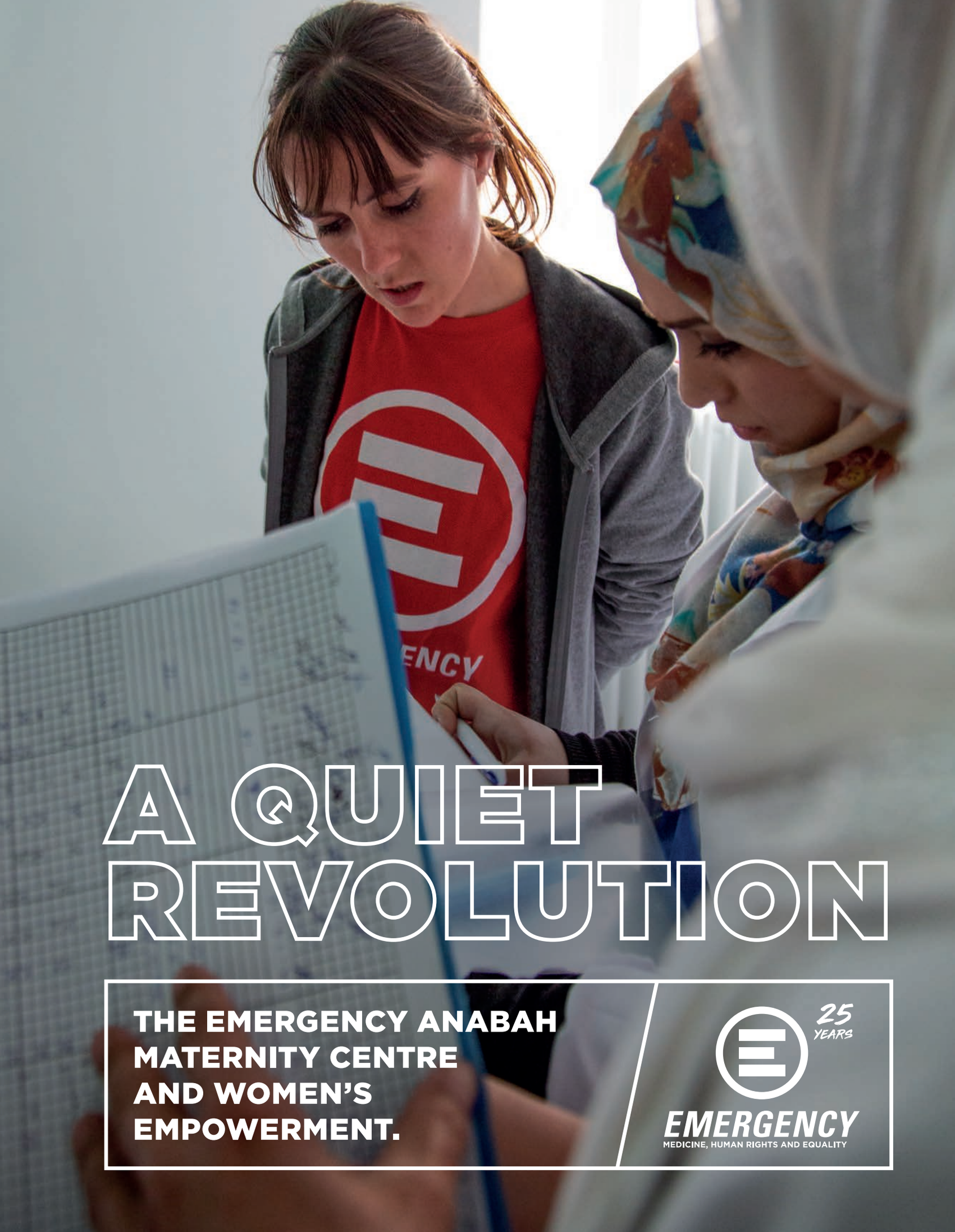


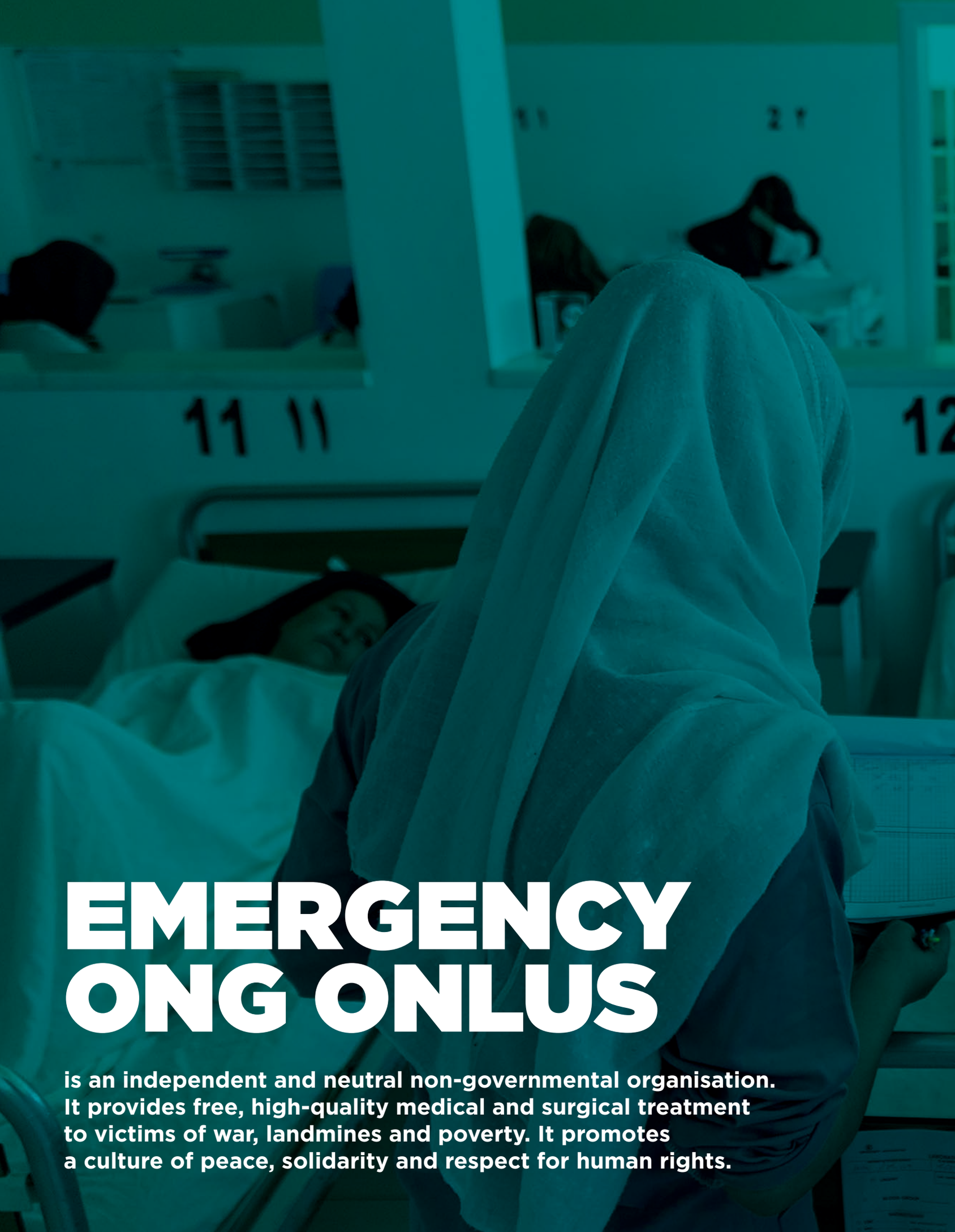
A QUIET REVOLUTION

THE EMERGENCY ANABAH MATERNITY CENTRE AND WOMEN'S EMPOWERMENT.

