Women in Afghanistan have an extraordinarily high risk of dying during pregnancy and childbirth and the highest maternal mortality rate in the world. Pre-natal care, maternal health care facilities and trained health personnel are virtually non-existent in large parts of the country, contributing to a very high percentage of preventable maternal and child deaths. Besides the lack of access to and quality of health services, other factors such as lack of adequate food, shelter and clean water, low marriage age, high fertility rate and lack of spacing of child births contribute to the extremely poor health of Afghan women.6

The root causes of the alarming health indicators in Afghanistan are poverty and the two decades of warfare that stalled economic and social progress and led to destruction of livelihoods and high levels of disability. This situation has had a particularly negative impact on the health and mortality of women and children, but there does not appear to be any evidence of deliberate gender-based discrimination within the health sector - the exception being the Taliban insisting on separate medical facilities for males and females, which increased the de facto differences in service provision to men and women. However, factors such as the prevailing poverty and lack of health facilities and trained staff, along with the predominant cultural attitudes related to purdah norms, have had a devastating effect on women’s reproductive health. This chapter focuses on the material circumstances and constraints affecting women's health in terms of access to and availability of health

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6 Physicians for Human Rights, 2002
services, as well as on prevailing socio-cultural norms which act as constraints to improvement in the situation.7

Maternal and Child Mortality
Surveys conducted in 2002 by UNICEF and the U.S. Centers for Disease Control and Prevention in four provinces of Afghanistan estimated a maternal mortality rate (MMR) of 1,600 per 100,000 live births. There are indications of large variations across geographical areas; Kabul for example, had an estimated MMR of 400 per 100,000 while Badakhshan with 6,500 per 100,000 had the highest MMR ever reported globally8. In comparison, the MMR is 500 in Pakistan and only 76 in Iran.9 The proportion of deaths of women that were due to maternal causes ranged from 16% in Kabul, where at least one maternity hospital was functional at the time of the survey, to 64% in Badakhshan, where health care access was profoundly limited. While the lifetime risk of maternal death is 1 in 15,10 the UNICEF/CDC study also showed that when the mother of a newborn infant dies, the child has only one chance in four of surviving until its first birthday.

Available health data indicate that while the present health situation in Afghanistan is very poor, for the larger part of the population there has not been an actual deterioration as compared to pre-war times. Despite of the devastating effect of the war and recent drought on all public services in Afghanistan, its pre-war health statistics were even worse. The under-5 mortality has fallen from 360 in 1960 to 260 in 1990 and 257 in 2002. Likewise, maternal mortality rate has fallen from 3,070 per 100 000 in 197811 to the present 1,600,

7 Sources: The UNICEF Multiple Indicator Cluster Survey 2003 has national coverage - but does not cover the nomadic population. Even then, there are considerable uncertainties regarding actual figures, e.g. population figures are estimated on the basis of growth rates estimated from the 1979 census data, which did not achieve full coverage due to the resistance to the PDPA government. Other important source materials are the MICS 2000, which covered only East Afghanistan, and more detailed, but regionally limited studies such as Maternal Mortality in Afghanistan (2002), covering four provinces, Maternal Mortality in Herat Province (2002) and Women’s Health and Human Rights in Afghanistan (2001), a population based study in four geographic areas, both by Physicians for Human Rights and the UNICEF and the CDC Nutrition and Health Survey in Badghis Province (2001)
8 Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability. The survey covered rural and urban settings (Kabul, Laghman, Kandahar and Badakhshan), gathering information on an estimated 85,000 women
9 http://unicef.org/infobycountry/index.html
10 Wilma Doedens/WHO/RHR/21-09-01
and life expectancy has increased from 38 years (1970) to 43 today. Overall, there have been modest improvements since the 1970s, which presumably are largely due to the scattered service provisions by NGO during the years of conflict. More than 80% of functional health facilities have some form of NGO involvement, but the coverage is far from even, with a concentration in the urban areas and areas near the Pakistan border. The key point is that in terms of its social indicators, especially female social indicators, Afghanistan has not participated in the dramatic improvements that have occurred over the past several

