Afghanistan country profile: reproductive health

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Summary

Two decades of conflict and human displacement, compounded by three years of drought, together with a history of discrimination against women from policies of controlling authorities, have severely affected Afghanistan's health sector, with women being hit the hardest. Since the 1996 UNDP Human Development Report, which placed Afghanistan 169th out of 175 countries on the Human Development Index, Afghanistan's status has not appeared in subsequent reports due to lack of data. Unconfirmed reports indicate very high rates of maternal morbidity and mortality. Women's health is extremely poor due to malnutrition, frequent pregnancies without basic care or trained delivery assistance, and lack of access to information or services. The purpose of this paper is to provide a brief profile on the Reproductive Health situation in Afghanistan to facilitate policy and programming. It points out that family planning is not a problem when there is access to primary health-care services. The reluctance to adopt family planning is partly due to child survival issues. Thus, services to stop children from dying are urgently needed.

Malnutrition of women, which negatively affects pregnancies and deliveries as well as the health of children, is not only caused by food scarcity linked to the conflict and the drought, but is also related to traditional preferences for males which make women reduce their own food allowance in favour of men and children. With regard to mental health, the overall state of women's mental health is poor with more than 70% of women exposed to the Taliban's policies meeting the criteria for major depression. The poor health situation is aggravated by the lack of basic health services and resources, particularly in rural areas; the strict segregation of medical staff; and the small number of trained women doctors, nurses and midwives that remained in the country.

As many as 16,000 Afghan mothers die each year and many more thousands suffer permanent disabilities as a consequence of childbirth. Given the extremely high fertility rate of 7-9 births per married woman in a lifetime, 1 in 12 women can expect to die as a consequence of childbirth. Pregnancy complications are believed to be the most acute health need, with haemorrhage and abortion as the common causes of maternal mortality. Overall, nearly 90% of deliveries take place at home, of which only 9% are attended by trained traditional birth attendants (TBAs). There have been reports of women delivering their babies as well as cutting the cord on their own.

The national coverage for antenatal care has been estimated between 8% to12%; 64% of women in the southeastern region and 41% in the eastern region do not receive any prenatal care. More than half of the women with recent births in the east of Afghanistan are protected against tetanus. Those with some education are more likely to be protected against tetanus compared to those with no education at 55%. Fifty-five per cent of pregnant women in the southeastern region and 91% of pregnant women in the eastern region were anaemic. In the same group, 83% of non-pregnant women in the southeastern region and 95% of non-pregnant women in the eastern region were found to be anaemic.

The total fertility rate per woman is 6.9 and the contraceptive prevalence rate [1972-73] data for Afghanistan is given as 2%. A random sample survey of 472 women out of 134,000 in 12 refugee camps in the North West Frontier Province (NWFP) found 10% contraceptive use [18] and 48% unmet need [22% for spacing and 26% to stop childbearing]. In a survey of Afghan refugee women, injectable contraception was most common at 68%, oral contraceptive pills at 17%, intra uterine devices (IUDs) at 2%, and 12% included natural and other methods. The records from the outpatients department (OPD) for Obstetrics and Gynaecology for January 2002 showed that, of the 900 clients served by the clinic during the month, 70 were for family planning services. The clinic doctors reported that, during the Taliban regime, they were completing a format for husbands' consent before providing any contraceptive method to women, but the practice has been discontinued now.

Ovulation suppression due to lactation is the major factor in spacing births in Afghanistan today. The highest level of contraception appears to be caused by lactational amenorrhoea (22%), which has not been included in either modern or traditional methods of contraception in the survey. *Coitus interruptus* [withdrawal] has always played an important role in family planning in Islam. A Population Council survey quotes data demonstrating that *coitus interruptus* can be more acceptable and have a higher continuation rate than most other methods. The limited literature on this method suggests that its failure rate is about the same as that of condoms.