25 YEARS

EMERGENCY

MEDICINE, HUMAN RIGHTS AND EQUALITY



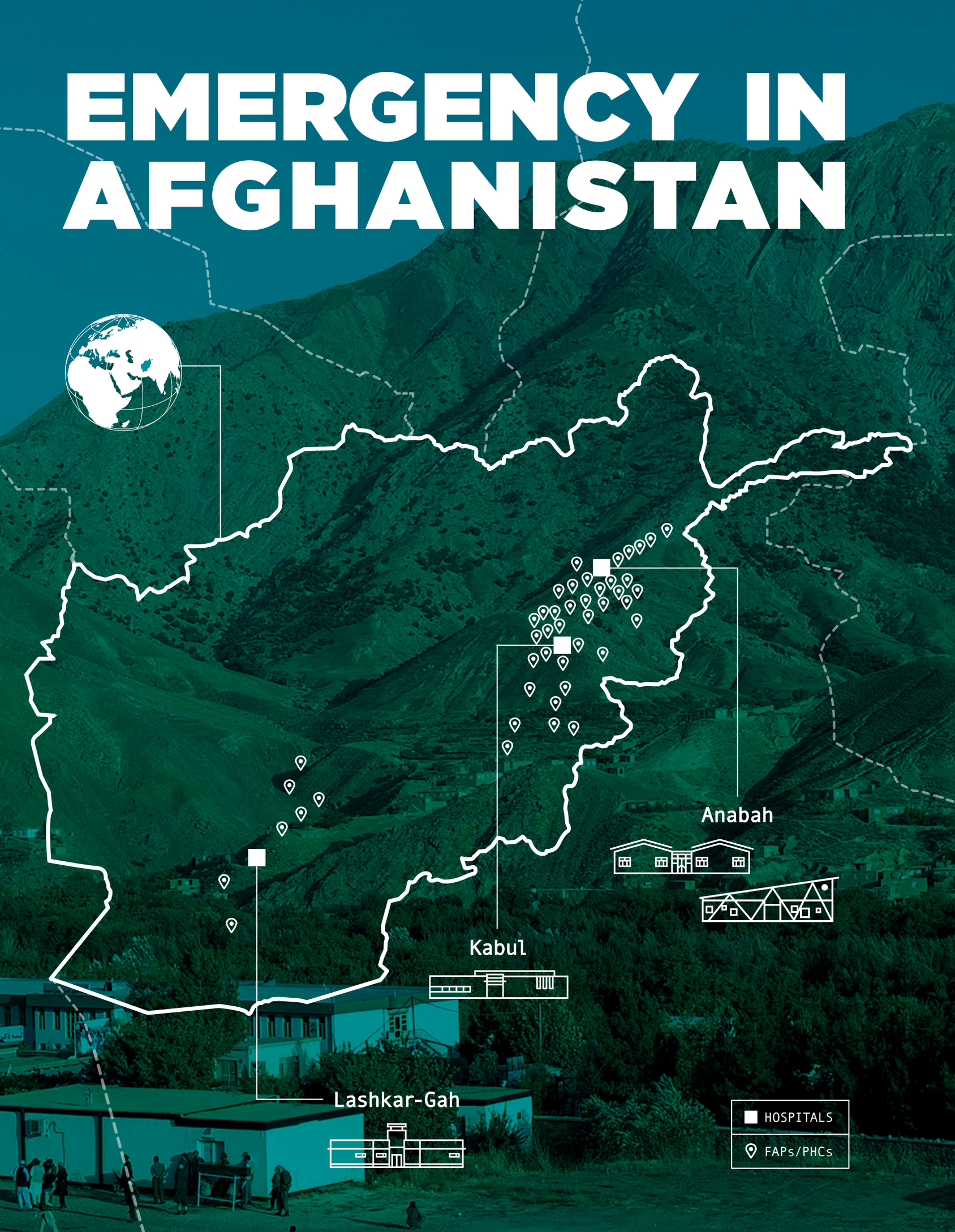
EMERGENCY ONG ONLUS

is an independent and neutral non-governmental organisation. It provides free, high-quality medical and surgical treatment to victims of war, landmines and poverty. It promotes a culture of peace, solidarity and respect for human rights.

