Traditional practices in Afghan marriage,
responding to women's health needs.

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Masters in International Health,
September 2008 - October 2010.

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<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AIHRC</td>
<td>Afghanistan Independent Human Rights Commission</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ANDS</td>
<td>Afghan National Development Strategy</td>
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<td>AREU</td>
<td>Afghanistan Research and Evaluation Unit</td>
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<tr>
<td>BBC</td>
<td>British Broadcasting Cooperation</td>
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<tr>
<td>BHC</td>
<td>Basic Health Centre</td>
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<td>BPHS</td>
<td>Basic Package Health Services</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CHC</td>
<td>Comprehensive Health Centre</td>
</tr>
<tr>
<td>CIA</td>
<td>Central Intelligence Agency</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package Hospital Services</td>
</tr>
<tr>
<td>EMRO</td>
<td>East Mediterranean Region Office</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPI</td>
<td>Human Poverty Index</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>IFRC</td>
<td>International Federation of the Red Cross</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MoWA</td>
<td>Ministry of Women Affairs</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>OHCCHR</td>
<td>Office UN High Commissioner Human Rights</td>
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<tr>
<td>PNC</td>
<td>Postnatal Care</td>
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<tr>
<td>SEARC</td>
<td>South-East Asia Research Centre</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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<td>UNAMA</td>
<td>United Nations Assistance Mission in Afghanistan</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Populations Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNIFEM</td>
<td>United Nations Development Fund Women</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>VVF</td>
<td>Vesico-Vaginal Fistula</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Afghan definitions

Baad: practice of justice being done by giving a girl for marriage to an opposing family resolving a dispute, crime and as a form of compensation.

Jirga: community council, composed of influential persons (landlords, wealthy, religious clerics and elders recognized for wisdom and, or charisma). Exercising authority for settling (with money or baad) community disputes and enforcing binding norms based on the traditional law.

Constitutional Loya Jirga: Jirga at the highest level, governmental council and leading by the principles in which the State is organized.

Mahram: a male relative who serves as chaperone for Afghan women, especially when entering public life.

Purdah: (gender boundaries) gender separation and order applied for men and women, with men sitting separate in rooms with male hosts. It Includes the wearing of the boghra by women when entering public spaces.

Sharia: Islamic law (school of Hanafi) practiced at the Madrasse, with the Quran as Islamic Holy writing.

Walwar: (bride price) financial compensation for the brides family, for having nursed the girl or women.

Zina: consensual sex outside the marriage.

Abstract

Traditional practices in Afghan marriage
responding to women's health needs

Traditional practices in marriage, such as early and forced marriage, bride price and baad or restorative justice, are common in Afghanistan. These traditional practices, as well as the concepts of polygamy, zina and boy preference, can be harmful to Afghan women's physical, mental and social wellbeing.

The major study objective is to understand how traditional marriage practices influence Afghan women's health, the impact and magnitude, in particular how they lead to vulnerability for violence. As well, to describe women's health needs and map accordingly the Afghan health system response.

The literature research, led to limited country specific quantitative data, while the actual determinants to Afghan women's health were revealed by qualitative evidence. Young age marriage, leading to pregnancy shows an increased risk to maternal mortality, morbidity in sexual reproductive health and forced marriage may lead to violence at the home, women's self destructive behavior and even to honour killing. Some Afghan traditions root into inequity, inequality, and gender discrimination and determine women's life cycle, which leads into needs of sexual reproductive health.

The Right to Health (UDHR) is used as framework to identify progress, gaps and limitations in the health care system, in relation to women's health needs. The number of traditional marital practices is higher in rural regions, here the health services are often not available or accessible. Contraceptive use and skilled birth attendance, can positively influence the maternal outcome at community level. Sensitive issues of sexual reproduction (as STD, HIV/Aids, unwanted pregnancy and gender based violence), require development of health policies and enables institutionalization of supportive health care services, as the counseling regarding violence, VCT and shelters for protection. National health promotion, by active involvement of religious leaders allows a wider societal, behavioral change and supports new health strategies implementation, of family planning and mental health. Traditional marital practices, are in contradiction with the legal law and require the law re enforcement, accessibility to enable women's protection.

Key words: early and forced marriage, traditional tribal law, sexual reproductive health, maternal mortality, gender based violence, health care system.
Chapter 1. Background

1.1 Geographic and Demographic

Afghanistan is located in the mid-western part of Asia. It is at the cross route of major continents, and has in the past brought together a mix of diverse cultures, religions and ethnicities. Present, the Afghan Islamic Republic has a landmass of 652,200 square kilometers, and it's capital city is Kabul. The surrounding 34 provinces are subdivided into districts. Afghanistan's population is nowadays 28.4 million people, consisting of the ethnic groups according CIA, "Pashtu 42%, Tadijk 27%, Hazara 9%, Uzbek 9% and other 13%, with as main religion 80% Sunni Muslim, 19% Shia Muslim and 1% other"(CIA 2010). It's remoteness, mountainous terrain and harsh climates make sustaining of a regular livelihood difficult for a huge part of the population. Of the whole Afghan population, 5.5 million are women in the age 15 to 49 year, there are 5 million children under 5 year (MoPH 2008) and 57% of the population is under 18 years of age (WHO EMRO 2006.a).

Figure 1.: Cartographic Map Afghanistan.

![Cartographic Map Afghanistan](source: map number 3598 Afghanistan, United Nations, 2009)

1.2 History of Politics and Governance

Afghanistan has been undergoing several decades of power struggles. This has resulted in the State controlling only some of the country's areas, while warlords are in charge of the most outskirts (Yakin 2005). The main instability by conflicts started in 1978, by a coup of Afghan communists (Tanner 2002). A year later the Soviet military invaded Afghanistan, whose occupation ended in 1992 by the Mujahedeen fractions (Tanner 2002). The Mujahedeen fractions were unable to reach an agreement, so in 1996 the Taliban stepped in and seized Kabul (Tanner 2002).

The Taliban's power grew till it almost controlled all of Afghanistan and practiced and imposed extreme Islamic laws, which suppressed women without tolerance. In combination with the USA terrorist attack on the eleventh of September 2001,
the US military and allies took over Kabul. This lead to the Taliban's withdrawal of the major areas of Afghanistan (Tanner 2002). The Bonn Agreement set in 2001, was the formal decision of world's leaders to appoint an Afghan President and in 2003 it led as BBC say's to, "an adopted constitution by the Constitutional Loya Jirga", or establishment of the new Afghan Government (BBC News 2008). Currently the Taliban is regaining strength again, resulting in increased regional insecurities.

1.3 Health Status and Health Care System

Compared to other Asian people, life expectancy in Afghanistan is remarkably short. UNFPS say's, "Afghan women's life expectancy is 43.9 year and men's 44 year" (UNFPA 2008). In comparison with it's neighboring country Iran, women and men live to be 72.8 and 69.5 year's old respectively (UNFPA 2008). Despite the ongoing Afghan conflicts and it's loss of men's lives, the Afghan gender ratio stills shows that the male gender prevails by 4% over the female gender (Yakin 2005). The table in figure 2, shows the three main causes of mortality for all ages and under 5 year old children.

<table>
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<tr>
<th>Three main causes of mortality (all ages)</th>
<th>Value, (%) of total mortality all ages</th>
<th>Year</th>
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<tr>
<td>Perinatal conditions</td>
<td>13</td>
<td>2002</td>
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<tr>
<td>Lower Respiratory Infection</td>
<td>12</td>
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<tr>
<td>Diarrheal diseases</td>
<td>9</td>
<td>2002</td>
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<th>Three main causes of mortality (under 5 year old)</th>
<th>Value, (%) of total mortality under 5 year old</th>
<th>Year</th>
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<tbody>
<tr>
<td>Neonatal causes (incl. diarrhea)</td>
<td>26</td>
<td>2000-2003</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>25</td>
<td>2000-2003</td>
</tr>
<tr>
<td>Others (than diarrhea, malaria, measles, injuries)</td>
<td>22</td>
<td>2000-2003</td>
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</tbody>
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<tr>
<th>Three main causes of mortality (neonates) (birth till 28 days of age)</th>
<th>Value, (%) of total mortality neonates</th>
<th>Year</th>
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<tr>
<td>Neonatal tetanus</td>
<td>26</td>
<td>2000</td>
</tr>
<tr>
<td>Severe infection (pneumonia, meningitis, sepsis)</td>
<td>23</td>
<td>2000</td>
</tr>
<tr>
<td>Birth asphyxia</td>
<td>19</td>
<td>2000</td>
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</tbody>
</table>

Source: Mortality country factsheet, WHO EMRO, 2006.b

WHO mentions, a high "under 5 year mortality rate of 257 per 1000 life births" in 2004 (WHO 2006.b). For more than 6.5 million Afghans food intake is too low, resulting in stunted growth of almost 55% of children below the age of 5 year (UNDP 2007).

Due to the nation's lasting instability, huge parts of the infrastructure, including the health care system has been demolished. The Ministry of Public Health (MoPH) is leading the national health system, of which a basic outline given in annex 1. The provision of health is divided into the basic package health service (BPHS) for basic health services and the essential package health service (EPHS) for hospital services (ANDS 2008). The BPHS strategy aims to re-establish the health structure, establish health promotion, to achieve gender equity, prioritize urgent health problems and the distribution in most rural area's (Ameli 2008). The actual implementation of the full basic package and part of essential package is provided through formal agreements by non-governmental organizations.
Major donors like World Bank, European Community and USAID directly fund NGO's delivering the health services, the Afghan government is financially unable is to do so (ANDS 2008.a).

1.4 Socio Economic

The Afghan gross domestic product has risen in recent years to 329 (US$) per capita (in 2005) and 36% exists through agriculture (UNDP 2007). According UNDP, "the Afghan human development index (HDI) is 0.345 and is much lower is than Iran’s HDI of 0.746, the HDI for Afghan women is 0.261 compared to 0.402 for men and the Afghan human poverty index (HPI) 62.3"(UNDP 2007). Worldwide, the Afghan developmental indicators are of the lowest. Educational opportunities for women are limited as only 16% are literate and 31% of men, the primary educational level is attended by only one out of three girls and one out of four girls in the secondary level (Unifem 2008). More often in developing countries, girls are being married while in childhood (under the age of 18 years). Although it is difficult to retrieve precise statistical data on childhood marriage from Afghanistan, it is a well known practice. Even lower ages of marriage are not uncommon and related to lifestyles in urban or rural districts, ethnicity and poverty (Amnesty International 2003).

1.5 Statutory Law system

The Afghan formal statutory law system, including the civil and penal code, is part of the Afghan constitution and prohibits only marriage under 16 years of age for girls. The informal statutory law system, contains fundamental principles of religious, Islamic law (or Sharia), but in rural areas the traditional or customary laws are used in practise (Kakar 2003). The traditional law is as the Islamic law, informal. It is set and applied by the community jirga (local council) and these customary laws govern traditional practices, such as marriage (Kakar 2003). But, Yakin says' based on the "Universal Declarations of Human Rights (UDHR), the ratified Convention on Elimination all forms of Discrimination Against Women (CEDAW)¹ and the Convention Rights of Child (CRC)², the Afghan State is obligated to uphold these international human rights laws (Yakin 2005). In 2003, the Afghan Ministry of Women Affairs (MoWA) and Afghan Independent Human Rights Commission (AIHRC) were established (UNDP 2007). As governmental institute, still today the AIHCR's is to promote, check the formal law application, educate and seek solutions for major provincial law problems (UNDP 2007).

In 2006, the Afghan National Development Strategy (ANDS) was developed. It was a formal plan, agreement by the Afghan government and the international community to increase, ANDS says Afghanistan’s "a) security b) governance, the rule of law and human rights c) economic and social development", as guidance for re-building of the Afghan nation and as fundamental conditions in the goal to achieve the MDG’s, 2020 (ANDS 2008.a).

Chapter 2. Problem Statement

¹ CEDAW ( Human Rights Law, under the UDHR): to eliminate all discrimination against women, including traditional practices which are harmful (CEDAW 1979).

² CRC (Human Rights Law, under the UDHR): to respect, ensure the rights of children (below the age of eighteen, unless by the applicable law attained earlier) without discrimination of any kind (CRC 1989).
2.1 Health problem

Marriage is one of the most fundamental institutions in Afghan peoples lives. The process of decision for a girl, women’s marriage, in particular traditional practices can determine the future for the women, her husband and their family (AREU 2009). Early marriage is common, estimated is that 57% of Afghan girls does marry under the age of 16 year (Unifem 2008). Early marriage can impact the health of young girls, as Unicef mentions by “psychosocial disadvantages and emotional consequences, a relational power imbalance, higher susceptibility to sexual transmittable diseases (STD) and the human immune deficiency virus, acquired immune deficiency syndrome (HIV/Aids), risks of Vesico Vaginal Fistula (VVF), denial of education and reproductive health rights” (Unicef 2001). In Afghanistan, the most prominent cause of mortality among girls age 15 to 19 year is pregnancy and related illnesses. Moreover, the risk to maternal mortality is five times higher for girls under 15 year as compared with women in their twenties (Unicef 2001). Traditional practices contribute to the number of young age marriage by Afghan girls. The traditional practices of the bride price and baad, can lead to forced marriage and are embedded in the traditional Afghan law. Prevailing preference for boy's, accusation of zina and polygamy, are based on lesser societal importance of women and show gender inequality and inequity (Cottingham 2009).