<table>
<thead>
<tr>
<th>Table 2: Reproductive Health Indicators</th>
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<tbody>
<tr>
<td><strong>Indicator</strong></td>
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<tr>
<td>Under-5 mortality rate</td>
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<tr>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Total fertility rate</td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Crude death rate</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Crude birth rate</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maternal mortality</td>
</tr>
</tbody>
</table>


* National Human Development Report, 2004

decades in most developing countries, even very poor countries. Thus Afghanistan has fallen much further behind most of the rest of the world and hence is starting from an extremely low base in terms of progressing toward the Millennium Development Goals (MDGs).

A study in Herat province concludes that the extraordinarily high number of deaths of women during pregnancy and childbirth are largely preventable. They are a direct consequence of the very young marriage age for women and girls (according to UNIFEM, 54% of girls under the age of 18 are married), poor health and nutrition, too-frequent childbearing, and virtually no access to gynecological and obstetrical services. Small, anemic mothers with undeveloped pelvic bones are at greater risk of obstructed births with devastating consequences for both mother and baby, and they may not withstand pregnancy or the usual blood loss during delivery. Other studies similarly point out that 40% of child deaths are due to the preventable causes of diarrhea and acute respiratory diseases. There are no national figures for average marriage age for girls, but in this study it was found to be the age of 15 (range 5-39). The Tufts University study based on NRVA data informs us that 16% of girls are married under the age of 15; while 52% are married by the time they become 18 years old.

The main causes of maternal mortality are hemorrhage (24%) and obstructed labor (32%). To this should be added the extremely high prevalence of anemia (MICS2000 recorded 55%-91% for the Southern and Eastern regions). More than 90% of women give birth at home and most of these births occur without the assistance of a trained health attendant. Even if a primary health care clinic is available, 70% of these are unable to provide even basic mother and child services, while 90% of hospitals do not have the complete equipment to perform C-sections. Furthermore, there is widespread reluctance to let women be treated by male health workers, particularly in the case of obstetrical and gynecological matters. In this

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12 www.unifem.org: Women’s Leadership Role in the Reconstruction of Afghanistan
13 Physicians for Human Rights, 2002, p.5. A population-based survey of 4,486 women from 34 urban and rural towns and villages in seven of thirteen districts in Herat
14 AREU, 2003, p.48, note 62
15 Feinstein International Famine Center, 2004, footnote 153
16 UNICEF/CDC, 2003
17 Multiple Indicators Cluster Survey (MICS), carried out in 2000 in Eastern Afghanistan
context, the fact that in 2002 nearly 40% of basic health facilities did not have female health care workers, only 24% had at least one female physician, 21% had at least one female nurse, and 20% had at least one midwife becomes even more salient. Where female health workers are present, women's utilization of health care facilities increases dramatically, as is the case in the MSF-supported clinic in Baharak (Badakhshan Province), staffed with two male and two female doctors. Such clinics in Eshkeshem and Dashta Barchi reported similarly high usage by women.

Even with availability of female medical staff, pregnant women may not receive the necessary medical attention. In Eshkeshm it was reported that most problems during birth were taken care of by relatives or by a mullah, who would provide amulets or written verses from the Koran. In the same vein, the Herat study found that besides women's limited access to health facilities, other factors also contributed to the very high incidence of maternal mortality. These included: (1) women and their families do not know the warning signs of potentially lethal conditions during pregnancy and childbirth and therefore cannot avert potential complications; (2) women often cannot afford to pay for health care services even when they know they are in danger; and (3) lack of transportation makes it impossible for the sick woman to reach the health clinic in time. Since women normally would consult their male family members about seeking medical care, and in any case may need their assistance for the travel to a health clinic, the lack of male knowledge and understanding of reproductive health care is as important an obstacle as women's own lack of awareness.