Between 1994 and 2019, in its hospitals, Healthcare Centres, Outpatient Clinics, and Rehabilitation Centres, EMERGENCY has provided free healthcare to over

10 MILLION PEOPLE.

EMERGENCY IN AFGHANISTAN



SURGICAL AND PAEDIATRIC CENTRE — Anabah

Accident and emergency, inpatient and outpatient departments, 2 operating theatres, intensive care unit, physiotherapy, radiology, laboratory and blood bank, pharmacy, classrooms, play room, technical and support services

FROM DECEMBER 1999

78 BED SPACES

329 LOCAL STAFF MEMBERS

MATERNITY CENTRE — Anabah

Triage and outpatient department with ultrasound service; inpatient departments: 2 operating theaters, intensive care unit and postnatal ward, neonatology department including NICU (neonatal intensive care unit), labour ward, delivery rooms, technical and support services shared with the Anabah Paediatric and Surgical Centre

FROM JUNE 2003

104 BED SPACES

126 LOCAL STAFF MEMBERS

SURGICAL CENTRE FOR WAR VICTIMS — Kabul

Accident and emergency, inpatient and outpatient departments, 3 operating theatres, intensive and sub-intensive care units, physiotherapy, CT (computed tomography) scan service, radiology, laboratory and blood bank, pharmacy, classrooms, technical and support services

FROM APRIL 2001

120 BED SPACES

352 LOCAL STAFF MEMBERS

SURGICAL CENTRE FOR WAR VICTIMS — Lashkar-Gah

Accident and emergency, 3 operating theatres, intensive care unit, inpatient departments, physiotherapy, radiology, laboratory and blood bank, pharmacy, classrooms, play room, technical and support services

FROM SEPTEMBER 2004

94 BED SPACES

264 LOCAL STAFF MEMBERS

FIRST AID POSTS AND PRIMARY HEALTH CENTRES

FROM DECEMBER 1999

354 LOCAL STAFF MEMBERS

37 First Aid Posts (FAPs) and Primary Health Centres (PHCs): Anabah, Abdara, Dara, Darband, Dasht-e-Rewat, Khinch, Paryan, Gulbahar, Kapisa, Koklamy, Oraty, Changaram, Anjuman, Sangi Khan, Shutul, Said Khil, Pul-e-Sayyad, Mirbachakot, Maydan Shahr, Mehterlam, Ghazni, Chark, Gardez, Pul-e-Alam, Grishk, Garmsir, Musa Qala, Marjia, Urmuz, Tagab, Andar, Sheikhabad, Hesarak, Ghorband, Barakibarak, Sangin, Shoraki

6 PHCs in Kabul prisons: Governmental Jail, Investigation Department, Pul-e-Charki, Juvenile Rehabilitation Centre, Female Jail, Transition Prison

2 PHCs in Kabul orphanages (male and female)

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All EMERGENCY staff at Anabah Maternity Centre

INDEX

PROUD OF THIS PROJECT

ROSSELLA MICCIO
President of EMERGENCY

Afghanistan plays an important role in EMERGENCY's story. After 20 years of work there, EMERGENCY has also become part of the country's history. A history that in the last four decades has been characterised by a senseless war that has robbed many people of their rights, particularly women, who have always been more vulnerable in the country.

In the last 20 years we have learnt that war victims are not just the tens of thousands of people killed, injured and mutilated by bombs, bullets and landmines. Many more people pay the price of war. They are the children who cannot enjoy a safe, protected childhood but risk their lives every day to get to school, or die from preventable diseases because war has destroyed the country's infrastructure. They are women, already constrained by an oppressive culture, who are marginalised even further when violence breakes out.