Afghanistan has been prominent in the media, particularly from 1996 onward. The Taliban's reputation of Islamic patriarchal ideologies, extremism and gender crimes are most commonly portrayed. After the fall of the Taliban, the Afghan government has come to the difficult task to try to stabilize, secure and rebuild the country. The 2006 ANDS gives structure by an agreement to re-establish security, governance and the economic, social development. However the formal statutory law system in the country is unfortunately interfered by the informal traditional law (UNDP 2007). Derived traditional practices do determine women's daily live, as they are ingrained into the social system and so influence their health. Meanwhile, Afgan women's life expectancy is of the lowest globally and marked with a high maternal mortality and under 5 year old mortality. Besides, indicators show poor outcomes in gender specific areas, Afghan’s have a low position in the global HDI index and a low literacy rate, marked by inequity for women.

The Afghanistan’s MDG’s were agreed upon in 2004, after the withdrawal of the Taliban and cover specific targets regarding gender equality and maternal health care. The maternal deaths are to be reduced with 75%, gender inequalities in educational and financial systems to disappear, access to and fair application of the statutory law system for both the genders (ANDS 2008.b). Due to political and infrastructural set backs, it was agreed upon with the government to postpone the achievement of the MDG, “Afganised” targets to 2020 (UNDP 2005). Despite immense international aid and contracting NGO’s for essential support in the health system by the MoPH, meeting the health needs of the Afghan population remains far from sufficient. Currently the BPHS, especially in rural areas is often absent and if available not uncommonly inaccessible for women. Access to the Afghan health system entails curative, preventive care and health education, emergency care, female medical staff, an appropriate health infrastructure for the most vulnerable population of women has urgency. In
particular the improvement of quality and the making of long term efforts, are most imperative (Reilley 2004).

2.2 Problem definition

The Afghan maternal mortality is high, while compared to other countries. Young Afghan women have an clear increased risk to maternal mortality. Early marriage and subsequent early pregnancy can lead to harmful effects on women's physical, mental and social health. The traditions of the bride price and baad, are based on the traditional law and provide the rational for marriage at a young age and, or forced marriage. Not unknown are gender differences as part of the Afghan social system and some traditional practices are in contradiction with the Afghan statutory law, but at most with the UDHR. It is clear that the traditional law and practices can negatively influence women's health, however about the potential impact and its magnitude is less known. Therefore, I like to examine this, reflect on, and describe the required health care systems response.

General objective

To understand the influence of traditional practices in marriage on the health of women in Afghanistan.

Specific Objectives

1) To describe the traditional practices in Afghan marriage and to explain how these practices influence the health of Afghan women, physically, mentally and socially.
2) To explain how traditional practices in marriage makes women vulnerable to violence and how it becomes an added factor in women's ill health.
3) To identify and to describe the health needs of the Afghan women in relation with traditional practices in marriage.
4) To map in line the current health system response, to understand progress, gaps and limitations with this system and give recommendations accordingly.

2.3 Methodology

Research and methodology

The study is to explore Afghan women’s health from a human and gender rights perspective, seeking possible root causes that influence health, rather than to identify direct and more obvious determinants. By the literature study I identified determinants to Afghan women's health, which are rooted in marital traditional Afghan practices. It entailed a broad, but also concentrated holistic view of women’s health status taking aspects as their social position, mental health and gender based violence in account. This will be compared and set off against women’s health needs versus the health systems response and the Government's obligations in the Right to Health, as part of the UDHR.

The Afghan traditions and law system were identified and read in specific reports by international law institutes; studying Afghan’s system and written in line with the Bonn agreement and for re-establishment of the country’s constitution. Many Afghan traditions could be translated to English from these writings. Going
onward, health indicators were mainly retrieved from global, annual reports of WHO and the UN and limited quantitative data. Additionally, some statistical information was gained from Afghan governmental sources. Some country study research and surveys attempted to reflect on the relation of direct, indirect determinants and Afghan women’s health.

To explore the health problem deeper, I have used qualitative research material, which gives a broader understanding of traditions, underlying factors and the overall impact on health from a holistic view. This was provided by UN institutes, NGO’s and Human Rights organizations via Google search. It provided some firm statements by women on their at times deprived living and health situation, as resemblance of gender based violence undermining health. The use of a human rights framework; the Right to Health with availability, accessibility, acceptability and quality, provide criteria for a health care system development, for an correct response leading to gender equality and equity.

This is mainly a explorative and descriptive writing, studying traditional practices in relation to women’s health. This study will identify means for enhancing the health systems response, using standards of the Right to Health and leading to primary recommendations.

**Limitations**

The country’s ongoing conflict, the remoteness of some districts and partly collapsed health surveillance system makes it difficult for MOPH to maintain a well informed Health Management Information System. The Central Statistics Office had deficiencies in providing quality statistics, with data being inaccessible. Therefore, reliable quantitative data on gender specific health indicators was searched for but hard to retrieve, and mostly globally orientated.

Research on the impact of health determinants in relation to health indicators is very limited. However some articles were available on Afghanistan's maternal mortality, under 5 year morbidity and mental health. Since this thesis' focus is on women's health, I have chosen only to include the impact of a mother's health on her child, when it applies to, or is related to traditional practices.

Certain topics in traditional marriage practices, are surrounded by a clear defined cultural and religious context sensitivity. Quantitative statistics on their actual impact is showed therefore to be extreme limited. To express the magnitude of the problems in health, I could only depend on scarce, but at times very explicit qualitative information as by interviews and statements.

As I was unable to conduct research in Afghanistan and have not been to the country, I assumed to understand the particular situation regarding women’s health in relation to traditional practices. By this literature research, I was actually able to provide a "snapshot" of the studied health issue, collected by a wide diversity of fragmented information.

**Search strategy**
Databases such as PubMed, ScienceDirect, Cochrane have been accessed and searched for scientific articles. Through internet, I directly accessed the MoPH, AIHCR and ANDS website for some of the countries statistical information. The KIT and VU library provided some relevant journals. Via internet, I also entered several UN official reports by special UN researchers for OHCHR, UNFPA, Unicef, Unifem and made applicable human rights laws available for insight and understanding. By signing in at the Women’s United Nations Reporting Network, I received a lot of documentation on gender equity and mainstreaming, Afghan traditional law, women’s specific health rights and health system frameworks, by Human Rights Watch, Amnesty International and UN agencies. Again by the use of search terms, websites for organizational documents, guidelines and policies, work of NGO’s as AREU and human rights organizations were accessed.

Search terms:

Early, forced marriage, maternal mortality, sexual reproductive health, gender based violence, mental health, gender inequity or inequality, right to health and Afghan women, traditional practices or law, health care system.
3.1 Traditional Practices in Afghan marriage

Traditional practices are essential in Afghan's live. It determines the way, Afghan people live and shape tribal identity, the social relations. As in most societies, marriage plays a central role in shaping an Afghan's life. Therefore it is important to explore if, but also how this social determinant is related to Afghan women’s health.

Culture of honour and traditions by law

Since 1747, Afghanistan is an independent nation. It's history and heritage is rooted in the traditional law or Pashtu, tribal code (Yakin 2005). I refer to this Pashtunwali law (of the Pashtu tribe), as the majority of Afghans adhere to this outspoken traditional law and since there are only a few differences between the four main ethnical laws.

This traditional law is inherited through individual tribal clans and is experienced as one with the Islamic law of Sharia (Kakar 2003). Secondly, the day to day adherence to the traditional law is equal to the actual Pashtu character (Kakar 2003). On cultures as the Afghan, Moss wrote, " it is an evaluative conversation constructed by people out of raw materials afforded by tradition and ongoing experience, continuously modified by them in the processes of social interaction, behavior is guided by anticipation of such cultural evaluation” (Moss 2002). The Pashtu traditional law is built on the honour principle, with four basic traditions, Kakar mentions “chivalry (bravery), melmastia (hospitality), purdah (gender boundaries), and the jirga (local counsil)” (Kakar 2003). A person will be rejected from the community and social benefits when honour is lost, meanwhile many Islamic scholars do object on the application of some Afghan traditional practices and mention incorrect interpretations of the Islamic law (Yakin 2005).

The Afghan traditions and women's role

Socially, Afghans gather in rooms with only the same gender (purdah). Women have limited public space and enter public life only with a mahram (male relative for her guidance), while wearing the Islamic veil (boghra) (Kakar 2003). Respect is shown to authority in this patriarchal system, with men in charge and their power is translated into traditional practices, which enables control of families possession and status (Kakar 2003). Among tribal members, valuable items as goods, harvest, houses, land and women is talked about in ways of honour, with men representing the community and women are suggested for exchange among families, by the marital arrangements and money paid for the bride (Moghadan 2002). It states the marriage importance, but also of male's honour having to be maintained. While women bringing shame, can ruin a family's honour and status in the community. Many families do give disapproval of the extent women are affected by traditions, but to ensure the families security and safety adherence is given and women feel protected by wearing a Islamic veil (UNAMA 2009). It is said that no community exists without a culture and always connected is to collective spiritual believes transferred by social interactions, the interactions may be based on power and religion can be used in its application (Winter 2006).

3.1.1 Young age and forced marriage
By the Islamic law, a girl can be married as soon she comes into puberty and by tradition or practically puberty is determined by gender's bodily development. In Afghan's remote areas, the real marriage age for girls can be 6 or 8 year and boys are also married at an immature age (Max Planck Institute 2005). In figure 3, the global trend is shown of early (thus at young age, under 18 year of age) marriage and despite that it should be the individual's own choice, often forced marriage. Globally, 64 million girls marry below 18 years of age, of which 50% in South Asia live (Unicef 2009.b). Although Afghanistan is not shown on the map, it is a very common tradition and marriage under the age of 16 accounts for 57% of Afghan women (Unifem 2008).

Figure 3.: Global and regional trends in child marriage (below 18 years of age)

The Afghan statutory law sets a minimum marriage age of 16 for girls, and 18 for boys (Amnesty International 2003). Systems of birth and marriage registration are mostly non-existent, and if it exists registration is not taking place, therefore the precise marriage age is likely not to be known (Amnesty International 2003). I will speak of girl when under the age of 18 year, mention the actual age where significant and women when aged above 18 years.

Marriage for most women and men is arranged by their parents or family, but the person will still choose to marry or not. Nevertheless in reality the difference between choice and being forced into is blurry. Often, marriage suits the families best interest (Advocates Human Rights 2007.a). According Advocates Human Rights, “marriage is forced when one or both to be married individuals cannot give free or valid consent to the marriage, it involves degrees of force, coercion or deception, ranging from emotional pressure to imprisonment and abduction” (Advocate Human Rights 2007.a). Up to 80% of Afghan marriages occur without a person's own clear approval (Unifem 2008). Rivalry, restoring honour, and clearing financial loans are common reasons for couples to be married or it is just of families preference (Unifem 2008).
3.1.2 The bride price

Until the actual marriage, man and women do not meet another. First, both family members gather to discuss a possible marriage arrangement and the tradition of the bride price (walwar). By agreeing on the amount of money depending on families income, position and higher in case of multiple marriages or virginity, money is given by the grooms relatives to the brides family (Kakar 2003). It is meant for the parents upbringing of the women and is suggested of increased importance in remote regions due to poverty and lower educational (Max Planck Institute 2005). Research shows that in rural areas, 85% of girls is being married under 18 years of age and 43% of girls in urban areas for reasons as the bride price (Max Planck Institute 2005).

3.1.3 Restorative justice of baad

In case of crimes, the norm in Afghan traditional law is, the International Legal Foundation says, "based on restorative justice rather than of retributive justice relied on in the Western, international law" which does lead to punishment (International Legal Foundation 2004). In the traditional Afghan law the solution for creating justice is to repair honour by the accused towards the victimized person and, or his family. The accused is requested through the local jirga to give money in order to show regret, the victim to forget hostility and receive forgiveness (International Legal foundation 2004). Depending on the intensity of the harmful act and as part of the traditional law, the tradition of baad takes place, which is the giving of a girl to be married to the victimized family and by the accused person (Kakar 2003). In case of an intentional killing, two girls are given which clears the violation, the extent of the explicit traditions application is unclear, but foremost applied in rural areas (International Legal Foundation 2004).

3.1.4 Polygamy and boy preference

These two concepts are often inter tangled with above mentioned Afghan marital traditions. Muslim men can marry up to four women. Polygamy is often described as a tradition, it is also legally allowed by the statutory law and derives from the Sharia law (Advocate Human Rights 2007.a). A precondition for polygamy is the ability to support and to treat all the women equally (Max Planck Institute 2005). Various reasons are given for polygamy, such as a wife’s infertility or illness, no baby boy yet born, social prestige, restorative justice and status by warlords, or commanders (Max Planck Institute 2005). By tradition, the male gives the continuation of a family name, the honour and is able to safe guards the family heritage, which is a means of social security within families life. The Quran say’s, mal behaviour towards either gender or the preference of boys to be rejected, despite in many world regions boys are favoured, which can lead to neglect of the opposite gender (Jamal 2002).
3.2 Afghan marriage traditions and women's health

In this section is described how the traditional practices; early and forced marriage and as much as possible underlying rational, the bride price or baad, effect Afghan women's health. According WHO, health is "the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”, as a basic right by the UDHR\(^3\) (Asher 2004).