However, the massive rehabilitation effort undertaken since 2002 is beginning to show results. The first comprehensive study on women and children conducted by the Afghanistan Central Statistics Office and UNICEF in 2003, revealed that estimated infant mortality has fallen from 165 to 115 deaths per 1000 live births and under-5 mortality from 257 to 172 deaths per 1,000 live births. Furthermore, provision of the Basic Package of Health Services

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18 UNICEF/CDC/Afghan Ministry of Public Health, 2002; AREU, 2003, p. 48, note 62
19 Strategic Monitoring Unit, 2001, p.36. Sample drawn from 45 villages
20 Reilly, B et al,  2004
21 Strategic Monitoring Unit, 2001, p.36-40
22 UNICEF, 2004. The survey is based on interviews with 20,800 individual households in 32 provinces across the country
Box 2: Training Skilled Birth Attendants: Successful NGO Interventions

Since 1999 the International Medical Corps (IMC) has trained a thousand birth attendants and basic health workers (female and male), in the rural areas of Paktia, Paktika, Bamiyan, Nangarhar, Kandahar and Kabul. Recognizing the inevitable limitations to managing of birthing complications, agencies have also established referral systems.

In urban areas, home-based midwifery is proving to be a successful mode of providing access for poorer women to skilled maternal and infant care. Terre des hommes has been operating in the poor districts of Kabul City since 1995 and more recently has expanded to Kandahar. Midwives are selected by urban district communities themselves, and identify clients on a ‘knock on the door’ basis. While evaluation reports indicate a reduction in maternal mortality over time, the close community relationship has also enabled Terre des hommes to address more sensitive issues such as domestic violence and child abuse. This is supported by its membership of the Ministry of Women’s Affairs’ national women’s protection network which includes specialized agencies such as Medica Mondiale (for psychosocial counseling, legal support), and the Ministry of Women’s Affairs Legal Department (for gender-based violence, child abuse).

(BPHS) has expanded to about 60% of the population, and 95% of children are vaccinated against measles and polio. Female staff are now available at 60% of health facilities. While these are very positive indicators, there is still a long way to go.23

Gender Differences in Mortality

According to the newly published National Human Development Report (2004), life expectancy at birth in Afghanistan is 44.5 years which is about the lowest in the world, comparable to Niger, Burkina Faso and Guinea-Bissau and only Sierra Leone is lower. The neighboring countries of Pakistan and Iran have life expectancy at birth at 60.8 and 70.1 years respectively. Never-the-less, women do have an overall biological advantage in survival at birth, but this survival advantage is extremely small and in the region, only Nepal ranks below Afghanistan, in that respect. The sex ratio in South Asian countries (with the exception of Sri Lanka), favors men - the starkest indicator of women’s poorer health status compared to men’s. In Afghanistan too, there are 94 women to every 1000 men - but the sex ratio is the same as in Bangladesh and India. Thus, Afghanistan falls well within the regional patterns in overall gender differences in mortality. However, survey data from Badghis on age-specific death rates

shows that women’s death rates in Afghanistan in the reproductive period are particularly sobering and - as women are almost three times as likely as men to die in the 15-49 age group:

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>2.86</td>
<td>2.23</td>
<td>2.51</td>
</tr>
<tr>
<td>5-14</td>
<td>0.20</td>
<td>0.15</td>
<td>0.18</td>
</tr>
<tr>
<td>15-49</td>
<td>0.18</td>
<td>0.47</td>
<td>0.32</td>
</tr>
<tr>
<td>50+</td>
<td>0.76</td>
<td>0.69</td>
<td>0.73</td>
</tr>
<tr>
<td>All ages</td>
<td>0.69</td>
<td>0.74</td>
<td>0.72</td>
</tr>
</tbody>
</table>

* Number of deaths/10 000 population /day

Source: UNICEF & CDC Nutrition and Health Survey Badghis Province, 2001

There is little information on gender discrimination within the household in matters of nutrition and access to health care, but it seems that breastfeeding is discontinued earlier for girls than for boys: breastfeeding was discontinued by age 12-15 months for 6.7% of boys, but for 11% of girls.24