We decided to open our Maternity Centre in the Panjshir valley at the end of 2001. It is a beautiful, very narrow valley, one of the few places in the country that the Taliban have never managed to capture. That is partly why things are easier for women here. Many of people said we were mad to think a facility run 'by women for women' would last in these mountains. We doubted ourselves more than once, but the strong, determined women we met, the enormity of their needs and the trust our work earned us in the local communities made us even more intent on carrying out this ambitious project.

Today, we are extremely proud to be able to share the results of our work, which has silently changed to lives of thousands of women. More than 350,000 women have been treated safely, to a high standard, and free of charge. Hundreds more have worked with, and been trained by EMERGENCY in the last 16 years.
With them we have discovered that, with the right approach, we can turn even heavy social and cultural barriers into a chance for liberation. We have seen that a hospital in a war-torn country can offer much more than medical treatment. It can restore dignity and hope for the future to people, and become a model for collaboration between government bodies and civil society.

Afghan women are becoming active members of society. This is their gentle, silent revolution. By doing our daily work, we are helping fight this great battle. The women working with us today are no longer a "tolerated exception" to the rule. They are quickly becoming respected members of their communities, promoters of change, and an example for overcoming traditional roles.

This report does not aim simply to recount our work at EMERGENCY's Maternity Centre. The real heroes are the 350 women who have helped us, told us about themselves in whatever way they could, and brought us into their lives from our privileged position at the hospital in Anabah. They have showed us a reality completely different from the stereotypes. **We owe them an enormous thanks, along with everyone else who has worked with such passion and professionalism on this project.**

1. THE REPORT

a. MATERNITY AS A BENCHMARK TO ANALYSE THE GENERAL LIVING CONDITIONS OF WOMEN IN AFGHANISTAN

For two decades, the status of women has been one of the most prominent topics in the discussion around Afghanistan. **The country is often described through the lens of religious conservatism, endless conflict and the role of women in society.** The same attention has been paid to the process of 'social reconstruction' which began in 2002 with the support of the international community. The objective of this process was to bring about a 'cultural revolution', guaranteeing a more proactive and pivotal role in society for women, who were finally acknowledged as a key element in the country's progress and development.
Since 2011, the Afghan Ministry of Women's Affairs (MOWA), has been regularly publishing data on gender issues (the 'Women and Men in Afghanistan' series).[1] The surveys carried out on the social conditions of the country's population have increasingly paid attention to women's issues - not only maternal healthcare but also education, employment and their role as decision-makers within the family and society.
While interest in those Afghan women who have attained leading roles in the public and political spheres is well-grounded, considering this small, elite group cannot give a representative picture of the female population at large. **What brings together most Afghan women is their relationship to motherhood. It is therefore difficult to discuss the condition of Afghan women without touching upon this subject.**
The contemporary experience of motherhood in Afghanistan is grounded in economic and health concerns. As in other low-income countries that lack strong health and welfare systems, **giving birth to many offspring is often seen as an important way to weave a social net capable of providing income and assistance to elderly or vulnerable relatives across multiple generations. Infertility can become a family tragedy: instances of divorce and polygamy are rooted in the need to have a large number of children.**
The impact of this, as well as the dire condition of the health system, has prompted the international community to invest considerable resources in maternal healthcare in Afghanistan.[2] This development plan, though still an ongoing process, has enormous potential. This is because, firstly, it seeks to improve healthcare directed at mothers and babies, but also because **maternal care represents, due to cultural sensitivities, a large professional niche where women can be employed**. Thanks to the requirement for female personnel in this field, maternal care is an important way in which Afghan women can access specialised training and employment.