The Afghan culture is based on the honour principle and marriage is a means for maintaining families status. When a girl menstruates she is expected to be fully mature and ready for marriage, despite her actual age and her own, individual developmental needs (Max Planck Institute 2005). By marriage parents eliminate the fear of her having pre-marital relations or sexual intercourse. Sexual activity is expected and imposed soon after the marriage ritual, without taking into account if she is actually physically, psychologically, socially mature (Max Planck Institute 2005).

3.2.1 Marriage and pregnancy at young age

Globally, 10% of all pregnancies per year are attributable to girls between the age of 15 and 19 years old, it is estimated that 14 million girls between this age become pregnant, and 90% are from less developed regions of the world (Mahaini 2008). By tradition, soon after the Afghan women is married, she is expected to get pregnant and have a child (Unicef 2001). Marrying at a young age is thus likely to lead to early pregnancy. In literature it is also referred to as, pregnancy at a young age or under 19 years of age. The Afghan total fertility rate\(^4\) (TFR) is 7.03 and just as the population growth rate high with 3.9% a year, while compared with 1.4 in neighboring Iran (UNFPA 2008).

Figure 4.: Health consequences of adolescence pregnancy (15 to 19 years of age)

![Diagram showing health consequences of adolescence pregnancy](image)


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\(^3\) UDHR mentions, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (OHCHR 2008).

\(^4\) Total Fertility Rate: average number of children per women (UN Millennium Project 2005).
Figure 4 shows how early and likely forced marriage leading to an adolescence pregnancy, comes with an increased risk of maternal morbidity and mortality, as well of the infant. Maternal health is mothers health while pregnant, in labour and in the 42 days after child’s birth. Maternal mortality\(^5\) is Unicef says, "directly caused by obstructed, prolonged labour, eclampsia, uterine rupture, postpartum haemorrhage, puerperal sepsis and unsafe abortion", and Unicef says, "indirectly by anaemia, malnutrition, HIV/AIDS", but also by societal, financial factors as poverty, poor education, gender and cultural customs (Unicef 2001). Evidence shows that globally, the chance of dying while pregnant or in labour, for girls in adolescence age doubled is and for girls of even 14 years of age or younger, even five times higher is due to increased risk of complications, when compared to pregnant women 20 to 24 year of age (Unicef 2001).

**Obstructed childbirth**

A girl under 19 year's old body may not be sufficiently developed for pregnancy and childbirth (labour or delivery) (UNFPA 2007). Her pelvis may be too small to allow safe passage for her child’s head during delivery, resulting in prolonged obstructed labour. In this case, the child's birth may not progress, while ongoing contractions can cause uterus rupture, girls exhaustion by the long duration and excessive blood loss can even lead to death of the mother and child (Unicef 2001). Of all Afghan’s, 60% is said to be stunted, caused by a poor food diet and an inadequate intake, which does lead to an added factor of obstructed labour while pregnant at a young age, as it too withholding the physical development of the pelvis (MoPH 2003).

**Anaemia and eclampsia**

The risk of eclampsia and anaemia among early pregnancies, occurring in girls under the age of 19 years old, is higher than pregnancies for women above this age (Mahaini 2008). Anaemia in a pregnancy is according WHO "a haemoglobin lower than 11g per dl" (WHO 2007.a). Evidence has shown, that anaemia in girls under 18 years of age, is a lot higher due to the lower ability to retain iron reserves in the body, which has an accelerated effect during pregnancy (Lannotti 2005). A poor food intake for Afghan women does lead to a low iron intake and anaemia is with 70%, shown to be prevalent among Afghan, regardless of being pregnant (UNAMA 2005). However, when a young girl does start her pregnancy with anaemia and has very low iron reserves, the extreme blood loss during child’s birth and up to 6 weeks post partum can sooner lead to a huge, even fatal drop in her total blood volume (Unifem 2008). The biological trigger to eclampsia (marked by high blood pressure, leading to a women's life endangered condition) is researched but still not exactly know, the relation and increased risk in young age pregnancy is however shown by evidence (Assis 2008).

**Risk of vesico vaginal fistula**

As childbirth at a young age can be dangerously prolonged, the head of the to be born child gives ongoing pressure, which can cause permanent damage and

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\(^5\) Maternal Mortality: the death of a women while pregnant or within 42 days of termination or pregnancy (UN Millennium Project 2005).
breaks of the tissue in the birth canal, for the women (UNFPA 2007). In case of damaged and dead tissue's, urgent surgery is required for it's removal as else inflammations lead to a cavity and remaining fistula or VVF. Unrepaired it can lead to connected and extensive urethral and rectal infections, disable the normal urine and reproductive tract functioning, which may involve unavoidable urine leakage (UNFPA 2007). Often women face shame and carry a stigma due to the disabilities, it even entails the risk of being isolated and out casted by family, or surrounding social contacts (Unicef 2001).

**Young age of mother and child survival**

The relation of mothers age and her (unborn) child's health, which health can be impacted should not be under estimated. Globally, the risk to death of children between 28 days to 1 year old is mentioned to be 60% increased, in case mom's age lesser is than 19 year as compared to women aged above (Unicef 2001). A young age pregnancy is less likely to be full term, leads to child's early birth and the neonates (birth up to 28 days) weight is more often too low (less than 2,5 kg at birth) (Unicef 2001). Besides, child's birth not progressing due to obstruction of the head, can lead to child's critical shortage of oxygen, and complicate the child's survival (Mahaini 2008). The immature age of a mother, may reveal in the lack of skills and not knowing how to care for a new born, specially when a child is low in weight and increased vulnerable for diseases, mothers caring tasks and her actions may be crucial for the child (Unicef 2001).

3.2.2 **Sexually transmittable diseases**

Early marriage imposes the girl to sexual activity and does lead to a higher risk of STD's and HIV/Aids, trough the possible infected partners sexual contact, as young girls irregular hormone levels lead to a higher sensitivity of the vaginal cells and does increase the ability for infections or a virus to enter (Unicef 2001). It is said that increased stress in an imbalanced marital relation sooner resolves to psycho social discomfort, even depression which lowers the general immunity fighting off these infections (Campbell 2002). The other reason mentioned for an increased risk is force by intercourse, which does lead to tears in the cell tissue and allows the infectious disease transmission in the reproductive and urological tract, but also into the bloodstream (Campbell 2002).

3.2.3 **Gender role and education**

Individual's gender is physical, but also socially defined by existing groups of religion, law and economics, which does create roles and responsibilities, leads to options and rights for male, female (WHO EMRO 2009.b). Marriage at a young age, or by force generally leads to a role in the household, agriculture and the obligation in motherhood, it disables the girl to mature uncomplicated and her decisions depend on her husband (Unicef 2001). Automatically, women's access to education is denied, which a tool is for improved health and enables personal growth, it extends women's capacity in public life (Unicef 2001). Afghan women's literacy rate of 16% is of the lowest globally, in contrast with the literacy rate for Iran's total populations of 75% (Unifem 2008). The Quran mentions that both genders have a right to education, even stronger both have the duty to seek theoretical understanding which leads to increased awareness (Jamal 2002). In Afghanistan (2005), there is no school system is present in 29% of the districts
and just 19% of schools were for female (Unifem 2008). A survey, questioning Afghan children from 5 to 18 year about absence of school attendance, showed that nearly halve of these children in day to day labour involved is (AIHRC 2007).

3.3 Marriage traditions and vulnerability to violence

By marriage, women are allowed into their new families space, with respect and adherence to the families expectations, gender role and in return receiving the families support and trust, which can eventually lead to a wider social life (Kakar 2003). For families living in poverty, having many children can be an economic strain, the bride price can trigger to make a daughter available even under 10 years of age, with marriage ahead when she comes to puberty (Yakin 2005). The costs for the bride start from 2000 US dollar and may be even thirty times higher (Max Planck Institute 2005). With a high bride price being paid, problems and even violence at home may start when the married girl or women does not behave as expected and the risk of not being valued or accepted as an in law increases if baad is the initial reason for marriage (Yakin 2005). Afghan women, interviewed confirm that the marriage type leads to predictable issues; as a poor bridal price permitting mistreatment of the bride or in case of polygamy, which leads into conflicts between the different wives, and by which it is said to be the husbands role to end disputes, possibly using force (Hyder 2007). The ecological model (in figure 5) is a concept, showing how people do relate to another.

Figure 5.: Ecological Model, "Violence against women"

Source: Primary prevention intimate partner and sexual violence (adapted from Heise, 1998), WHO 2002.

Subjected to own specific circumstances, individuals do influence others trough diverse interconnected layers of social constructions and need all to be taken in account when trying to achieve societies structural change (WHO 2002). Within, the wider community can uphold traditional practices and, or give protection as part of a society which triggers or lowers violence with authority (WHO 2002).

3.3.1 Gender based violence

By the traditional inferior gender role, women can get in a cycle of harm of one or even several types of violence (WHO 2002). The types of direct gender based violence are 1) bodily directed by aggressive behavior (as stomp) and may lead into deliberate accidents and harm 2) mentally directed as by coercion, depriving or restrictions 3) sexually directed as by non consensual intercourse, using power and threats (Krantz 2005). The UDHR, prohibits gender based violence (GBV) as described by CEDAW® (CEDAW 1979). In 2006, AIHCR registered 1.651 Afghan

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6 CEDAW defines gender based violence as; "violence that is directed against women because she is a women, or violence that effects women disproportionally, it includes acts that inflict physical, mental or sexual harm or suffering or threats of such acts, coercion and other deprivations of liberty, whether occurring in public or private life, including traditional practices harmful to women" (CEDAW 1979).

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women reporting their harm of which 30.7% said it was physical, 30.1% mental, 25.2% sexual harm and 14% mentioned all three violations, the Ministry of Women Affairs (MoWA) noted the same year, nation wide 2.133 cases of violence (Unifem 2008). Figure 6 shows who initiated the violence as reported by women after being subjected to gender based violence of data collected by Unifem from beginning 2003 till August 2005 (Unifem 2006).

Figure 6.: Percentage of violence by perpetrator


Of these women, 65% was married, 40% was aged between 16 to 35 year and 82% of the violence was committed by a relative or the husband (Unifem 2006). Besides direct violence, indirectly it occurs via institutionalized societal systems, which according UNDP includes, "the value’s, customs and laws that actively discriminate against women", it may lead to societies higher tolerance of violence (UNDP 2009).

3.3.2 Zina accusations

When women escape a violent position at the family’s house, the community will speak of it as she "ran away from home". Women seeking support outside their house is automatically translated to the conduct of "zina", which is a relation outside marriage and sexual intercourse with own consent (Advocates Human Rights 2007.b). The Afghan statutory law does mention zina as punishable by jail sentence (Yakin 2005) and in the prison of Herat (2003), nearly all women (66) were taken and held for this reason (Amnesty International 2003). Most women interviewed said to be subjected to marriage at young age due to financial family problems, underwent violence and therefore left the house, as in Jalalabad where women reported to be physically abused by police first and then charged for zina (Amnesty International 2003). The juristic system is thus not accessed and does fail to defend women's rights, which also predicts the under reporting of gender based violence (UNAMA 2009).

3.3.3 Self immolation and suicide

By running from their home, women obviously do not feel safe and are unable to release stress. An inability to cope can lead to ones self directed harm, trough self immolation or even suicide (Wahed 2007). WHO says that 90% of all suicidal deaths is associated with mental, psychological wellbeing (WHO 2002) and yearly does lead to the death of 80.000 people, of which 85% in low income countries live (Prince 2007). India has similar traditional marriage practices and in 2001,
163,000 women were found death by fire related incidents, it were mentioned to be acts of self harm initiated due to extreme marital distress (Sanghavi 2009). In Herat, AIHRC recorded during half a year (up to April 2004), 380 women after harming themselves by swallowing sharp objects, using acid or fire, which did lead to major injuries and death (Amnesty International 2005). Of the women, 80% mentioned family abuse as their reason, it was unclear if some acts were initiated by the victim's or by a relative as some injuries seemed to be connected to honour crimes (Amnesty International 2005).

3.3.4 Honour Killing

The custom of Honour killing, based on restoring of family status is exceptional and sets Afghanistan regularly in the media. Sexual intercourse by women and men outside their marriage can occasionally be dealt with in an extreme way, as both besides the zina accusations, may be killed (International Legal Foundation 2004). Per year, about 5000 women die through this deed by family members to restore the honour (WHO 2002). In Lahore Pakistan, 266 cases were confirmed in one year, 81% was executed by a direct family member of which none was legally being charged (Mahbub 2000). The crime occurs on traditional grounds and does not go unnoticed in the community, therefore said to be part of larger complex societal constructions (Meetoo 2007). Amnesty International mentioned, "Amina, 29 year old from Badakshan province, who was sentenced and stoned to death after adultery" as decided by the jirga without any formal process of law (Amnesty International 2005).