There are no data on HIV/AIDS and sexually transmitted diseases (STDs). Reproductive tract infections (RTIs) are likely to be relatively high among poor women without access to clinical care. In 2000, the International Committee of the Red Cross/Crescent (ICRC) performed 1000 RPR tests for syphillis among Afghan refugees and all were negative. Regarding HIV, the Ministry of Public Health (MoPH) said that 10 years back 3 HIV/AIDS cases were detected in Kabul under the Global Programme on AIDS support to blood banks. The prevalence of HIV/AIDS is thought to be very low and ICRC found none in screening about 5,000 units of blood recently. The risk factors for HIV/AIDS remain significant though, given people's mobility and returning migrants

In this patriarchal society, girls marry at a very early age; 54% of girls under the age of 18 were reported to be married. High-risk pregnancies combined with malnutrition and a lack of antenatal care is a deadly combination for young women and girls. There is no information about any specific adolescent reproductive health (RH) programmes in the country. The draft Health Policy document of MoPH has identified the critical needs of this vulnerable group and includes that in reproductive health *"appropriate services to adolescents and to young adults will be provided."*

There is no data analysis of common gynaecological problems, but doctors in Rabia Balkhi and the Maternal and Child Health (MCH) centres and hospitals cite abortions (incomplete, threatened, missed); menstrual disorders, pelvic inflammatory disease and infertility (mostly secondary) appear to be the common gynaecological problems seen among outpatient clients. The current abortion regulation in Afghanistan by the Inspection and Regulations department of the MoPH provides for medical termination of pregnancy on health grounds after certification from three doctors. Surgical procedures for vesico vaginal fistula (VVF)/prolapsed repair do not appear to be regularly performed at the referral hospitals visited.

The civil war and militarisation of society led to an increase in the number of abductions of young girls and women by the fighters, but exact numbers are hard to come by as families are reluctant to report cases of abductions due to the social stigma attached to a daughter or sister kidnapped or sold for sex. Families of girls and young women were reportedly forced to marry them or give large sums of money instead. Often, families married off young girls at an earlier age in order to use the bride price for their survival.

Afghanistan has 17 national, 9 regional, 34 provincial and 41 district hospitals; the peripheral network consists of 365 basic health centres and 357 health posts. A significant number, 50 of the 330 districts (average population 72,000) has no health facility at all. Only 11 of the 33 provinces have any capacity to deliver emergency obstetric care, public or private. Only 35% of the districts have any reproductive health services, and 84% of health facilities are either operated or supported by non-government organisations (NGOs).

Issues related to health facilities discussed during the visits to several hospitals (Malalai, Rabia Balkhi, Saidabad/Wardak province, Karte Se, Avicena, Attaturk, Noor, Kabul Mental) and health centres/NGO clinics during the mission include:

- need for infrastructure rehabilitation, redeployment of excess staff concentrated in Kabul
- community involvement in hospital maintenance, need to prevent duplication of support for equipment and others
- training of staff in the use of new equipment being provided
- underutilisation of hospital services
- strengthening blood banking
- physical and financial access to the hospitals for emergency obstetric care (EOC)
- quality and safe delivery services due to paucity of equipment/training, drugs
- lack of service delivery protocols for referral
- community awareness on service/provider availability
- paucity of female providers
- differential incentives/salaries issues
- need for communication / information, education and communication (IEC) materials others.

A large number of small and large NGO partners are active in the health sector service delivery in Afghanistan, including international and local NGOs. Most NGOs focus on primary health care (38%); some focus on specialised services such as rehabilitation of war victims; tuberculosis, nutrition others. Some operate government health facilities, others have constructed their own health facilities. The Swedish Committee for Afghanistan (SCA) is one of the large NGOs and has 168 clinics in 137 districts in the country, of which 54 have an MCH component.