Fertility and Family Planning
In Afghanistan, there is a marked preference among parents for a newborn to be a boy rather than a girl, which is also a common feature in all the neighboring countries. In the 1970s, before the conflict started, a ratio of almost 2 to 1 favoring boys was reported,25 and rural women reportedly desired two times as many offspring (boys and girls) as their urban counterparts. In a number of countries of East and South Asia, this has resulted in sex-selective abortion resulting in a dramatic shortfall of women. Fortunately there are no such indications from Afghanistan, where the technology for sex determinations is not yet available, and where the high fertility rate recorded, partly a result of the young marriage age,

25 Hunte, 1978, p.20
reflects the fact that numerous children (boys and girls) are seen as a blessing. Having many children functions as a social safety net in a country with no welfare system, related to power in a society where differences are settled through violence and provision of livelihood support by offspring. Children are important as a female status symbol since a woman’s status in the family improves according to the number of children and especially boys she has borne, and failure to conceive is sufficient grounds for a husband to demand divorce. Recent surveys among Pashtun women noted that the desired number of children ranged between seven to ten, while economic considerations and deterioration in the mother’s health have been found to be common reasons for men and women to limit their fertility. The current fertility rate is recorded as 6.8, and although high it still constitutes a reduction from the pre-conflict rate of 7.7 recorded in 1960. To this picture should be added accounts of a virtual ‘baby boom’ in the refugee camps, where Dupree reported a fertility rate of 13.6. It is not known how comprehensive and representative a survey is behind these data, but an increase in fertility rates during a period of war and conflict is however not unusual in any culture.

The high fertility rate results in high annual population growth roughly estimated at 3.8% per annum during 1992-2002 according to one source. This is problematic at the individual household level due to the strain it exerts on maternal health and on the economic resources and well-being of the household. The NRVA survey reveals that family size is inversely related to per-capita expenditures, and poverty as such also correlates with schooling, literacy and health. At the national level, rapid population growth will reduce the benefits to the people (in terms of average per-capita income) of any given rate of economic growth.

Family planning was introduced to Afghanistan in 1970 when the Department of Family Planning was established in Kabul, with branches extending to 20 provinces a year later. Women in particular did recognize that many child-births and lack of spacing of births took a

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26 Azarbaijani-Moghadam, 2002, p. 25
27 Afghanistan Working Group, 2001. The surveys in question refer to the Review of Family Planning in two regions- Eastern and Southeastern; Swedish Committee for Afghanistan, 1999; Reproductive Health Survey and Ibn Sina and P. Hunte, 1985
28 Dupree, N.H, 1998
29 www.who.int/country/afg
30 World Bank, 2004:15
heavy toll on their health, while the male response to family planning was considerably cooler. The contraceptive prevalence rate reported in 1972/73 by UNFPA was 2%. During the 1980s, little attention was paid to birth control measures, and the Department of Family Planning was closed down with the advent of the mujahedin government in 1992.\textsuperscript{31} In this context the very low prevalence of contraception reported recently (Table 4) is not surprising, and it probably reflects both the lack of awareness of and lack of access to contraceptive methods.

While contraceptive prevalence in Afghanistan is only 1/5 of the prevalence in Pakistan and 1/11 of the prevalence in Bangladesh, recent surveys have indicated that women in Afghanistan and their husbands are keen to limit family size. Where women do want to limit

<table>
<thead>
<tr>
<th>Country</th>
<th>Contraceptive Use Among Married Women 15-49, All Methods (%)</th>
<th>Contraceptive Use Among Married Women 15-49, Modern Methods (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>54</td>
<td>43</td>
</tr>
<tr>
<td>India</td>
<td>48</td>
<td>43</td>
</tr>
<tr>
<td>Indonesia</td>
<td>60</td>
<td>57</td>
</tr>
<tr>
<td>Iran</td>
<td>74</td>
<td>56</td>
</tr>
<tr>
<td>Malaysia</td>
<td>55</td>
<td>30</td>
</tr>
<tr>
<td>Nepal</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Pakistan</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Sri Lanka (Data prior to 1997)</td>
<td>66</td>
<td>44</td>
</tr>
</tbody>
</table>

\textit{Source: PRB 2004 World Population Data Sheet}

\textsuperscript{31} Afghanistan Working Group, 2001
fertility, access to contraception is the most important determinant. Estimates of contraceptive prevalence vary substantially, and as in other countries, regional differences are great, with 2% contraceptive prevalence in the South-eastern region compared to 8.4% in the Eastern region are reported by the MICS 2000.