3.4 Harmful traditions and women's health needs
Above study results give the impact of traditions in marriage as determinants of Afghan women's health and can be divided into, a) risk of young age pregnancy leading to health consequences (in maternity and sexual reproduction) b) the risk of traditions, the bride price and baad to lead into violence for women. CEDAW mentions these, "harmful traditional practices in marriage to be based on gender discrimination" (CEDAW 1979). In this summarized overview, Afghan women's health needs derived by the impact on health by marital traditions are presented.

3.4.1 Life cycle approach

All actions influencing women's health, lead to a positive or negative gradually build up impact in gender specific stages throughout life, of women and perhaps even her child's health (Cleason 2000). By the life cycle approach, health care interventions and strategies are targeted within these specific stages of women's life and are thus increasingly effective, to reduce risks in health (Claeson 2000). Childbirth is expected soon after marriage, as it shows fertility and automatically makes Afghan women's life with specific stages, to be centralized around sexual reproductive health (UN Millenium Project 2005). Sexual reproductive health is male's and female's own safe desicion taking in sexuality and reproduction, at a time of own choice and enables the ending of women's pregnancy if wanted, or can lead to a full term desired childbirth, which is aimed to be without morbidity or mortality related to sexual reproduction and enables the caring, upbringing of the new born child in good health (Hardon 2001).

Figure 7.: Conceptual map of sexual and reproductive health.


7 CEDAW states gender discrimination as, “distinction, exclusion or restriction made on the base of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, on a basis of equality of men and women, of human rights and fundamental freedoms in political, economic, social, cultural, civil or any other field” (CEDAW 1979).
Figure 7, shows the crucial role of sexual reproductive health in the life cycle approach and contains the following topics, 1) sexual reproduction 2) maternity 3) psycho social wellbeing, it reveals the diversity of women's health needs by traditions in the marriage. Sexual reproductive health topic's as of an undesired pregnancy, termination of pregnancy, STD's and HIV/Aids can systematically infiltrate into Afghan women's live in case of neglect, denial and abuse based on her gender (Rizvi 2008). The Right to Health, a basic right by the UDHR includes women's right regarding sexual reproduction8 (OCHCR 2008).

3.4.2 Sexual Reproductive Health needs

By traditional practices in marriage, women's own needs regarding sexuality and reproduction are likely undermined, as childbirth and an inferior gender role are pre-determined, especially in the case of early, and forced marriage. In addition, certain Afghan cultural value's and of Islam do lead to extra pressure for women, in relation to the sexual reproduction as Douki mention's the value of "women's virginity, boy preference and polygamy" (Douki 2007). The high TFR existing in Afghanistan, is partly described by the huge number of early, forced marriages, and soon expected pregnancy, influencing the countries total amount of maternal mortality (Maine 1997).

Pregnancy at a very young age, shows increased risks of maternal complications, postponing pregnancy by family planning methods can reduce these risks. Sexual reproduction is a part of MDG 5 since 2005, aiming at the full populations access by 2015 and ANDS says it includes "the contraception prevalence, adolescence childbirth rate, antenatal care (ANC), family planning, unsafe abortion, STD's and HIV/Aids, infertility" (ANDS 2008.b).

By the bride price or baad, Afghan women are increased vulnerable to gender based violence and sexual violence do lead to an increased risk for STD's and HIV/Aids. Medical screening and counselling is required in the case of violence, however this need may only arise once the infectious disease symptoms become present, as in case of infertility (Amnesty International 2010).

WHO EMRO mentions, "the Afghan maternal mortality ratio9 (MMR) of 1900 per a 100,000 live births a year", which is thirteen times higher compared to the MMR in neighbouring Iran (WHO EMRO 2006.b). The UN Millennium Project mentions, "a life time risk of maternal death10 of 1 in 6", with increased maternal health risks for 57% of the Afghan girls, when married under 16 year (UN Millennium project 2005). It therefore needs consideration in the nations maternal health strategies.

8 Right to Health on sexual reproductive health, “States should enable women to have control over and decide freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, free from coercion, lack of information, discrimination and violence (OHCHR 2008).

9 Maternal Mortality Ratio: the number of deaths by women in maternity per a 100,000 live births (both, at a same, specific given time) (UN Millennium Project 2005).

10 Life Time Risk Maternal Death: the likelihood that a women will die of maternal causes (UN Millenium Project 2005).
Evidence based approaches lowering the MMR, are to lessen pregnancies, lower risks of major complications while pregnant, in labour and minimizing mortality when there is a complication (Maine 1997). The MDG 5, 2020 does include WHO EMRO say's, "the Afghan MMR reduction with 75% and skilled birth attendance (SBA) in child labour of 90% by 2015" (WHO EMRO 2005). So far, lowering the MMR in Afghanistan seems difficult and from 1990 till 2005 there was even an increase of 6% in the mortality (Mahaini 2008).

In case of complicated childbirth, women's need are for professional support by a SBA or emergency obstetric care (EOC), which does require the availability and accessibility of these health care services during maternity. In line with the safe motherhood program (UNFPA), the UN Millennium Project confirms as effective health interventions, "1) SBA during delivery 2) access to EOC 3) referral system 4) access to family planning", in line with UNFPA's safe motherhood program (UN Millennium Project 2005).

According the Quran, marriage partners help, provide safety and comfort to one another, both male and female can choose their own partner and end marriage when this is thought over well (Zaidi 2009). In reality, Afghan women live up to standards of a patriarchal system. Own choices, opportunities are often denied and families high expectations may lead to women's mental harm (Wahed 2007). Mental health\textsuperscript{11}, is included in the WHO general health definition, it is influenced by physical, social wellbeing and while challenged by poor economic, educational status, it may require protection by application of specific human rights law (WHO 2007.b).

Mental health is not included in the MDG's, but goal 3 aims ANDS says, "gender equality and empowerment of women", which includes the legal law enforcement (ANDS 2008.b). Psychosocial wellbeing, influenced by health itself and specific external stressors, triggers individuals coping mechanism and societal protection mechanism in order to prevent mental disorders (IFRC 2008). When coping and protection mechanism fail, disorders as depression may appear with symptoms as sleeplessness, anxiety, apathy and loss of self care and lasting deteriorating feelings may lead to intentional self directed harm (IFRC 2008).

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\textsuperscript{11} WHO definition of mental health "it is not just the absence of mental disorder, it is defined as a state of well being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO 2007.b).
3.5 Health needs and health care system response

The life cycle for Afghan women does lead to health needs of sexual reproductive health. In annex 2.1, a brief overview is given of the sexual reproductive health services as planned by the MoPH (MoPH 2005). In this section, an elaboration of the current Afghan health care system response is given. Of all BPHS settings, just 17% indeed provides the full recommended health service package (WHO EMRO 2005). The three major donors, decided 4,5 US dollar per individual, a year for the service provision at the BPHS to be sufficient, but it is shown not to allow the implementation of all planned health care services (Sabri 2007). Only sporadically the MoPH gathered evidence based information on the health impact by provided health service, which makes it difficult to follow up existing health programs (Sabri 2007).

3.5.1 Sexual reproduction

The health care system, responding to population’s health needs depends on the provision, or supply of health services (controlled by the MoPH) and on utilization by the population, leading to a health service demand.

3.5.1.1 Family Planning:

Family planning and methods of birth control are meant to lead to prevention of women’s pregnancy. By the use of contraceptives and depending on individual needs, girls married at a young age are able to postpone pregnancy to a mature, later age. In a study 80% of Afghan women said, having to be sexually involved with their partner even when she does not desire and only 12% mentioned to use contraceptives (Amowitz 2002). Of all undesired pregnancies among girls under 19 year of age in Asia, nearly 95% did not use birth control and it is by evidence mentioned as the main reason for medical planned termination of the pregnancy (Guttmacher 2010).

The strategies for family planning by the MoPH are; the advice on childspacing, dispensing of contraceptive tablets, injectables and condom use and offering fertility interrupting operations at EPHS (MoPH 2005). ANDS mentions an "Afghan contraceptive prevalence rate of 15% in 2006" (ANDS 2008.a). Although planned by the BPHS, family planning methods are not often available here. Insufficient contraceptive stocks and a lack of educational material are two important barriers in providing adequate family planning services (ANDS 2008.a). Another critical obstacle is that many Islamic leaders do not encourage, or even sanctions the use of contraceptive methods, yet the Quran does not prohibit family planning methods (Management Science Health 2007).

The Afghan MoPH trained 6300 community health workers in 2004, to provide birth control methods, immunization and mosquito nets, under the approval of religious leaders and worked in surrounding villages from their own home (ANDS 2008.a). Community health workers are not trained medical professionals, but have received schooling in this case on family planning. A survey was conducted to show the result of their work within three provinces. During the two years, community health workers increased the distribution of birth control by tablets and injections by 17% (Management Science Health 2007).
3.5.1.2 Health promotion

Health promotion, provides means to manage factors influencing health best and aims to achieve a better health status and according the Ottawa Charter, health promotion "leads to a supportive environment, personal skill development, health policies formulated, it strengthens community action and leads to re-orientation of health services" (Nutbeam 1998). Information, education and communication (IEC) as part of health promotion, enables the community members collective involvement in looking after health issues, in order to try and maintain health by awareness raising methods, as of workshops and meetings (Nutbeam 1998).

IEC activities, included as an integrated health promotion component of the Afghan family planning services does not specifically target adolescent girls and boys, this vulnerable population requires accurate health information to make family planning decisions. Results from a birth control study, underscore the importance of such activities reaching Afghan women. Of the Afghan women surveyed, 20% reported wrong idea's about contraceptive methods, perceptions varied, ranging from tablets giving psychosocial problems, affecting long term ability to conceive, injections causing problems in periodic bleeding (Management Science Health 2007). These misperceptions together with a lack of awareness of own sexual reproductive rights, make it difficult for women to discuss the sexual reproductive needs at family planning services.

By the Islam, women have the right to enjoy their sexuality and do have the choice in their own reproduction, the Iran government used this in their public approach on birth control and under clear support of the religious leaders (Roudi 2002). Now, Iran's women have average two children and nearly 75% of women do indeed use birth control methods (Roudi 2002). In Afghanistan there is no nation wide program, as the Iran's successful health promotion program on birth control (see annex 3) which is supported by religious Quran writings and actively distributed health messages trough national campaigns, all the contraceptive methods are without costs available (Roudi 2002).

3.5.1.3 STD's and HIV/Aids

Marriage leads to expected and unprotected sexual contact. An imbalance within the sexual relation, by force or even rape leads to a higher risk of STD's and HIV/Aids for especially girls, which married young (Unicef 2001). The presence of syphilis, chlamydia and gonorrhoea can lead to women's infertility. The STD's can be transmitted by mother to the unborn child. WHO mentions a "STD prevalence of 6 to 40% by chlamydia, syphilis and gonorrhoea" in less developed countries (WHO 2007.a). Afghan nation statistics of STD prevalence's is absent and the people with HIV/Aids is said to be under 1000, which is low compared to nearly 100.000 infected in Pakistan (WHO EMRO 2009.a). AIHRC reported cases of violence, and one fourth of the women did experience sexual violence, medical counseling in this case can exclude a STD's, HIV/Aids infection (Unifem 2006).

In Afghanistan, case management of STD's is inherent to regular consultations at the BPHS and for HIV/Aids or Voluntary Counselling Testing (VCT) services there is no national strategy available, but HIV quick test are mentioned to be present at most hospitals (MoPH 2005). Hospitals in Kabul, mentioned the use of globally standardized protocols for their treatment of STD's and HIV/Aids (Todd 2008).
Provision of condoms is said to take place at the BPHS (MoPH 2005).

Women's limited opportunities for education, seem to lead to an unawareness of specific sexual reproductive health concerns as STD, HIV/Aids and prevention methods (Unicef 2001). This low awareness shows by a study in a Kabul hospital, as only half of pregnant women did ever hear of HIV/Aids and only 5% gained the awareness by a medical professional (Todd 2009). Of all the medical staff in the hospital, Todd said "66% knew of HIV and only 5% knew about syphilis, only 20% knew that condoms do prevent STD and HIV/Aids" (Todd 2009).

3.5.1.4 Responding to violence

In annex 4 evidence based and practised strategies of coping with violence based on gender, used in Latin America are outlined. For the Afghan women there is no national health policy or strategy, regarding gender based violence and medical counselling is part of regular medical consultations (ANDS 2008.a). Besides, women are rather to be shamed when subjected to violence and in the case of rape she even wears the stigma, rather than the rapist (UNAMA 2009). In the MoPH strategy, I have not found information on the availability of post exposure prophylaxis of HIV/Aids (MoPH 2005). Bangladesh has similar traditional customs and reported 186 acid burn injuries in one year, initiated by relatives and as basic reasons, conflicts on the money paid for the bride and refusing of marital sex (Wahed 2007). In Herat 2003, AIHCR registered 380 women during seven months of own burning acts by acid or fire, it left women with major scars and disabilities as the hospitals did not have proper tools and pain medication to treat the burns of the women (Amnesty International 2005).