With this in mind, a Maternity Centre situated in rural Afghanistan provides an ideal observation point for understanding the status of women in the country. It is a place where Afghan women embody their social roles in a new and innovative way: the patients belong to the growing number of mothers who decide to give birth in a hospital assisted by skilled birth attendants, and the medical staff is comprised of female workers whose profession affords them an increased level of autonomy and social status inside their family and society at large. **The report aims to investigate if the EMERGENCY's approach in this area of Afghanistan can provide a model to be replicated in other areas of the country and beyond. It also aims to explore how the societal role of the women that come into contact with EMERGENCY's facilities has been impacted by the assistance offered to patients, and by the training provided to female healthcare workers.**

b. METHODOLOGY

The research was carried out between mid-August and October 2018. The information that was collected consisted of:

1. A quantitative questionnaire aimed at **300 patients who had recently given birth at the Anabah Maternity Centre**, that were previously trialled in order to verify cultural and linguistic suitability;
2. A quantitative questionnaire aimed at **50 female healthcare workers at the Anabah Maternity Centre and surrounding FAPs/PHCs** (midwives, nurses and OB&GYN residents), that were previously trialled;
3. **Semi-structured interviews with 20 female healthcare workers at the Anabah Maternity Centre**, following up on the answers provided in the questionnaire;
4. **Semi-structured interviews with EMERGENCY's international healthcare workers.**

Additional information was collected through a review of the literature available, and with several interviews with other EMERGENCY staff members, key interlocutors within the Ministry of Public Health and other informed government officials.

The questionnaires were distributed to the patients by a team of five Afghan female healthcare workers who had been trained for the purpose, and were explained to the respondents in their preferred language, Dari or Pashto. The interviews were carried out by the lead researcher in the interviewee's preferred language. All respondents, both patients and staff, were informed of the purpose of the questionnaire and gave oral consent to participate anonymously.

Data from the questionnaires was entered into computerised databases between October and November 2018 and formed the basis for the subsequent analysis. Findings from the questionnaires were discussed with EMERGENCY healthcare workers and compared with health data and indicators from the Anabah Maternity Centre.

In certain instances, selective use of data from the staff questionnaires was made in order to allow for a comparison with the patients' questionnaires. For instance, in the section of the questionnaire focused on household decision-making, only the answers of those female healthcare workers who are married were taken into account, while the answers of unmarried staff members were excluded.

The survey covers only a circumscribed area of Afghanistan, though a representative one. The home districts of the patients surveyed are representative of the population of central Afghanistan – including Kabul and the surrounding areas – yet also include several areas affected by extreme poverty, remoteness and insecurity (see *Background Reading*).

In terms of the type of patients surveyed, the largest risk of potential bias came from the fact that, in order to avoid placing additional stress on women shortly after childbirth, the interviewers waited until potential respondents were relaxed enough to face an interview. Therefore, the group of respondents may have been disproportionately comprised of, firstly, women who did not face excessive complications during childbirth and who were therefore happy to respond to the questionnaires shortly after delivery, and secondly, women who had spent a relatively long period of time in the hospital because their newborns were kept in intensive care for more time.

Finally, respondents were aware that the research was being carried out by EMERGENCY, and therefore the desire to comply with the imagined expectations of the interviewers might have influenced some of their answers.

c. KEY FINDINGS

The research carried out at the Anabah Maternity Centre provides illuminating insights into the lives of both patients and female healthcare workers. They show how adequate maternal healthcare represents a factor for the empowerment of women in the area, in terms of both health and professional attainment.

CONSTRAINTS IN HEALTHCARE

Lack of security still constitutes the main obstacle to accessing healthcare: 40% of the patients cited it as their primary concern, compared to 31% who cited family opinion/cultural issues, 10% who mentioned distance and 8% costs.

The proportion of patients at the Anabah Maternity Centre who have carried out at least four Antenatal Care (ANC) consultations is relatively high, at 36.6%; this is more than twice the national average of 18%.[3]

WORK AS AN EMANCIPATING FACTOR

Medical professions have traditionally been among the few viable careers for women in Afghanistan. Despite initial prejudices, female healthcare workers' local communities have in time become supportive of their professional choices, as locals can benefit from the presence of highly-skilled birth attendants and healthcare workers, as well as their financial contribution.

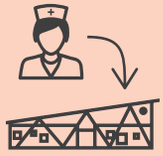
Female healthcare workers reported experiencing newfound respect and social status in their communities, and an increased role in the decision-making processes of their households. In turn, they are better equipped to raise awareness around maternal healthcare and to encourage other women from their villages and neighbouring areas to follow in their footsteps. While, among patients, only those with a high level of education reported having a reasonable chance of rejecting family decisions (46%), among EMERGENCY staff, the proportion of women with this level of autonomy represents a clear majority (61.5%).