While data on reproductive decision-making is lacking in Afghanistan, available evidence seems to show that while women may openly have little say with respect to the number of children they bear, in fact they do have a high unmet need for contraception. The Tufts University survey in 2003 also reported high interest in birth control among women in Badghis, Herat, Kabul, Kandahar and Nangarhar, and several women stated that their husbands would support their use of contraception. Even more striking is a survey of 360 women in 12 areas of Kabul by Terre des homes, which reported that 98% women expressed interest in receiving contraceptives and 96% confirmed that their husbands would agree with family planning methods.

Knowledge of family planning and its use vary considerably between rural and urban areas. According to the MICS 2003, 21% of urban but only for 6% of rural women below 50 years of age reported using contraception. Available figures also indicate that the awareness and usage of contraceptive methods are far higher in the Western part of the country than in other areas. Thus, women in Herat province are more likely to use contraception than those in Kabul, and even very poor and under-serviced provinces like Farah and Nimroz figure well above the national average when it comes to use of contraceptive methods. Even a very gender conservative province like Kandahar ranks high in terms of both awareness and use of contraception. The reason may be that many Afghans from the western areas were refugees in Iran, where they may have been exposed to the Iranian family planning campaign. (This may also explain why Bamiyan Province in Central Afghanistan ranks high regarding awareness of contraception, since many Shi’as from the central areas chose to become refugees in Iran).

32 NRVI, 2003
33 Feinstein International Famine Center, 2004: 86-87
34 Terre des homes survey about family planning in Kabul city. Press release, 25. April, 2002
Poverty, Conflict and Gender: Other Effects on Health

In the Health Sector, a picture of a largely under-serviced rural population is apparent. In 1976-77, there were a total of 176 government-licensed trained nurse-midwives in the whole of Afghanistan, and of these 150 were in Kabul Province alone. Today the ratio of basic health centers to population ranges from approximately one per 40,000 people in the central and eastern regions to approximately one per 200,000 in the south. Nineteen districts have no health facilities at all. In 38% of the rural districts countrywide, the majority of people (>50%) have no access to even the most rudimentary forms of healthcare. The slightly more

Box 3: Models of Family Planning - Iran and Bangladesh

Iran forms an interesting comparison to Afghanistan in terms of fertility and family planning. After the Islamic Revolution in 1979, there was no family planning program, as the dominant view was that Islam does not encourage people to practice family planning. After the start of the Iran-Iraq war, political and religious authorities advocated having more children to strengthen the nation by increasing the population. As a result, in 1988 the population growth rate in the country stood at 3.9% per annum, i.e. comparable to the present Afghan growth rate. This caused serious alarm among policy-makers, who realized that the costs of this burgeoning population were going to far exceed the government’s capacity to provide adequate food, education, housing and employment. Hence policies were drastically changed, paving the way for one of the most successful family planning programs ever seen. Iran’s population growth rate was within a decade more than halved to 1.47%, through a combination of strong political commitment backed up by religious leaders, integration of family planning with primary health care, and comprehensive sex education at both school and community level for both men and women. Parallel with this development has been an equally dramatic rise in literacy levels - for women rising from less than 25% in 1970 to more than 70% today.

Bangladesh shows equally significant results in terms of controlling population growth and over the last 20 years has reduced total fertility rate from about 6.4 to 3.3 births per woman at present. In addition, contraceptive use by women under the age of 50 rose from 3% to 54%. These results were achieved by building health and family welfare clinics all over the country, training more than 35,000 female workers to take family planning advice directly to the people’s doorsteps, and using mass media campaigns to generate awareness about family planning. The prerequisite for these achievements was above all a strong political commitment.