3.5.1.5 Unwanted pregnancy

Although Afghan marriage leads to expected childbirth, women can be pregnant without their own choice, under pressure or by abuse and may lead to the choice for pregnancy termination. Abortion is the ending of pregnancy by removing, or the bodies rejection of the foetus, embryo (in total or pieces) from the womb (WHO 2007). Unsafe abortion is the ending of an undesired pregnancy by a person without qualified medical skills or, and in a setting under minimum, specific medical criteria (Guttmacher 2009). The only information I found on this delicate topic in the Afghan context, is that safe abortions are legal in case the mother’s life is depending upon the abortion (Guttmacher 2009). Safe abortion takes thus place at a established medical facility and by a designated medical professional under safe conditions, as a right in universal sexual reproductive health.

The number of women, unwillingly pregnant in 2008 in Central Asia was high with almost 40% out of all pregnancies (Guttmacher 2009). Of all illegal and not safe pregnancy terminations in low income countries, 14% occurs among girls aged 15 to 19 year (Mahaini 2008). Within Pakistan, 32% of all abortions is performed in not safe ways, which by global evidence showed to lead to a 35% higher risk for complications (Guttmacher 2009).

Complications are of lasting pain, extensive bleeding and tremendous infection and can lead to infertility or even death (Guttmacher 2009). Globally, unsafe way's of terminating pregnancy lead to around 68.000 deaths per year (Lancet
2006). In reverse, by evidence is shown that safely medical performed abortions lead to avoidance of mortality in maternity (Maine 1997). There is no information given on the availability of the morning after pill in the Afghan health strategy outline (MoPH 2005).

3.5.2 **Maternal Health**

The current interventions within maternity for Afghan women, as planned by the MoPH and by the health system are presented within annex 5 (WHO 2007.a).

3.5.2.1 **Ante natal and Post natal care**

As mentioned, pregnancies under the age of 19 year, give a two to five times higher risk to maternal mortality, as compared to women aged above. Screening and identifying of girls with a higher risk in maternity by ANC does not lead to a lower MMR, but does to preparations for the childbirth, familiarization with sexual reproductive health services and consultation for infections, low hemoglobin, high blood pressure (UN Millennium Project 2005). ANC and post natal care (PNC) are provided at some of the Afghan basic health centre (BHC) and comprehensive health centre (CHC) by a nurse or SBA, components as of family planning and immunization are locally provided by community health workers (MoPH 2009). Patients ANC attendance, can also lead to health advice by medical professionals on topics as unwanted pregnancies, STD's or HIV/Aids, SBA and contraceptive use and the provision of micronutrients. For example of iron tablets preventing mothers anaemia and in combination with vitamin A, lowering the risk to unborn child's low weight and infections (Yacoob 2009).

A study in Herat Province, revealed that only 10% of all women ever, once had made use of any ANC services (Amowitz 2002), an lower attendance of 3% was stated in the Badakshan province (Bartlett 2005). The MoPH recognizes the unequal spread of BPHS services over Afghan provinces and confirms by saying that 35% of Afghan's do not have any access (ANDS 2008.a). Besides, not every BPHS setting provides the ANC services, this service coverage is said to be just over 30% country wide (WHO EMRO 2009.a). There was no specific data by the MoPH available on the PNC service utilization by which the risk for mothers, and newborns infections is checked, advice given on child feedings, family planning and nutrition, in case of a suspected low blood level, patients can be referred to a hospital (MoPH 2009).

3.5.2.2 **Skilled Birth Attendance**

The SBA as a medical professional with midwifery skills and trained to manage normal births, to diagnose, timely refer obstetric and neonatal complicated cases to an EOC, she is licensed (WHO 2007.a). A medical professional can perform a clean birth, avoid maternal infections, act to prevent an extensive bleeding after child’s birth, decrease the risk to VVF and the number of maternal complications can evidently be lowered (UN Millenium project 2005).

In Herat, only 1% of women in Herat had support of a SBA during their childbirth and 97% did receive help from a traditional birth attendant (TBA), which is a none medical professional (Amowitz 2002) and another study, in four Afghan provinces mentioned 15% of births being supported by a medical professional
In a huge contrast Iran, has a SBA attendance of 90% (UNAMA 2005). Testing the knowledge of Afghan nurses and SBA, showed that 70% was unable to meet a minimum required score and 50% did have unofficial diploma’s (WHO EMRO 2006.a). The MoPH initiated in 2002 a new training for community midwife or SBA, which lasts one and a half year and mainly practical orientated, schooling for women to work in their own community, which lead to an increase of SBA reaching women living remote, from 500 to 2150 in 2008 (Unicef 2008.a)

3.5.2.3 **Health referral system**

Planned or emergency medical assistance during mothers childbirth, requires a referral system by ambulance or car, preferably guided by medical professional. Although an increased access is seen as important to the MoPH, this difficult task is hindered by insecurity and poor road infrastructure, as at least 35% of people are out of reach of BPHS settings (ANDS 2008.a). The BPHS services locations, are not well divided over provinces and most available in larger cities, which leaves people living rural to depend a referral system (AREU 2006). The distance to health settings influences families initiation to seek health care, as a study on maternal mortality did show it is one obstructing factor for only 30% of women to seek health care in the rural Badakshan, while 72% did so in Kabul (Bartlett 2005). Besides, absence of a vehicle and of women's independent ability to seek health care, were in the study mentioned as other factors of postponement in service utilization, meanwhile 78% of maternal mortality was avoidable (Bartlett 2005). In Nangarhar province, 85% of women experienced no access to medical care as main traumatic experience during the past decade (Scholte 2004).

3.5.2.4 **Emergency Obstetric Care**

EOC can lead to a direct, adequate obstetric intervention in case of complications in pregnancy and childbirth, provided by a SBA or obstetrician in an established medical facility for which WHO standard indicators are given (see Annex 2.2). In Afghanistan, the comprehensive health centre (plus) allows supported vaginal delivery by a SBA (basic EOC), hospitals allow surgical intervention (EmOC) and may have a blood bank (MoPH 2005).

Evidence tells that overall, 15% of all pregnant women develop a condition which results in life threatening obstetric problems during childbirth and estimated is that 2 out of 100 pregnant women dies within maternity (UN Millennium Project 2005). The global criteria is for all pregnant women to have EOC in reach, as the intervention at an adequate EOC facility can prevent maternal deaths and lead to reduction of the MMR. Extreme bleedings and none progressing childbirth are the main obstetric problems in case of a young age pregnancy and in a study shown to be the main reasons for a high MMR in four Afghan provinces (Bartlett 2005).

This study in the remote Badakstan province, shows a MMR which is twelve times higher than in Kabul and absence of EOC, the long distance to travel were of the major factors leading to this difference (Bartlett 2005). There is only one EOC facility in Badakstan, while WHO standards recommend five EOC facilities for the province population number (Bartlett 2005). Another study in Herat province, talks of the concentration of four EOC facilities in one district, which as well lead to inaccessibility for most women living remote (Amowitz 2002). Besides, an inadequate supply of surgical material, of essential medication and the absence
of a blood bank were mentioned as missed quality factors (Amowitz 2002). The EPHS or hospitals, for EmOC are concentrated in provincial main cities and again logistical problems, a weak referral system, poor management and practical skills of employees are mentioned (WHO EMRO 2006.a).

3.5.3 **Mental wellbeing and protection**

3.5.3.1 **Psychosocial support**

By psycho social support, the individual with specific characteristics is guided in the integration within a broader social context (of relations, norms and value’s), in the community with structures as of the family, in order to achieve a healthy psychological functioning and avoidance of mental harm (IFRC 2008). It is not focussed on related disease and tablets, but on a diversity of socio, economic and political matters within the health context benefiting the individual (IFRC 2008). Globally, young people show an extra vulnerability to mental diseases and in the attempts ending their life, which is evidently associated with depressions, while suicide the third leading cause of deaths among 15 to 19 year old (WHO 2003). Symptoms of depression were identified in nearly 60% of Afghan women, in the Nangarhar province and by evidence the relation was shown with the loss of relatives, finances, physical and sexual abuse, the tradition of zina (Scholte 2004). The screening tools used in this study by Scholte are however discussed, as it does not allow defining of specific mental disorders and the differentiation from normal reactions in trauma events (Bolton 2004). Additional research is required for validation, although of relevance, the mentioned results seem quite high. The Afghan MoPH will receive doners support for implementation of psycho social support and mental health care programs at the BPHS, if proven to be beneficial cost wise (Health Fragile States Network 2009). A NGO, providing psychosocial support by a program in the Nangarhar province, does mention by research not even thirty US cent per person for psycho social counselling (Health Fragile States Network 2009). Health Fragile States Network say's that, "by a MoPH training program, 30 health care workers were trained in psycho social support and work in ten support centres divided by three provinces, supposedly 10.000 Afghans receive psycho social counselling in four years" (Health Fragile States Network 2009). This as a pilot project, aiming to expand the counselling services to all BPHS settings, linked to nearby hospitals for possible diagnostics and treatment and is evaluated this year, 2010. (Health Fragile States Network 2009). Iran incorporated psycho social support and mental health services in almost 85% of all rural health programs, reaching 16 million people and targeting adolescents (Yasamy 2001). This are results of the set up of a special MoPH unit, intensified mental health research, nation wide spread mental health promotion and increased medical professionals knowledge by integration into of tutorials, trainings and professional gatherings (Yasamy 2001).

3.5.3.2 **Women shelters**

Not uncommonly, Afghan women are kept in prison for zina and are accused without a trail, while the true reason is they only escaped a violating situation at the house. Nearly all women in the Herat jail are kept for zina and did mention non consent early or forced marriage, undergoing regular physical and sexual violence at their home (Amnesty International 2003). Interviews in Herat with 380 women (in 2003) who committed self immolation said to want to live, but
were not able to otherwise express and escape the ongoing stressors (Amnesty International 2005). Shelter and security are after individual physiological needs, the basic needs for human survival (IFRC 2008). Several NGO's established safe houses for women's protection, operating at a secret level due to low societal tolerance and Yakin mentions "four in Kabul and one in Herat, one in Mazar-I-Sharif" (Yakin 2005). Medica Mondiale has a successful program; it consists of training for 40 Afghan female medical professionals working in women's centers, which are integrated in several major hospitals (Medica Mondiale 2009). In the centers, medical support specifically regarding sexual reproductive health and psychological support for victims of violence is given, as needed referral to the legal system takes place (Medica Mondiale 2009).

3.6 Socio economic determinants in health service utilization

Women's autonomy

In Herat, 95% of women mentioned in interviews their dependence on husbands approval before attending any health care services (Amowitz 2002). In the Kabul province, nearly 80% of women said to be limited in the ability to take decisions while pregnant and in motherhood, which was defined a) by permission required from house leader and b) mahram guidance to access the health services (Masal 2008). Regarded as normal traditions, but shown by the study in Badakshon is that these factors do influence women's decision and time to start seeking urgent health care in maternity and may lead to postponement in the receiving of the appropriate care (Bartlett 2005).

Female health care workers

The Afghan cultural norms, do preclude women from being examined by male physicians, which does lead to the need of female health workers presence for women's health service attendance (Amowitz 2002). Absence of female health workers is partly explained as schooling often is cut for women (Bartlett 2005). According the MoPH, 30% of female medical staff work in remote areas and 50% in populated areas (ANDS 2008.a), while 30% of the whole Afghan health care system is said to function without female medical employees (UNDP 2005). This shortage resulted in the MoPH employment of female health workers out northern bordering countries and is for some followed by the MoPH training to midwife (WHO EMRO 2006.a). The number of nurses and SBA is since 2004, doubled WHO EMRO say's to, "5 per 10.000 Afghans in 2008, the number of medical doctors stays low with 2 per 10.000 Afghans" (WHO EMRO 2009.a).

Cost of health care

About 29 US dollars is expended in total on health, per individual, a year (2007) and WHO EMRO say's, "governments health expenditure to be 10 US dollar per person, a year" (WHO EMRO 2009.a). In practice, patients entering the BPHS or EPHS, pay at least 65% directly for the use of health services (Sabri 2007). Only in some services, medication or vaccinations are provided for free by support of the WHO, UNICEF or UNFPA (Sabri 2007). Even higher out of pocket payments for health services are mentioned (which exclude travel, medication expenses) and together with an Afghan's average daily income of just 2,0 US dollar a day, it is said for one third of all Afghan families to lead to selling of goods, land, the
creation of loans and debts (ANDS 2008.b).

3.7 Seeking justice by Law

Estimated is that 80% of all the Afghan family disputes, individual injustice and criminal acts are dealt by local jirga’s, or the traditional law (Yakin 2005). Afghan women trust is not with the statutory nor customary law, as it is labelled with insecurity, impunity and prioritizes male interest as a result of educational gaps, shortages of students in jurisdiction and a lack of training for legal authorized employees resulting in a blend of the countries laws application rather than the tightening of the formal law (Amnesty International 2003). A professional approach rather leads to legal and responsive reactions once women officially report violence based on early, forced marriage or even rape. Annex 6.1, gives examples of police offices in Latin America providing gender sensitive services and training of judges on violence and legal support strategies (Unicef 2000). By 2011 the Afghan constitutional and legal reform would be re-established, the ANDS includes according UNAMA, “the civil administration, police, prisons and judiciary as aim to ensure equal, fair and transparent access to justice” watched by the government, AIHCR and under UN guidance (UNAMA 2006).