IMPACT OF EDUCATION

50% of the patients interviewed have no formal education, though this percentage drops to 27.7% when accounting only for those living in urban areas. Women with a high level of education, and in particular those who work outside the home, are more capable in making autonomous decisions on various matters such as healthcare, the household, and having children.

ADDED VALUE OF EMERGENCY

The main reasons why women would return to the Anabah Maternity Centre are: safety of the environment (20%), attitude of the staff (19%), free-of-charge care (16%), 24-hour care (15%), and high-quality professional skills and technology (12%). The perceived safety of the Anabah Maternity Centre rests on both the total ban on weapons inside its premises and on the presence of an all-female staff.



The main reasons why female healthcare workers at the Anabah Maternity Centre choose to work for EMERGENCY are: safety of the environment (18%), high-quality healthcare (17%), the training offered to staff (16%), appropriate work environment[4] (14%), salary (11%), and an international work environment (8%). The possibility of gaining more varied experience, and at a faster rate, compared to other hospitals also seems to play a major role in their choice.

58% of female staff reported being the first woman in their family to work, and 53% reported being their family's main breadwinner.

2. THE AFGHAN CONTEXT

a. THE IMPACT OF WAR ON HEALTHCARE

2019 marks the 41st consecutive year of war in Afghanistan. For most of that period, **the country has been devastated by full-scale wars that have resulted in huge material and human destruction, with millions of people being killed and even more people becoming internally displaced or being forced to flee the country**.[5]

The war in Afghanistan began in the 70s. Since 2001, with the US invasion of the country, followed by the forces of the so-called 'International Coalition', the most recent phase of the war has been fought between the coalition-backed Afghan government and the Taliban.

Since the completion of the scheduled transition of security responsibility from international forces to the Afghan forces in 2014, the Armed Opposition Groups (AOGs) have stepped up their military efforts and the once-asymmetrical war has increasingly turned into a pitched battle between the Afghan National Security Forces (ANSF) and the Taliban for control of the territory and the lives of its inhabitants. **Military and civilian casualties have soared, reaching a record death toll of almost 10,000 per year for security forces on the government side, and over 3,800 civilian deaths in 2018 alone, the highest number of casualties in any one year since records began. Furthermore, 7,189 civilians were wounded that year, amounting to a total of 10,993 war victims among civilians.**[6]

The Afghan government is heavily dependent on foreign aid, with around 66% of its budget for the Afghan calendar year 1396 (March 2017-February 2018) being funded through international donor support.[7]
A significant reduction in aid, the expectation of further cuts ahead, and the increased internal political and military challenges that have characterised the last few years, have put the Afghan government under tremendous pressure (see *Background reading*).

Many factors have endangered the Afghan situation: blurred distinctions between combatants and civilians as the conflict has increasingly been outsourced to local paramilitary actors; the emergence of more radical and brutal militant groups; the disruption of existing infrastructure and the lack of reconstruction; increased travel risks as frontlines continue to shift; difficulties in delivering services on the part of a government focused on military survival; and increased risk of being targeted as one of the few international humanitarian actors who remain in the country. **Healthcare quality and access to medical facilities have been negatively affected by this situation**.

Healthcare has been used by both opposing sides as one of the main assets that could win them the support of local communities. The AOGs, with the exception of ultra-radical groups like Islamic State (Daesh/ ISKP in Afghanistan), have come to tolerate, if not encourage, the activities of NGOs and other healthcare humanitarian actors in the territories they control. Despite this, **medical facilities and personnel are more vulnerable to the risk of violence, not to speak of patients when they need to travel. Hospitals have been subjected to search operations by government forces, fired upon or used as fighting positions during clashes by both the ANSF and insurgents, hit by attacks or airstrikes, or simply abandoned by medical staff due to their lack of security.**
Healthcare workers have frequently been subjected to threats and have been targeted by abductions and killings, with **59 security incidents aimed at health centres and healthcare workers in 2019 as of the end of June**.[8] In particular, there have been incidents connected to foreign organisations at the hands of Daesh/ISKP.[9]
Progress in the healthcare sector has been made at an uneven pace across the country since 2001. The most conflict-affected provinces have lagged behind from an early stage and, as insecurity spreads, they risk falling further behind.

