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Maternal Mortality in Afghanistan: An Emerging Cultural Complexity

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Abstract
While helping run clinics in Kabul, Afghanistan, with doctors and nurses, I heard from many families about the gravity and prevalence of maternal mortality and also met several women that have dealt with this issue. I possessed the first-hand anecdotal evidence, but needed factual proof. As a result, this paper takes a statistical approach to examining one of Afghanistan's leading killers: complications in pregnancy. It also reports on findings from the literature from several articles about gender inequity, reproductive health knowledge, and post-partum hemorrhage, seeking to explain several cultural factors that promote maternal mortality in Afghanistan. Lastly, it identifies possible solutions and accompanying barriers to maternal health (or attributing factors to maternal mortality), making the claim that nurses could greatly improve the situation by educating the women and the community. The goal of this paper is to raise awareness of maternal mortality in Afghanistan.
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**Background**

Though the notion of a “cultural group” can be difficult to define, I view it as a set of individuals who share a common culture, including certain knowledge, behaviors, traditions, values, practices, and skills (Newcomer, 2009). Traveling to Afghanistan this summer and working closely with the natives, I became immersed in their culture and observed the unique aspects that differentiate them from other groups. The most prominent characteristic is their strong devotion to Islam. This not only governs their lives spiritually, but also personally, economically, legally, and politically. As you will soon discover, they have many practices stemming from their religion that run counter to standard Western health care. Unlike the United States, Afghanistan has a national religion since over 90% of the population is Muslim. Thus, religious principles often translate into culture and law, and they are very careful in enacting their faith. Family is also paramount and defines notions about marriage, children, and gender roles that other cultures do not hold true. In Afghanistan, reputation and family size are inextricably linked; because of this, families attempt to have as many children as possible and consider themselves more blessed when they do. (Newcomer, 2009). Lastly, the Afghans’ resilience through all the trials and tribulations they have faced such as the Soviet invasion, civil war, drought, famine, epidemics, and strict dictatorship, such as the Taliban regime, helps them stand out as a cultural group. These adversities have destroyed the nation’s internal infrastructure, and as a result, have left the health care system in a constant state of turmoil. (Newcomer, 2009).

**Introduction**

Bartlett, Crouse, Dahl and colleagues (2005) examined numbers and effects of maternal mortality in Afghanistan. They discovered that an Afghan woman dies every 27 minutes from pregnancy-related complications. In fact, in the district of Badakshan, 6,500 women will die for every 100,000 babies born; this is 600 times the risk that North Americans face. This investigation also uncovered that in 2000, the United Nation’s estimated maternal mortality ratio (MMR) for Afghanistan was 1900 out of 100,000 births, and in 2002, 60% of Afghans had no access to basic health services. Two thirds of Afghanistan’s districts lacked maternal and child health services, and only 10% of hospitals were properly equipped to service cesarean deliveries. Out of the four districts surveyed, three rural districts named pregnancy as the number one cause of death in women of childbearing age. Only in Kabul, the capital of Afghanistan and the most urban area surveyed, was the maternal mortality similar to other causes of death. Bartlett and his colleagues found that the most common causes of maternal mortality were hemorrhage and obstructed labor. Some barriers to healthy pregnancies include limited availability of health care, abnormally high fertility, poor health practices, low rates of literacy and education, and lack of birthing attendants with skilled knowledge about safe delivery.

**Gender Inequity**

In July 2006, The United Nations Population Fund (UNFPA) published an article about how gender inequity affected maternal mortality in Afghanistan. (The United Nations Population Fund, 2006). This nation is one of only two countries in the world where women have a lower life expectancy than men. The article discussed possible reasons including the fact that Afghan women are often treated as objects as they can be bought or sold to other clans in a twisted effort to resolve conflict. This practice is rationalized through the ancient Islamic teachings that promote a patriarchal society where the men are far superior to women. Many Afghans interpret this to mean that the primary purpose of women is to bear as many children as possible, no matter what resources are available or how poor the family is. (Newcomer, 2009). According to UNFPA, women often lack the necessities that the males are given when money and food are scarce. This often translates into illiteracy, malnutrition, and early marriage for women. UNFPA’s study also illustrated that more than 40% of women from Badakshan are married before the age of 15, when sexual development is far from complete; yet these girls are thrust into early pregnancy resulting from frequent sexual activity. Teenage girls are five times more likely to die in childbirth than women in their twenties. Forty percent of Afghan women were married before age 18 and some are married as young as age seven. Early marriage is primarily due to poverty and the need to protect young girls from premarital pregnancy, which is strictly forbidden in the Islamic religion. Not only are these girls malnourished, but their growth is stunted due to poor nutrition; this results in poor outcomes during pregnancy.