There are contradictions in law, as marriage of girls under 15 year is prohibited by the statutory law, but the same law article allows marriage AIHCR says “if agreed by the genuine father or competent court of law” (AIHCR 2007). Besides, often women have no option for justification by a legal system in case of marital issues, as only 5% of all marriages legally are registered (Yakin 2005). In 2009, President Karzai did even agreed on a (Shiite) law approving none consensual sex in marriage, which was defined as rape trough media coverage (Al Jazeera 2009). Such legal law regulation demolish women’s rights, it rather requires the legal law to include punishment of violence, based on gender and to enable protection (UNAMA 2005). A women raped outside of marriage, can be legally charged of zina and escape her imprisonment only when four people can confirm that the act was against her own consent (Yakin 2005). Again, punishment of the perpetrator is neglected, women fear accusations and risk to be the repeated victim (Amnesty International 2003). Bangladesh, re-enforced the human rights law by setting additional laws of the CEDAW in use (annex 6.2) regarding traditional marriage practices (CEDAW 1979).

3.8 Harmful traditional practices and structural change

The UN adopted, global principle of gender mainstreaming is a concept leading to structural change, influencing and shifting systems by law, policies and into programs towards male, female equality, abandoning gender differences and of impact on involved dimensions of power constructions (SEARC 2008). Instead of lowering power from vulnerable groups in the society, it empowers these groups by including strategies of socio economic systems, SEARC mentions "at micro, meso and macro level"(SEARC 2008). Afghan ministries and donor agencies do incorporate gender mainstreaming into their policies, but as mentioned before, a lack of follow up on health service programs makes efforts for inclusion of the gender perspective in health programs remain undefined and underestimated (Human Rights Watch 2009).
3.8.1 Right to Health

The Right to Health as a basic human right, which leads to the legal commitment of States to set conditions allowing best health status standards (annex 7), as achievable for its population and optimizing the health care system accordingly. It outlines peoples fundamental rights regarding health, which as Asher say's, "need to be respected, protected and fulfilled by the government" (Asher 2004). By social righteousness, it strives for both gender's equality\(^\text{12}\) and equity\(^\text{13}\) (WHO EMRO 2009.b). Gender equality leads for male and female to the same options, ability in accessing the health system and use of health service. By gender equity, the health care system advantages are fairly divided, gender differences are avoided and gender specific needs are taken in account. Automatically, the Right to Health does demand extra consideration for vulnerable groups and is a thorough guidance for health managers providing health care programs (Asher 2004). As a conceptual framework, it allows a critical reflection of the existing health care system response towards populations true health needs, by using Asher say's "the standards of availability, accessibility, acceptability and quality" for health service systems (Asher 2004).

\(^{12}\) WHO on gender equality," the absence of discrimination based on gender determinants for both sexes in access to opportunities and services and allocation of resources and benefits" (WHO EMRO 2009.b).

\(^{13}\) WHO on gender equity," referring to fairness, justice and balance in distribution of benefits, responsibilities and roles, taking in account both genders needs and abilities differences being identified and addressed in a matter that rectifies the imbalance between sexes " (WHO EMRO 2009.b).
Chapter 4  Discussion

The Afghan health care system response, it's limitations, progress and gaps in relation to women's health needs determined by harmful traditional practices in marriage are discussed here by the standards of Right to Health.

4.1 Availability

A low ANC attendance at the Afghan BPHS settings by pregnant women, is partly due to the absence of this service at some settings and the unequal spread of BPHS settings over Afghan provinces. For this reason, women living rural are negatively effected, as most health services are concentrated in urban area's and larger cities. According the WHO standards, women preferably have four ANC visits and three PNC visits during maternity (WHO 2007.a). ANC creates an opportunity for individual counseling on sexual reproductive health issues and the supplementation of iron tablets can lower anemia. However, ANC and PNC services can only impact young women's maternal mortality directly by avoiding pregnancy, family planning and contraceptive use (WHO 2007.a). Early detection by screening of endangering factors in young age pregnancy by ANC can be useful, but is not meaningful in case of EOC absence.

Young women, and by forced married seem disabled in their sexual reproductive health rights, as the process of maturing, choice in fertility and motherhood is pre determined. Of all Afghan girls, 57% is married under 16 year of age and if it leads to pregnancy it gives a two to five times higher risk to die in maternity, as to pregnancies above twenty years of age (Unicef 2001). The low contraceptive use by women during the reproductive phase and a young age marriage, both influence the TFR and evidently the amount of women's maternal mortality. Just, because women preventing pregnancy, are not exposed to dying by maternal causes (Maine 1997). Postponing pregnancy to an older age, is the effective strategy to be used in health interventions towards adolescents. Altough family planning is meant to be universally accessible, methods are said often not to be available at the BPHS, or community level (ANDS 2008.a). The access to contraceptives is improved by MoPH family planning provision trough community health workers, which can be complimented by other program componants. Still, it is a missed opportunity, as delivery of a wider range of sexual reproductive health services at the BPHS, answering sensitive topics by medical professionals seems a more comprehensive approach.

As complications in delivery can be dealt with by EOC and with all women having a risks to die in maternity, universal access to EOC is aimed. Evidence shows that average, 15% of women develop life risking complications and EOC itself can lead to reduction of the MMR, if in reach (UN Millenium Project 2005). This does include the presence of an adequate medical stock and blood bank. The studies explored, mention insufficient numbers of EOC’s facilities in several provinces, EOC's are concentrated in the main cities and a poor referral system leaves women living rural likely without access. In this case, women need the assistance of the SBA and a referral system, which may lead to timely referral of the obstetric complicated cases. As many women, living remote will never reach the health service, the exact numbers of maternal mortality seem not fully clear.
Traditional practices in marriage, harmful to women lead to force, neglect, abuse and tend to be tolerated throughout diverse levels of the ecological model. More into depth research, of the association by age, or violence based on traditional practices and women's mental health status can be useful. Psychosocial support can lead to relief of women's distress, societal needs can be assessed, supported and coping mechanism enhanced. The pilot project by the MoPH of psycho social support programs can lead to multiplication and a wider availability in provinces of support centers, once with success evaluated (Health Fragile States Network 2009). Training can be extended to community health workers, working in mobile teams in rural Afghan regions and reaching women without BPHS access, as they are said to be most affected by traditional practices in marriage. As Iran's integration of psycho social programs in rural communities, increasing the access and targeting at vulnerable groups as adolescents, Afghanistan's mental health program can be enhanced by nation wide promotion of health, workshops and adapted tutorials for medical scholars as valuable tools for extended program success.

4.2 Accessibility

4.2.1 Non discriminatory

Over 80% of gender based violence is initiated by relatives and is taking place at women's restricted area, the house. Women will likely be excluded from their family, when officially reporting this type of violence and it result in out casting, leaving her with no resources and can in reverse lead to under reporting of violations (Yakin 2005). Over 2000 cases of gender based violence were reported in 2006, which may only be the tip of the iceberg. In the case of self immolation, provision of medical tools and expertise in hospitals can decrease the risk for women's disability and mortality (Wahed 2007). Investigation of accidents and reported violence by AIHCR leads the increased understanding of the magnitude of violence, it is a tool for advocacy to demand law application, change and policy developments. It leads to an obvious need for institutionalization of confidential, professional and accessible services for women subjected to gender based violence, linked to a system of referral for appropriate health care. It may entail the shifting of socio economic, political systems to gender equity and requires the integration of rights based approach to gender issues, in the curriculum and training of judges and police with legal authority.

While Afghans mainly depend on the traditional law, this does lead to gaps in fundamental human rights as of birth and marriage registration, the minimum marriage age, free choice marriage partner, access to education, public life and legal justice for women. Legally, additions to the applicable CEDAW can reinforce the legal statutory law and prohibit certain traditional practices. Elimination of certain traditions seems rather a paradox for the time being, but dialogue with tribal leaders and cooperation in the efforts to sensitize communities on the mothers, children's health impact can be effective for behavioral change. Afghan women do turn to self destructive behaviour or run away risking to be a double victim. Women needs are profound, and are of medical assistance, psychosocial support, demand human rights application by an well accessible and responsive legal law system, leading to support and protection. Approval of non consensual marital sex by the legal law leads to adverse responses (Al Jazeraa 2009).
4.2.2 **Physical access**

The required permission of males and guidance of a mahram for 95% of women, does lead to her dependence in mobility and access to health care services (Amowitz 2002). Both factors, influenced in the Badakshan study women's initiation to seek urgent maternal health care. Women's individual ability to look for health care is one factor, but main mentions, "the access and quality factors of health care services also determine the initiation process to select and receive correct health care services without delay"(Maine 1997). In remote regions, professional skills of a SBA may lead to a more conclusive and on time decision to seek EOC, in case of women's complications in maternity. In Nepal, evidence showed that ANC services of birth preparation, promotion of maternal autonomy and a thorough system of referral, lead to the increased use of EOC (Jahn 2000).

Absence of BPHS services for over one third of Afghans does indicates a common deficiency in basic health care access (ANDS 2008.a). The travel distances to health settings leads to an influenced timing of arrival and in case of maternal emergencies, access to EOC (CHC, Hospital) is crucial. Systematic referral by transport is a key strategies which can lead to lowering of maternal death (UN Millennium Project 2005). An institutionalized national system of referral seems difficult due to a lack of infrastructure and insecurity. The set up of a local health support system, consisting of community members and health care workers and supported by the BPHS, can set up an urgent medical transport system, financial loan scheme for families and can lead to active registration of births, deaths and causality at community level (Roudi 2002).

4.2.3 **Economical access**

For all Afghans the financial expenditure on health is equal, which makes the poorest most negatively effected and leads to non equity within health care service utilization (Sabri 2007). Meanwhile, poverty makes one third of Afghans to seek external financial sources to pay health service costs directly at the BPHS or EPHS. Travel expenses and absence of daily labour have to be added to the costs for people living rural and may effect decisions to seek health care, unless urgent. Poverty and lack of education, do have the biggest impact on women trough existing traditions based on gender inequality.

4.2.4 **Access to information**

Education is a tool for empowerment, it raises self esteem, increases awareness and may lead to a persons different behaviour (Nutbeam 1998). Initially, traditional practices effect young girls, IEC targeted however at groups of women's at community level on topics of specific sexual reproductive health can lead to an increased ability to make choices and discuss own health needs. By the high fertility rate and risk of complicated deliveries at young age, topics of birth control and promoting SBA are essential, but both foremost need to be available. In thirteen provinces, misunderstandings for women on contraceptives prevailed, it indicates a need for understanding in related to the cultural context. Traditional practices based on gender differences are embedded in social systems, with an obvious cyclic health impact for women and requires a national strategy of health promotion, to reach the diverse ecological model levels. Sensitization of, and involvement from religious, tribal leaders is essential and
commitment embodies the approval within the wider community. The national campaigns in Iran on birth control and planning are successful in behavioural change (Roudi 2002).

4.3 Acceptability

By traditions, as the bride price and restorative justice, women may be more vulnerable for physical, mental and sexual violence. Women in distress, need to be protected instead of being stigmatized or double victimized, especially in case of self directed, destructive behavior. Six of women's shelters are mentioned, of which four are concentrated in Kabul, with the intensity of gender based violence of over 2133 officially reported cases in 2006, more shelters for protection are needed (Unifem 2008). Tools for women's empowerment, as like micro financing programs can be supportive programs within the shelters. The set up of women's centres in several hospitals by Medica Mondial, leads to proximity to the target group and can be mutually beneficial when linked to shelters for medical, sexual reproductive, psycho social support.

The absence of nations statistical information on STD's and HIV/Aids, may indicate an underestimation of the sexual reproductive health topic. It is a health concern for 60% of Afghan girls, married at an immature age and obligated or forced to a sexual relation, evidently factors leading to an increased risk. Patients suspected with an STD, require counselling, referral for diagnosing and treatment for both the partners. The low awareness of HIV/Aids, syphilis by health care users, providers and missed knowledge of 80% by medical staff of prevention by condom use, makes it rather an unknown health concern. One fourth of 2.133 reported victims of violence by AIHCR, was of sexual abuse and needed access to health service points for VCT, post exposure prophylaxis in the guidance of a national health strategy (Unifem 2008). The number of people with HIV in Afghanistan is stated to be low (under one thousand), while there is an absence of voluntary counselling services for screening.

Unwanted pregnancies are unconditionally linked to maternal mortality, as only pregnancy can lead to the mortality (UN Millennium Project 2005). Abortion is only allowed in Afghanistan, when it is a mothers lifesaving procedure. Unwanted pregnancies mainly occur due to the inability to access and use birth control, this is for 93% of Asian girls under the age of 19 year the case and clearly associated with the practice of abortions (Guttmacher 2010). The access to safe abortion in case of unwanted pregnancy, would require an health policy reform.

4.4 Quality

The SBA has a pivotal position, since her professional skills lower mother and child’s risks to morbidity, mortality. Evidence shows an extreme low availability of SBA at child birth, of one to fifteen percent in Afghanistan. Employing women within the community and providing a shortened training of community midwives, overcomes limited health care access, as of ANC, family planning and leads to an increased number of SBA for complicated births (WHO EMRO 2006.a). Ongoing refreshing trainings for SBA is essential, as MoPH tests for existing SBA showed a huge lack of knowledge.
Female medical professionals are key for the attendance of Afghan women at medical consultations, maximum 2 medical doctors per 10.000 Afghan's does limit this chance (ANDS 2008.a). No female medical staff is present at 30% of the BPHS or EPHS, this does influence women's decision, males approval for access and use of health care services for sexual reproductive health needs. The MoPH intensified efforts, attracting and building capacity of female workers from surrounding countries is successful, as the number of nurses and SBA is doubled (WHO EMRO 2009.a).