In 1998, there were 187 private clinics, with doctors working at least part-time. The number of pharmacies in 1998 was 2,598. There is potential for utilising these for social marketing of reproductive health products such as safe delivery kits, sanitary napkins, and other RH products. The supply of drugs to the private market is poorly regulated and quality is uneven, however. Other problems included poly-pharmacy and over-prescription, and an absence of standards for prescription. Mission discussions with Afghans suggest that, in the current sociocultural context, it may perhaps be more appropriate to institute demand generation activities through health centres with interpersonal counselling than a marketing campaign.

Estimates of total human resources inside Afghanistan indicate that there are about 17,856 public sector health care providers, made up of 3,906 physicians, 2,564 mid-level professionals, 4,993 nurses and technicians, and 6,123 community health workers and birth attendants. There is an urban bias

in the distribution of human resources. Another critical issue is the critical shortage of female health workers, particularly skilled birth attendants, midwives, and nurses.

The number of female doctors in Afghanistan is currently not available. A number of female doctors not specialised in OB/GYN are experienced in the delivery of reproductive health services. Higher medical education started in Afghanistan in 1932, when only boys enrolled in Kabul Medical Faculty. In 1957, a separate school of medicine was opened in the vicinity of the women's hospital when the Afghan government felt the need to train female doctors. When wearing the veil became optional in 1959, the female doctors joined the male medical school and the training of medical doctors became co-educational with 20% female students. During the Taliban period, female medical education was stopped.

Nursing/midwifery and allied health workers are trained through a system of 8 Intermediate Medical Schools. Despite the large number of training schools producing a large number of medical and allied health workers, there continues to be a limited availability of and access to quality health services for women throughout Afghanistan. Only 15% of students returning to training for all categories are female. Traditional birth attendants (TBAs) have established a role in the Afghan primary health care system to deliver health services to Afghan women whose access to health services is circumscribed by the traditional/cultural practices affecting their mobility in the public sphere. Currently, many different agencies are training TBAs, though few are supervising them or building functional linkages between them and the nearest available formal health services.

There are 1,386 community health workers that are involved in health information education, including RH aspects. Communication materials, particularly on safe motherhood, have been developed in some NGO projects. Most of the RH NGOs have also developed the capacity for training in reproductive health including for community health workers, TBAs, midwives, and others. Training duration for community health worker (CHW) certification, however, differs among NGOs and needs standardisation.

Conclusion

This paper provides a profile of the reproductive health status in Afghanistan and identifies issues and challenges for the provision of RH services. The available information indicates the acute need, particularly of women, for basic reproductive health services in the country (more in particular in underserved regions/provinces). United Nations Family Planning Association (UNFPA) has been designated as the focal agency for coordinating reproductive health by the MoPH, and the leadership of the Fund in this area is envisaged. Following this Country Profile document, a companion paper on

UNFPA support in the critical area of reproductive health in Afghanistan was also developed during the mission.

Below are recommendations for health/RH programming:

- Ensure participation of Afghan women in all stages of programming, including planning, implementation and monitoring of RH programmes.
- Employ Afghan women including in management positions in RH programmes.
- Ensure equal access to funding for Afghan women's organisations in RH service delivery.
- Give priority to the capacity building of professional Afghan women.
- All projects to develop/include indicators to measure progress and facilitate the monitoring and evaluation of all programmes and projects with regard to their contribution towards achievement of gender equity goals.
- Ensure that all reports /assessments studies include sex desegregated data and statistics on the involvement of women in all sectors as staff, participants and beneficiaries.
- Some specific gender programming recommendations for RH programmes include:
  - examine special incentives for female health staff working in rural/remote areas;
  - preferential employment of husband of female health providers in the remote duty stations;
  - provision of crèche facilities in health centres for female employees;
  - gender training: if RH programmes are to be based on a gender approach, there needs to be an awareness of gender on the part of health workers in the field, on the part of programme managers, and on the part of policy-makers and donors.

  Gender training is designed to promote such awareness. It enables people to examine their personal experiences and to realise how the neglect of a gender perspective has in the past disadvantaged men and particularly women. Such training also introduces participants to the tools of gender analysis and planning.