Poverty, Conflict and Gender: Other Effects on Health

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36 Larson, J., 1998; Peterson, S., 2004
37 www.EngenderHealth.org/itf/bangladesh
38 Hunte, 1978, p. 17
39 Waldman and Hanif, 2002
than half of the respondents in the Tufts University survey in Badghis, Herat, Kabul, Kandahar and Nanagarhar provinces, who were able to access some form of health care had to spend on average three hours of travel time to reach the health facility. Hence patients tend to wait until their health problems become severe before they travel to medical centers.\textsuperscript{40}

The uneven geographical distribution of health facilities is made even worse by the uneven distribution of female health workers. In 2002 there was one female nurse per 58,988 of population in Balkh Province, while there was one female nurse per 470,500 populations in Ghor Province. In Wardak, 59,000 members of the population shared one midwife, while 475,100 people shared one midwife in Helmand. In Nimroz, Paktika and Khost Provinces, there was not a single basic health facility providing delivery care services with a female physician, doctor’s assistant, nurse or midwife.\textsuperscript{41}

More than half of all hospitals in Afghanistan are located in Kabul and therefore serve only about one fifth of the entire population. According to WHO, approximately 2,700 of the 3,900 physicians and 600 of the 990 midwives work in Kabul, leaving the remainder of the country with few trained health care professionals.\textsuperscript{42} In fact, it was recently estimated that a trained health care provider attended fewer than 8\% of deliveries countrywide,\textsuperscript{43} and there is one doctor per 1,000 population in Kabul, whereas there is only one per 100,000 population in Bamiyan.\textsuperscript{44} In the case of rural health facilities which are fortunate enough to have a medical officer, he/she may only have limited medical education completed decades ago. The number of doctors plus the 7,000 medical students may exceed the number of trained community health workers in the country, which means that the primary health pyramid has been stood on its head, with a focus on curative care, whereas notions of public health are poorly developed.\textsuperscript{45}

The congruence of poverty, conflict and prevailing gender norms has also had other adverse effects on the health of women and men. The extreme anti-women policies of the Taliban

\textsuperscript{40} Feinstein International Famine Center, 2004, p.74-78
\textsuperscript{41} UNICEF and CDC, 2002
\textsuperscript{42} WHO Afghanistan, 2001. (Unpublished)
\textsuperscript{44} MOPH-WHO, 2001
\textsuperscript{45} Waldman and Hanif, AREU, 2002, footnote 12
regime from the mid-1990s to 2001 and the years of conflict have, for example, increased women's risk of mental diseases. For example, study of maternal mortality in Herat points out that a large percentage of Afghan women suffer from major depression or other mental health problems related to trauma and/or the suffering of losses in their lives. Evidence from Medica Mondiale, a German-based international organization supporting women in war and crisis situations, reports that a Herat hospital last year recorded 160 cases of attempted suicide among girls and women between the ages of 12 and 50. This is widely recognized by aid workers as being an underestimation of the problem due to reporting bias in favor of urban areas.

Nutritional deprivation stemming from food insecurity and issues of occupational health are some of the other issues of concern. The MICS 2000 reported 14% of children as being severely underweight and 25% as severely stunted, although gender disaggregated data is not available. In 2002 UNICEF and CDC conducted a child nutritional assessment in Badghis, covering 507 households, where chronic malnutrition was reported for 62% of boys and 54% of girls, while prevalence of acute malnutrition was 6-7% for both. Finally, specific work-related problems affect women and men differently. For instance, girls who work at carpet looms from an early age face problems of neurological and eye related problems due to the constant high concentration required. Other evidence on the health effects of conflict and poverty is lacking, and this is a critical area for further research.