Traditional practices do sequential determine women's life and can impact health critically. Gender equity, does entail women's right to sexual reproductive health and is only achieved when the health care system is responding to sensitive issues as contraception, fertility, STD, HIV/AIDS, violence based on gender and unwanted pregnancies. However, the low costs of 4,5 US dollar per person a year, for Afghan BPHS services currently does not allow more extensive services (Sabri 2007). Of all BPHS setting, 83% does not provide a full recommended health service package, which leads to unmet needs as of sexual reproductive health (WHO EMRO 2005). Methods for family planning as example, need to be available throughout all BPHS settings and accessible at community level. To understand the impact of health services over time and be able to evaluate, the effectiveness of BPHS health service programs, the conduct of new surveys on maternal mortality and the contraceptive prevalence rate, may be useful.
Chapter 5. Conclusion and recommendation

5.1 Conclusion

By this literature review, traditions in Afghan marriage have been examined as determinant to women's health as in the attempt to reveal root causality rather than to examine determinants of single health indicators. Absent or lack of data on actual distribution, provision and utilization of specific SRH services by the HCS, lead to the difficulty to quantify needed health services in response to the target population. Research of marital traditional practices in relation to women's health in Afghanistan is mostly orientated to a single region, which made it difficult to generalize its results to the whole population. Regardless, based on retrieved facts and while compared with countries which have similar traditional practices, the potential harm for women is shown and determines a clear health need and demand for certain health care services.

General conclusion

The traditional law and to some extend even the statutory law, do lead to the justification of traditional marriage practices, by which many Afghan women have increased risks in health, throughout their life cycle. Most vulnerable to the practices in marriage are girls under the age of 18 and it leads to increased risks for VVF, STD's and HIV/Aids, obstructed, complicated delivery or are pregnant beyond desire and it may lead to a new cycle of premature child birth, low birth weight and malnourishment. Early, but also forced marriage inhibits the women's autonomy, ability to take decisions and access to education, denies participation in public life, financial ownership and freedom of choice, all together making opportunities to defend own rights scarce. Traditional practices do prevail in diverse levels of structural social, economic and political systems of the society. By restorative justice, women are exchanged in order to restore families honour and may in their attempts to access the formal, statutory law, become double victimized and stigmatized, it allows a perpetrator's impunity. The bride price, or restorative justice can lead into reasons of violence of various forms, lead to difficulties in coping with distress, self immolation, even suicide and honor killing. Traditional practices in Afghan marriage, which lead to harm for women are based discrimination by gender and do show systematically in an inequality and inequity.

The lifecycle approach automatically reveals women's health needs. These health needs are, to prevent and lower maternal morbidity, mortality, to fore fill sexual reproductive health rights, the access to support and protection mechanism in case of violence and relief of distress by psycho social support.

Lowering maternal mortality

Access to birth control methods, is a proven method lowering the maternal mortality number and can delay till a mature pregnancy or avoid an unwanted pregnancy at young age. It is planned to be universal available and family planning provided under the obvious approval and support by religious leaders and the MoPH, can set off a wider behavioral change especially in conservative rural communities. As most Afghans live rural, absence of access to EOC seems rather common. Employing female and providing training to become community
midwife, working in their own community is a vital approach aiming to lower the MMR by increased access to professional support for women pregnant, during labour and right after birth.

**Increased health awareness**

Nations health promotion campaigns, lead to populations better understanding of sexual reproductive health topics. By a pro active support of religious leaders, trough the use of fatwa’s and the spread of health messages by the MoPH on family planning and psycho social wellbeing at the BPHS and EPHS. These two topics shown to initially, have sufficient cultural appropriateness, concern the general population and may gradually create an extended and specific sexual reproductive health promotion acceptance, targeted to adolescents.

**Protection and access to medical assistance**

Most vulnerable women, victim of traditional marital practices become obvious and approachable, once leaving their violent environment and when in a need of urgent medical assistance, entering the hospital. Women support centers, in hospitals leads to proximity of the particular target group and direct entrance to professional support for women, by counseling for specific problems of sexual reproductive and, or mental health. Linking the women's centre's to women's shelters, does lead to complementary services of protection and allows medical follow up, provides access to education and possibly the legal system, or tools for empowering women in their position.

**Extension of psycho social support centers**

The extension of psycho social support centers, to a larger scale and into all provinces, in reach of rural regions will hopefully be continued after this years evaluation. Efforts and expertise of medical professionals in the mental health field, by academic tutorial can eventually allow referral for specialized care. The magnitude of psychosocial problems in Afghanistan is not well known, but of high value in similar traditional cultures and essential to complete individuals health.

**Community health support systems**

The establishment of rural health support systems, has an health organizational role, looking after the communities health and optimizing conditions to achieve a more equal health service access by means of a referral system, loans, payment of travel cost and leads to collective problem solving. It leads to the recognition of general health issues and raises community members responsibility in health, while local birth and death registration, can lead into a nations collective system.

**Health service demand and provision**

The lack of maternal autonomy, health care costs directly to be paid and the absence of female health workers are demand barriers in Afghan women’s health service utilization and may lead to a delay in health care seeking. The Health care system provision of services, requires the availability throughout provinces, access is currently best achieved through local systems of referral and delivery of services within the local community. Upgrading of the existing health services
leads to quality of available health services, EOC's require essential medical equipment and medication, the EPHS medical tools and expertise for treating burn cases, logistical problems to be cleared and refreshing trainings of nurse, SBA, by the MoPH.

The Right to health as a law by the UDHR, describes women's rights in sexual reproductive health. For the universal access, ANC services and contraceptives need to be made available at all the BPHS settings. Inclusion of completer sexual reproductive health services at community level through the BPHS, is feasible and requires increased available costs by donors and specific topics of gender based violence, VCT and abortion, do require development of national health policies.

Power constructions based on gender differences, as the traditional law system, are of influence in different levels of nations structural social, economic and political systems. Structural change by gender mainstreaming, does include the righteous correct application of, and access to the Afghan statutory law, CRC and CEDAW.

5.2 Recommendations

Micro level

Communities are to be encouraged, guided by the district BPHS management, in setting up a health support system (by a community leader, teacher, health care worker or SBA), responsible for establishing a local referral system, setting up financial support or pre pay mechanism as a financing system for poor women to pay travel cost for health, or urgent health services as of EOC and re-enforcing registration of births, deaths.

Aiming to improve access and lower cultural boundaries in contraceptive use for women in local communities, as an effective way influencing maternal mortality, district health managers prioritize a monthly budget proportion for the ongoing supply and availability of free contraceptive methods (tablets and injection), at BPHS settings and for distribution by community health workers.

Health managers combining efforts at district level, to develop workshops and awareness programs on maternal health, the cyclic influence by traditions on family life and maternal services to community leaders and team of the health support system, eventually discouraging harmful traditional marital practices.

Health managers to asses community health workers capacity, increasing their tasks by adaptation of the MoPH family planning training, to promote maternal health services within local communities, if available, encourage ANC attendance and SBA and distribute iron tablets to women pregnant.

Meso level

First the MoPH's, continued employment and capacity building for women, by the 18 month training to community midwife, aiming the 90% SBA and overcoming access problems for pregnant women living rural, by support in pregnancy, child birth, post natal care and timely referral to EOC.
Absence of several societal and law protection mechanism, leads to an urgent need for women shelters. Based on research and investigation of violations, shelters set up and location should be considered by health program managers. Preferably in junction with program implementation of empowerment mechanism for women, as by health education, micro financing, literacy and vocational programs.

Health program managers may investigate the feasibility of setting up women's centre's provinces hospitals, proximity to victims of violence allows incorporation of sexual reproductive health counseling and preferably link to regional women's shelters. Only, secured anonymous registration of violations takes place, and is centralized by the AIHCR and as advocacy tool towards a righteous application of CRC, CEDAW, and access to the Afghan statutory law.

The provincial BPHS, EPHS management are allocating their budget in response to the catchment area, health requirements. To ensure quality of health services, the provision of sufficient medical equipment, essential medication and resolving of logistical problems requires primary attention in the division of budgets as it is fundamental to an adequate health facility, EOC functioning.

The MoPH, may allocate one hospital in provinces for upgrading of medical tools and expertise to treat burn cases.

District health managers, to establish cooperation with WHO or Unicef for the receiving of EPI vaccines, clean delivery kits and folic acid, iron, vitamin A supplementation, making ANC service logistically feasible by trained nurses or SBA at the BHC and CHC, under the development of protocols and guidelines for service continuation.

Consideration of the financial feasibility by health managers, to systematically provide incentives (by capacity building, bonus) promoting female health care workers being employed, working in remote regions.

Health managers in provincial districts, to collectively develop training programs leading to yearly refreshing trainings for professional certified skills, knowledge of SBA, nurses and community health workers at a later stage.

Macro level

The MoPH, with religious leaders involvement, to develop a strategy providing nation wide health promotion on family planning and the use of SBA, in support of fatwa's to create a societal acceptance, behavioral change.

MoPH and MoWA lobby for the future's development, of health policies on gender based violence and VCT by assigned ministers, which can lead to development of related health strategies, in the ultimate goal of institutional integration of comprehensive gender based violence support units at the BPHS level.

Consideration for multiplication of psycho social support centers, by the MoPH, to the availability in all provinces, continue the existing health workers training on psycho social support and develop tutorials and exchange programs leading to specialization in mental health, of academics.
Educational institutes, to adapt curriculum for the academic students jurisdiction, medicine and in the education of police and nurses, with inclusion of modules on gender based violence, basic statutory law principles.

New district surveys, to quantify achieved the health impact by provided health services of maternity (SBA, EOC utilization) and sexual reproductive health (contraceptive prevalence rate), by the Afghan central statistics office and MoPH at provincial level, it allows a closer follow up and evaluation of health programs.

Donors (WB, EC, USAID) direct consideration, to increase the costs available for the BPHS, making besides basic health services, the sexual reproductive health package feasible.
**National Health Care System Afghanistan (NHCS)**

**National Hospitals:** EPHS services, inpatient care, all medical specialties and emergency services, education and training, referral centres for tertiary care (at provincial and district), in major cities.

**Regional Hospitals:** EPHS services, 200-400 beds, all medical specialties, diagnosing, stabilizing, treatment and emergency services (referral hospital).

**Provincial hospitals:** all BPHS services, 100-200 beds (obstetrician, surgeon, anaesthetist, paediatrician, midwives, pharmacist) all supportive facilities and few extra medical specialties, rehabilitation services and infectious disease control (last referral hospital for district).

**District Hospitals:** all BPHS services, 30-75 beds, complicated case management (obstetrician, surgeon, anaesthetist, paediatrician, midwives, pharmacist) laboratory, radiology, blood bank, physiotherapy and outreach.

**Comprehensive Health centre plus:** maternal services, including EOC, 10 beds, laboratory, male and female doctor, nurses, midwife. Covers population 30-100.000.

**Comprehensive Health centre:** CHC, with a wider range BHC, limited space for inpatients, laboratory, male and female doctor, nurses, midwife. Covers population 30-100.000.

**Basic health Centre:** BHC with more complex outpatient care, supervising community services, one nurse, one to three CHW, two vaccinators. Covers population 15-30.000.

**Sub health centre:** one male nurse, one SBA (from their home). Covers population 2-15.000.

**Health post:** at community level, one male and female CHW (from their home). Covers population 1-1.900 (or 100-150 families).

**Basic Package Health Services (BPHS):** maternal-newborn health (ANC and PNC), EPI, Paediatric care, public nutrition and micro nutrient supplementation, communicable diseases (Malaria, TB, HIV/AIDS), mental health, disability and essential drugs.

**Community based:** health care services with 13.000 CHW to 5000 remote villages for family planning, EPI, refer self reported TB patients, promotion bed net.

**Essential Package of Hospital Services (EPHS):** clinical, diagnostic and administrative hospital services. With inpatient care, blood bank, disability and rehabilitation, education and training medical specialists.

Annex 2.1

**Sexual Reproductive Health services BPHS, Afghanistan:**

<table>
<thead>
<tr>
<th>Maternal and Newborn health</th>
<th>In Basic Package Health Services present:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment of incomplete miscarriage or post abortion care</td>
<td>Yes</td>
</tr>
<tr>
<td>Delivery Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Obstetric Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Post Partum Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Care of the newborn</td>
<td>Yes</td>
</tr>
<tr>
<td>Information, education, communication</td>
<td>Yes</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
</tr>
<tr>
<td>Information, education, communication</td>
<td>Yes</td>
</tr>
<tr>
<td>Community based distribution of family planning</td>
<td>Yes</td>
</tr>
<tr>
<td>Social marketing of contraceptives</td>
<td>No</td>
</tr>
<tr>
<td>Provide condoms,oral contraceptives, injectables, IUD’s</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgical sterilization for men and women</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV/AIDS and sexually transmitted diseases</td>
<td></td>
</tr>
<tr>
<td>Information, education, communication</td>
<td>Yes</td>
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<tr>
<td>Screening and treatment for sexually transmitted diseases</td>
<td>Yes</td>
</tr>
<tr>
<td>Voluntary counselling and testing services for HIV</td>
<td>No</td>
</tr>
<tr>
<td>Prevention mother to Child transmission services</td>
<td>No</td>
</tr>
<tr>
<td>Provision antiretroviral therapy</td>
<td>No</td>
</tr>
<tr>
<td>Social support for people living with HIV/AIDS</td>
<td>No</td>
</tr>
</tbody>
</table>

**Source:** A basic Package of health services for post conflict countries: implications for sexual and reproductive health services, Roberts B., 2008.