**Lack of Reproductive Health Knowledge**

In a survey of reproductive health issues in a cross section of women from Kabul, Bosman and colleagues found that decreased knowledge about reproductive issues and family planning is one of the biggest reasons for maternal mortality (Bosman et al., 2004). Since this is in the most developed area of Afghanistan with greater access to health care, the numbers are likely to be significantly worse in more rural areas. When asked how babies were conceived, only 16% of 15-year-old Afghan women gave a correct answer. In Afghanistan, many women are married and sexually active by the time they are 15, so it is crucial that they be educated about reproductive health. Their lack of sexual knowledge coupled with a male dominated culture where the husbands are equally deficient in accurate sexual knowledge contributes to poor outcomes. According to the 2004 survey conducted by Cosman et al., 89% of the women said they had to gain permission from their husbands to seek medical attention. As a result, most women give birth in their homes with unskilled female relatives rather than at a hospital with the skills of a physician or midwife. Results showed that 40% of the women thought their family size was set, study met, yet only 23% were utilizing some form of birth control. Among the married adolescents, 67% were pregnant and the rest were not using any form of birth control. Over half of all married women did not know of any method to avoid pregnancy. Bosman et al (2004) points out that these statistics are directly related to Afghan women’s lack of formal education; sex education is practically absent in this culture as well. Attendance of formal schooling, a luxury that most Afghan women do not have, was the strongest factor in healthy births. Women who attended school were more likely to use ante partum care, deliver at a proper institution,
use a skilled birth attendant, and utilize family planning measures. (Bosman et. al., 2004)

Post Partum Hemorrhage
In an effort to identify why Afghanistan has the second overall highest maternal mortality rate, Adams, Derman, Geller and colleagues (2005) found that the number one cause of death was postpartum hemorrhage (PPH). PPH affects 10.7% of women worldwide, translating into nearly 14 million women. Currently, there are no preventative measures or procedural treatments for PPH in developing countries such as Afghanistan. Since most births occur at home with unskilled attendants, it is difficult to treat PPH. In fact, most of the deaths from PPH occur because the women gave birth away from skilled preoperative and emergent treatment. For example, anemia predisposes women to serious outcomes from PPH, dietary prevention of anemia may have a positive impact. Dietary counseling regarding food choices that are consistent with the woman’s economic status and cultural heritage holds some promise. Secondly, educational programs focused on enhancing the clinical decision making skills of the local birth attendants and referring women to centers where more highly skilled providers are available may help some women. It is possible that educated attendants about infection control practices such as that hand washing and use of clean delivery kits may prevent unnecessary infection. In this review, little information was found about the processes and adequacy of prenatal care. Community based demonstration projects where nurses train local birth attendants to monitor women throughout their pregnancy and educate them about improved birthing practices should be implemented and evaluated.

Helping women who choose to limit or space their children through culturally sensitive family planning efforts holds the most promise. Given that 40% of women reported satisfaction with the current size of their family yet were ignorant of strategies to prevent pregnancy (Cosman), it is logical to assume that an institution exists for pregnancy prevention, if the health information is provided in a manner that respects the couple and their cultural beliefs. The community based pre-natal clinics mentioned previously could also become centers for family planning counseling. The conservative patriarchal culture in Afghanistan may object to women utilizing any form of contraception, and these resources are scarce even in the most rural areas. Still, natural family planning may be more acceptable. Since respect for modesty and sanctity of marriage is one of the prime Afghan cultural group distinctions, discussion of some of these topics might cause controversy in certain rural areas. (Newcomer, 2009). However, the UNFPA successfully launched campaigns alerting religious leaders about the dangers posed by early marriage. Yet, until women are put at high priority as men and given equal treatment, maternal mortality will likely always be an issue that requires attention. (The United Nations Population Fund, 2006).

Conclusion
In my personal experience with Afghan women, I noted their expressions of gratitude to the United States for intervening with the Taliban regime, as the treatment of women in Afghanistan has significantly improved. (Newcomer, 2009). For instance, in the past, most women were not allowed to leave the confines of the house unless they needed necessities for the family. All women were required to wear black burkas that cloak the entire body and leave only the eyes visible through a semi-transparent cloth. Currently, women in more urban areas such as Kabul can dress more fashionably and wear headpieces that solely cover their hair instead of their entire body. There is some evidence that the culture is changing since many Afghan men are more open to women’s reform. I have seen women fulfill careers and participate in social events within the community. The Afghan people I have interacted with in the clinics seemed very open to learning new ideas and practices. For instance, though it is considered inappropriate for a woman and a man to converse or even make eye contact in the Muslim culture, our group soon became great friends with the Afghan translators. Despite our gender, even the men in the clinic treated us with dignity and respect as medical professionals, taking our recommendations into careful considerations; in turn, I believe that they would be very receptive to the education measures that I have proposed. Since the strict oppression is lifting, the Afghan people are becoming more progressive everyday and would likely benefit from new knowledge that incorporates their culture and simultaneously improves their health.

References

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