**Innovative Programs Carried Out by NGOs**

NGOs have shown the way to effective health service delivery in the difficult conditions of Afghanistan, albeit on a small scale. A variety of approaches have been adopted to provide access for rural women to reproductive health information and services. Mobile clinics are used by agencies like Relief International (RI), which serves five districts of Nangarhar province traveling

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48 Esfandiari, 2004

49 Multiple Indicator Baseline carried out by UNICEF, and CIET International

50 *Nutrition and Health Survey Badghis Province Afghanistan,* February - March 2001, UNICEF and U.S. Centers for Disease Control and Prevention (CDC)
Box 4: Men as Partners in Health Service Delivery

In Afghanistan, perhaps more than in other cultures, it is important to involve men as key partners in health service delivery. In some programs, preventive health and hygiene, seasonal risks such as malaria and basic reproductive health information are transmitted to rural men and women via members of health committees by both OXFAM and Swedish Committee for Afghanistan (initiated during the Taliban regime and attached to all its clinics). Members comprise village-level community health workers or traditional birth attendants as well as individuals selected by the villagers themselves. Linked to a clinic, these men and women are trained by the clinic professionals, usually on a monthly basis, and return to their home communities to share the new information. To facilitate women working in rural areas of Badakhshan and Bamiyan, OXFAM has adopted a policy of hiring couples and/or making provision for accommodation and basic costs of a mahram - an approach which was used with success by several agencies (e.g. DACAAR) to deliver health education during the Taliban times. For rural village-level work, consultation with mullahs and elders has been instrumental in gaining acceptance not only of program content but also of men allowing village women’s participation.

from its capital in Jalalabad. The Afghanistan Institute of Learning (AIL) covers three districts of Kabul province from its Mir Bacha Kot based unit. Both agencies integrate direct care with preventive approaches implemented by non-health professionals in order to optimize outcomes for women. Over the past five years AIL has trained 10,000 female teachers to provide health education to women in their communities. Capitalizing on its relationship with the Ministry of Education (as an education provider) its mobile clinics also implement specialized health seminars in schools for both adults and for children. Relief International expands its outreach for preventive health education through literacy teachers as well as community health workers, and focuses its mobile clinic in those districts where women are participating in a non-formal education program.

Policy Implications

Afghanistan’s health indicators are among the worst in the world, in particular, when it comes to child health and women’s reproductive health. Under-five mortality rate of 257, infant mortality rate of 165, and estimated maternal mortality rate of 16 (all per 1000 live births); rate of chronic malnutrition (moderate or severe stunting) around 50%; and very high rates of disability due to polio, cerebral palsy, and conflict (including landmines) are figures that tell the sorry state of affairs. Recent surveys have revealed that almost half of all deaths among women of reproductive age are a result of pregnancy and childbirth - and that more than ¾ of these deaths are preventable. Among children, diarrhea, acute respiratory infections and vaccine preventable illnesses likely

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51 Polio used to be a major cause for disability, but polio eradication efforts overseen in the past couple of years have been very successful
account for 60% of deaths, and among adults tuberculosis results in an estimated 15,000 deaths per year, with 70% of detected cases being among women. Life expectancy is estimated at 43 years.

A range of factors contributes to this situation. On the supply side it is:

- Lack of access to basic health facilities - only 40% of the population is in the coverage areas of basic health facilities, and only 9% of rural households surveyed in 2003 reported a health facility in their village\(^5\)
- Lack of female staff at the existing facilities particularly in rural areas
- Strong rural-urban disparity in availability of health facilities
- Lack of roads, transport and security reduce mobility and access
- Public health system, including provision of community health workers, is highly underdeveloped compared to the curative care in the primary health system
- Lack of clean drinking water and sanitation facilities
- Lack of access to family planning information and contraceptive methods

Social factors, which negatively affect women’s health and their inability to access proper health care are:

- Low marriage age resulting in too many and too frequent child births
- Poverty
- Reluctance to let women seek medical assistance from male health workers
- Lack of awareness of maternal health care among men and women
- Insufficient awareness of health hygiene and nutrition
- Lack of awareness of family planning

\(^5\) World Bank, 2004, p. 105