Annex 2.2

**Emergency Obstetric Care Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Acceptable level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Availability of emergency obstetric care: basic and comprehensive care facilities</td>
<td>There are at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500,000 population</td>
</tr>
<tr>
<td>2. Geographical distribution of emergency obstetric care facilities</td>
<td>All sub national areas have at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500,000 population</td>
</tr>
<tr>
<td>3. Proportion of all births in emergency obstetric care facilities</td>
<td>(Minimum acceptable level to be set locally)</td>
</tr>
<tr>
<td>4. Meeting the need for emergency obstetric care: proportion of women with mayor direct obstetric complications who are treated in such facilities</td>
<td>100% of women estimated to have major direct obstetric complications are treated in emergency obstetric care facilities</td>
</tr>
<tr>
<td>5. Caesarean sections as a proportion of all births</td>
<td>The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15 %</td>
</tr>
<tr>
<td>6. Direct obstetric case fatality rate</td>
<td>The case fatality rate among women with direct obstetric complications in emergency obstetric care facilities is less than 1 %</td>
</tr>
</tbody>
</table>

**Source:** Monitoring emergency obstetric care, a handbook, WHO 2009.
Annex 3

Governments’ Support for Family Planning

Governments with organized family planning programs, such as Egypt and Iran, often involve religious leaders in their family planning campaigns. Egypt is home to Al Azhar Mosque and Al Azhar University, centers of Islamic teaching. These centers have regularly dispatched *fatwas* (religious rulings) in favor of modern contraception, *fatwas* which the Egyptian government has used in its successful family planning campaigns. Contraceptives are available in Egypt in all government primary health care facilities, but cultural reasons still act as barriers for many Egyptian couples to access family planning services.

Since the reestablishment of its national family planning program, the Iranian Ministry of Health and Medical Education in Tehran has regularly dispatched *fatwas* to its provincial offices and down to the lower strata of the health network to remove any doubts that health providers or clients may have about the permissibility of family planning methods in Islam. Health clinics often display the *fatwas* for their clients to see. Seeking *fatwas* on family planning is not the monopoly of the ministry of health office in Tehran. *Fatwas* on family planning can be sought from local clergies as well.

Currently, 74 percent of married women in Iran use contraception—the highest among Muslim countries and comparable with countries such as France and those in the United Kingdom. Iran is also distinct from other Muslim countries because it closed the gap between rural and urban women in the use of modern contraception—around 55 percent of women living in both rural and urban Iranian areas use a modern method. Iran's family planning program provides all contraceptive methods—including female and male sterilization—free of charge. The program places priority on involving men in taking their share of responsibility regarding contraception.6

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* Source: Iran’s family planning Program; Responding to Nations needs, Roudi F. (Population reference Bureau), 2002.
### Objectives and strategies used to address GBV in the Health sector

<table>
<thead>
<tr>
<th>Level</th>
<th>Objectives</th>
<th>Examples of specific initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laws and policies</strong></td>
<td><strong>To improve laws and policies</strong></td>
<td><strong>- Reforms of laws and policies regulating the medico-legal system (eg. introduction of forensic nurses)</strong></td>
</tr>
<tr>
<td></td>
<td>- Clarify providers legal responsibility</td>
<td><strong>- Reform of laws and policies regulating health care providers obligations to victims of GBV</strong></td>
</tr>
<tr>
<td></td>
<td>- Encourage a better health sector response to GBV through national, regional and municipal policies regarding screening, referral, documentation and counselling for victims of violence</td>
<td><strong>- National health policies and protocols</strong></td>
</tr>
<tr>
<td></td>
<td>- Ensure survivors rights to services (eg. emergency contraception, STI prophylaxis, VCT etc.)</td>
<td><strong>- Laws/policies governing forensic medicine: provider obligations, abortion, EC and patient confidentiality</strong></td>
</tr>
<tr>
<td><strong>Institutional reform</strong></td>
<td><strong>Strengthen response of health care and public health institutions to GBV</strong></td>
<td><strong>- Policies, procedures and protocols to improve the health care response</strong></td>
</tr>
<tr>
<td></td>
<td>- Raise awareness of the links between violence and health among service providers, managers, and public health policy makers</td>
<td><strong>- Sensitization and training of health professional</strong></td>
</tr>
<tr>
<td></td>
<td>- Improve the quality of care for survivors of violence, including identification, treatment, documentation, information, referrals and follow up</td>
<td><strong>- Routine screening and referral systems</strong></td>
</tr>
<tr>
<td></td>
<td>- Increase coordination with other sectors that provide service or work on violence prevention</td>
<td><strong>- Development of information systems as epidemiological surveillance and morbidity statistics on violence</strong></td>
</tr>
<tr>
<td><strong>Community mobilization</strong></td>
<td><strong>Increase community mobilization to address GBV as a public health problem</strong></td>
<td><strong>- Specialized survivor services (counselling, support groups)</strong></td>
</tr>
<tr>
<td></td>
<td>- Strengthen community support for survivor services</td>
<td><strong>- Improved and referral to NGO's and other sectors</strong></td>
</tr>
<tr>
<td></td>
<td>- Strengthen coalition and networks</td>
<td><strong>- Curricular changes in training of nurses and other medical staff</strong></td>
</tr>
<tr>
<td></td>
<td>- Improve attitudes, norms, practices and resources at the community level</td>
<td></td>
</tr>
<tr>
<td><strong>Individual behaviour change</strong></td>
<td><strong>Improve knowledge, attitudes and practices of key groups and the broader population</strong></td>
<td><strong>- Coalition for public health research and advocacy</strong></td>
</tr>
<tr>
<td></td>
<td>- Promote gender- equitable nonviolent sexual partnerships</td>
<td><strong>- Community level prevention and mobilization initiatives</strong></td>
</tr>
<tr>
<td></td>
<td>- Increase women's ability to make decisions about the timing and nature of sexual relationships</td>
<td><strong>- Community based awareness campaigns aimed at mobilizing journalists, policy makers and opinion leaders</strong></td>
</tr>
<tr>
<td></td>
<td>- Decrease tolerance for GBV by raising awareness of GBV as a public health problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Encourage victims of abuse to seek help and disclose violence to service providers</td>
<td><strong>- Clinic and community based education efforts (theatre, video's, pamphlets, talks)</strong></td>
</tr>
</tbody>
</table>

### Annex 5  
**Strategic Maternal interventions by level of care MoPH Afghanistan 2008 - 2013**

<table>
<thead>
<tr>
<th>Strategic intervention:</th>
<th>Health service:</th>
<th>At Health Facility:</th>
</tr>
</thead>
</table>
| 1) **Antenatal Care**  
or **ANC**              | Counseling (4 ANC visits in pregnancy)  
tetanus vaccination | SHC, BHC, CHC,  
Hospital |
|                         | Detection and management of pre eclampsia, STD’s, | BHC, CHC, Hospital |
|                         | Screening and refer complicated cases to hospital  
(malnourished, anemic, eclampsia) | BHC, CHC |
|                         | Administration of Folic Acid, Iron, Vitamin A | BHC, CHC, Hospital |
|                         | Promote good nutritional status, new born care | HP, SHC, BHC, CHC,  
Hospital |
|                         | Treatment complicated cases (malnourished, anemia,  
eclampsia, malaria, HIV/AIDS, STD's) | CHC/+ Hospital |
|                         | Promote skilled birth attendant and birth preparedness | HP, SHC, BHC, CHC,  
BHC |
|                         | Teach on danger signs, provide clean delivery kit | SHC, BHC, CHC |
|                         | Prepare to potential risk deliveries for referral | HP, SHC, BHC |
| 2) **Intra partum care** | Skilled Birth Attendant (referral in case of complication) | SHC, CHC |
|                         | Emergency Obstetric Care (EOC)  
Management mother and neonate health care | CHC/+ Hospital |
| 3) **Post natal care**  
or **PNC**               | SBA visit within 48 hour post partum | SHC, CHC |
|                         | Counseling (3 PNC visits after child birth)  
Mothers vitamin A supplementation | SHC, BHC, CHC,  
Hospital |
|                         | Promote exclusive breastfeeding, birth spacing and  
contraceptives | HP, SHC, BHC, CHC,  
Hospital |
|                         | Management of hemorrhage, anemia, puerperal infection  
or other complications | CHC/+ Hospital |
|                         | Raising awareness on child care, immunization, child spacing,  
nutrition | HP, SHC, BHC, CHC,  
Hospital |
|                         | Teaching on danger signs, post partum and neonate | SHC, BHC, CHC,  
Hospital |
|                         | Post partum examination child and mother, referral if required | SHC, BHC, CHC |


**ANC**: To prevent, alleviate or treat/manage problems/diseases (including those directly related to pregnancy) known to have an unfavourable outcome on the pregnancy, provide healthy pregnancy and childbirth, exclusive breastfeeding information.

**EOC**: receiving prompt adequate treatment of complications of pregnancy and childbirth by an therefore established medical facility.

**PNC**: to prevent, alleviate or treat/manage problems/diseases of the mother and newborn child up to six weeks after delivery, provide post partum, neonatal and exclusive breastfeeding information.

Annex 6.1  Domestic Violence, against women and girls

Source: Domestic violence against women and girls, Innocenti Digest no 6, Unicef, 2000.

Annex 6.2  Bangladesh Law adoption under CEDAW

Fact Sheet No.23, Harmful Traditional Practices Affecting the Health of Women and Children

States Parties shall take all appropriate measures ... to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (art. 5 (a)), adopted by General Assembly resolution 34/180 of 18 December 1979.

Bangladesh clearly upholds the principle of equality of men and women and prohibits discrimination against women. To protect the legal rights of women and to stop violence and repression against them, the Government has adopted the following legislation:

(a) Dowry Prohibition Act, 1980, which provides for punishment for giving, taking or abetting the giving or taking of dowry;

(b) Cruelty to Women (Deterrent Punishment) Ordinance, 1983, which provides for punishment for abduction of women for unlawful purposes, trafficking in women, or causing or attempting to cause death or grievous harm to a wife for dowry;

(c) Child Marriage Restraint Act Amendment Ordinance, 1984, which raises the marriageable age for women from 16 to 18 years, and for men from 18 to 21 years. It also provides for punishment for marrying or giving in marriage of a child;

(d) Muslim Family Laws Ordinance, 1961 (as amended in 1982), which provides for increased punishment in cases of polygamy and divorce in violation of the statutory provisions.

Source: Harmful traditional practices affecting health of women and children, Factsheet no. 23, CEDAW (OHCHR),1979.
Annex 7
The Right to health

How must a government comply with its obligations to respect, protect and fulfil the right to health?

Monitoring availability
- Are the numbers, quality, and distribution of functional public health and health care facilities in the country adequate, taking into account its developmental and economic condition?

Monitoring accessibility
Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and accessibility to information. When monitoring accessibility, attention needs to be paid to the following points:
- **Monitoring non-discrimination:**
  - Are health facilities, goods and services accessible, both in law and in fact, to everyone, including the poorest and most vulnerable or otherwise disadvantaged groups in the population? (See chapter 5)
- **Monitoring physical accessibility:**
  - Are health facilities, goods and services within safe physical reach of all sections of the population, including rural communities, ethnic minorities, indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons living with HIV/AIDS?
- **Monitoring economic accessibility (affordability):**
  - Are health facilities, goods and services affordable to everyone?
  - If it is required that people pay for health care services, or for any other services concerned with the underlying determinants of health, such as sanitation and drinking water, is payment based on the principle of equity?

**Equity** refers to the obligation of the government to ensure that such services, whether they are publicly or privately provided, are affordable to everyone and that poorer households are not burdened disproportionately with health expenses as compared with richer households.

Monitoring accessibility to information:
- Is everyone able to seek freely, and to receive and impart health-related information and ideas? For example, do young people have access to sexual and reproductive health education and information that is presented to them in an unbiased manner?

Monitoring acceptability
- Are all health facilities, goods and services provided in conformity with human rights and medical ethics? Is the dignity of patients or clients respected? Are they culturally appropriate?

_Culturally appropriate_ means that: they are respectful of the culture of individuals, minorities, peoples and communities; they are sensitive to gender and life-cycle requirements; they protect confidentiality; and they are adequate to improve the health status of those concerned.

Monitoring quality
- Are all health facilities, goods and services scientifically and medically appropriate and of the highest possible quality? This requires, for example, adequate provision of skilled medical and nursing personnel; scientifically approved drugs and equipment; safe, potable water; and sanitation.

References


