

A GLIMPSE INTO MATERNAL AND CHILD HEALTH IN AFGHANISTAN

During the months of November 2000 and March 2001 visits were made to 2 Maternal & Child Health projects that are funded through the Swiss NGO, Terre des hommes. The main purpose of both visits was to meet with programme staff and, in particular, female clients in order to carry out a participatory assessment within their homes and community environment.

Maternal & Child Health

The circumstances that impinge and affect Afghan women are similar in many respects. However, the two areas visited also mirror differences found between MCH in the Taliban controlled city of Kabul and that of Rustaq District, a remote rural region in the northeastern province of Takhar. Currently Rustaq is under the jurisdiction of Commander Ahmed Shah Masood, the former Afghan Defence Minister.

Similarities relate to statistical data, which indicate that Maternal Mortality ranks as the second highest in the world, with 1,700 deaths per 100,000 live births. A major cause of death is maternal and neonatal tetanus, which accounts for approximately one third of neonatal deaths. Maternal morbidity ranks as the fifteenth highest in the world and children, between birth and one year, are dying at the rate of 165 per 1,000 live births. For every 1,000 young children, just over a quarter of them (257) will not survive to reach their fifth birthday.

Poverty prevails, with 80% of people living below the 'poverty level'. The availability and access to health facilities and health care, coupled with unsafe water to 88% of the population perpetuate a precarious health situation. It was observed that rural areas, such as Rustaq, experience a huge lack of both human and material health resources.

In Kabul

Efforts to reduce maternal/infant mortality and morbidity amidst a population of 1.5 million people come from a team of Afghan midwives who provide an essential maternal and child health home-visiting programme (MCH/HVP) to women in Kabul. The 24 midwives, led and supported by their trainers and administrative staff have given an outreach service to clients since 1996. However, closures and a universal ban on women working hampered the early phases of the HVP, but this was later eased during 1999 when the Taliban permitted women to work as health workers.

Against a background of controversy the MCH/HVP midwives function as a closely-knit team of professionally trained women who work in pairs to seek out pregnant or postpartum women within their 12 designated areas. The destruction and damage to a large extent of Kabul means that many of the homes visited resemble bomb sites. The occupation of these cities are also 'fuelled' by internally displaced Afghans, seeking refuge wherever they can. Reconstruction work appears to be minimal and restoration of housing and essential services would require a huge financial investment.

The HVP midwifery service has become more crucial over the past year, as from July 2000 the Ministry of Public Health (MoPH) closed 27 of their 42 MCH clinics. At the time of visiting Kabul some two-thirds of the remaining 15 clinics were being supported by international non-government organization (INGO) funding. Such action would almost certainly have helped alleviate an impoverished PHC situation, such as that observed during a meeting with health staff and mothers at a non-assisted MoPH clinic.

Home births and delivery by family members is traditionally accepted in Afghanistan and Kabul City is no exception. In cases of obstetric emergencies and complications a women's hospital is available for referral, but like the community service, suffers from a lack of resources. Advice to seek hospital referral is also hampered by dire socioeconomic circumstances and the obstacles encountered by women in accessing further health care.

A high workload is pursued by the HVP, as demonstrated by the 28,179 clients visited in 2000, including the care of 4173 newborn infants and their mothers during the same period. Pregnant women are usually visited twice during the later stages of their pregnancy, with midwives advising them and their family members on how to achieve clean and safe deliveries. Essential iron folate and multivitamins are supplied to pregnant women and referrals to UNICEF immunization centres are encouraged for both mothers and children. Postpartum care follows a schedule of five home visits and continues until 42 days following delivery. During this time specific health topics are discussed with mothers and many other local women, who crowd into very cramped rooms to listen to the 'health messages'. In this way, the midwives have enabled dissemination of healthy MCH practices to 84,789 women during 2000.

This MCH/HVP not only sustains a vital service to many women in Kabul, it also enables the midwifery team to practice and maintain their skills and expertise, as professional educated women. At the same time, they are providing valuable family income against an unemployment background estimated as high as 90% within the formal work sector. However, the work of the MCH/HVP team is isolating.

The midwifery training school remains closed, with access to up-to-date midwifery and obstetric literature remaining elusive to both midwives and trainers. The strict segregation between males and females (non-relatives) can limit the teams contact with other INGOs. Even as a female, but foreign, it was not possible to travel in the same vehicle as the midwives, whilst male delegates of the funding NGO are unable to meet with the HVP team during their trips to Kabul. In order to redress some of their social and professional segregation, senior members of the HVP recently attended Terre des hommes workshops in Pakistan in order to visualize the future direction of their successful programme in Kabul. A gradual expansion of home visiting is planned, with the training of traditional birth attendants (TBA's) to work along the HVP midwives.

In Rustaq

In spite of the recognized and ongoing practical and personal difficulties faced by the Kabul team, the presence of trained staff in the city compares favourably with the situation found in the harsher, but spectacular, remote terrain of Rustaq District. Visiting this northeastern area of Afghanistan gave one a sense of timelessness, as lifestyles appear unchanged for centuries.

According to a local doctor the existing hospital or clinic was destroyed as a result of the Russian/Afghanistan war and currently the nearest hospital is some 7 hours car journey away in Faisabad. A period of intermittent clinic care in Rustaq Town has been the 'normal' pattern of health delivery to both town and village dwellers over the past 15 years. However, for the estimated 400,000 people living in scattered villages the presence of an operational clinic in Rustaq Town does not resolve the problems for many families. Accessing a service is difficult and a lack of appropriate antenatal, natal and postnatal care for women and infants are just some of the casualties.

Notwithstanding that transport is invariably by foot or donkey over rugged land, with tracks likely to be impassable during the austere Afghanistan winter months, the decision to seek

medical advice is frequently viewed as a community affair. Village unity is necessary if there are special needs required to transport a sick person for medical care.

Following two earthquakes in Rustaq District (1998) funding was obtained by Terre des hommes for a rehabilitation programme in 15 affected villages. Part of this initiative is the training of TBA's, coupled with basic Health Education for village women and a limited outreach health service to 5 strategically based clinics. Although MCH predominates the programme, which commenced in 2000, a process of adaptation and change is underway, in order to maximize the effectiveness and long-term impact for women, children and men. A focus for community health development and education is intended to include boys and girls who attend newly constructed schools.

The obstacles presented for development in an area such as Rustaq cannot be underestimated. The remote location, plus a culture and tradition relatively untouched by health intervention presents enormous challenges, not least because of the need to avoid a dependency on medical aid, which may not be sustainable. The people are already confronted with instability, as Taliban forces increase their control on this northeastern Masood held district, leading to an influx of 10,000 refugees into Rustaq last September. The frontline of fighting is close. Coupled with the ongoing conflict are the real concerns relating to drought and agricultural production in this rain fed region of Afghanistan.

Equally relevant is the continuing challenge presented to the donors and the NGO agency for MCH in Kabul and Rustaq. The dynamics within Afghanistan are constantly in the throes of change, thus the following statement appears especially pertinent to the complex and tragic situation that face Afghans on a daily basis.

'We need to focus on the person in need, trying to understand his or her whole being, as well as social and cultural context, without the interference of our own prejudices'. ('Stark Relief' by Tony Vaux in the 'The Guardian/Society Guardian' 16.5.01 p.10).