of the population. The current PPA (Performance-based Partnership Agreements) approach, which places responsibility on donor-selected NGOs for delivering basic health services in entire provinces, risks being neither sustainable nor accountable to the Afghan public.

2. Increased support for the Afghan administration is needed. It is unrealistic to believe that the MoH will ever be in a position to take primary responsibility for delivering health care without donor support for supplies, planning, infrastructure development and capacity building. Action must be taken to remedy the effects of inter-agency competition which has created a pull factor attracting qualified female health professionals from rural to urban centres.[6] The fact that many international agencies do not work in remote areas due to security concerns contributes to the further deterioration of RH care where it is most needed.

3. Maternity clinics and regional hospitals must be helped to obtain the equipment and trained staff needed to provide quality care. Any effective strategy to reduce maternal mortality must target all three levels: prenatal care, assistance during delivery and postnatal care. The last two have received little attention so far.

4. Priority must be given to basic needs in both rural and urban areas: safe water, nutrition, shelter, sanitation, security and education all contribute to safer motherhood.

The combination of traditions and unsatisfied basic needs is a lethal one for women of childbearing age in a country described as the most dangerous place on earth to become a mother.

Donors, agencies and the government must simultaneously address the needs of both IDPs and the general public. Overstating the role of social and cultural mores in perpetuating high levels of maternal mortality in Afghanistan risks becoming a dangerous collection of excuses to justify the failure of national and international actors to fulfil their pledge to rehabilitate health systems.

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1. See *The Taliban's War on Women*, Physicians for Human Rights (PHR), 1998. See also *Women's Health and Human Rights in Afghanistan*, PHR, 2001. See www.phrusa.org/publications/afghan.html

2. *Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability*, report published by the Afghan Ministry of Public Health, UNICEF and the Centre for Disease Control and Prevention, Nov 2002. See: www.afghanica.org/dokumente/mat%20mortality.pdf

3. *The State of World Population*, UNFPA, 2002 (www.unfpa.org/swp/swpmain.htm)

4. Interview with 30-year-old married woman in Kandahar province, Afghanistan, August 2003.

5. See FMR 18 pp38-39.

6. The draft of the 'National Salary Policy' is an attempt to overcome this problem. See 'National Salary Policy for NGOs Working in the Afghan Health Sector', by the Salary Policy Working Group (SCA, GCMU/MoH, IAM, AHDS, USAID/MSH).

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