b. MATERNAL HEALTHCARE: A LONG WAY TO GO

Forty-one years of war have seriously damaged the country, including the national health system. Certain gaps in the Afghan public health system are deep rooted. A study by the London School of Hygiene and Tropical Medicine stated that *"Although Afghanistan remained free of war throughout the 1960s and 1970s, health statistics occupied no higher a ranking amongst other countries in the region, or even amongst developing countries as a whole, as they do today. Child mortality was 30% higher than the average of the least developed countries in 1960 and 61% higher than the average for developing countries. Health care, largely provided by the government, was largely absent in rural areas (...)".*[10]
Recent conflicts have prevented investment and improvement in the health system. In particular, women's living conditions have worsened due to strong limitations on their access to healthcare and the difficulty in training new female healthcare workers.

At the turn of the millennium, afghans health conditions were among the worst in the world[11]:
- Life expectancy at birth was slightly higher than 40 years for both sexes;
- Maternal mortality was among the highest in the world (1,600 maternal deaths every 100,000 live births);
- Child mortality was also severe, with almost 4 in 10 children dying before the age of 5.

Since 2003, some attempts have been made to upgrade public health services. Two national programmes were implemented to meet these needs: the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The BPHS programme identified an essential package of health services including maternal and neonatal health. EPHS, developed later, aimed to complete the design of the national health system, establishing "the standards for the hospitals of the country".[12]

Today, in spite of a large number reports on Afghanistan, the overall picture of the country remains vague.[13] **The true extent of people's needs is difficult to define: there is little comprehensive national data, and many war-torn areas remain difficult to access.**

Uncertain and contradictory data has been published on maternal mortality, and no analyses on the long-term consequences of inadequate care, such as maternal, neonatal or infant disability, and the impact of maternal death on under-5 mortality of the surviving, are available. All existing reports present serious limitations in terms of data quality.
Afghan women remain a vulnerable category in society. Maternal and neonatal health still poses a major obstacle in Afghanistan's path towards equality and the fulfilment of human rights.
Adult mortality rate distribution per sex is staggering: **in reproductive age (between 15 and 49 years old), female mortality rate is 50% higher than male mortality rate**. According to a survey recently carried out by United Nations Population Fund (UNFPA) in six Afghan provinces, half of the women who die in their reproductive age do so due to pregnancy-related reasons. Furthermore, out of 2,000 pregnancy-related deaths in a two-year period, more than 50% occurred during delivery.[14] The latest national Demographic and Health Survey stated that for every 100,000 live births, 1,291 women die during pregnancy or the post-partum phase.[15] This means that one in 14 women die either during pregnancy or giving birth.[16]
Figures are similarly dire for newborns and children: **1 in 18 children die before their fifth birthday, and most of them (around 80%) within their first year of life. 1 in 45 newborns die during the first month of life**.[17]

There are many factors that underlie these rates, most of them avoidable. The high fertility rate implies per se a significant risk of a complicated pregnancy or post-partum. The use of health services to prevent or diagnose and treat pregnancy-related problems is still low, especially in rural areas. Most women do not undergo the prescribed routine controls in pregnancy, and the rate of home deliveries is almost double in rural areas. The number of caesarean sections carried out in rural areas is four times lower than in urban settings. The practice of adolescent or child marriages is much more common in rural areas, where the rate of pregnancy during adolescence is higher.[18]

3. A WOMEN-RUN CENTRE FOR WOMEN

EMERGENCY first established operations in the Panjshir Valley in 1999, during a period of fighting between the Taliban and the Northern Alliance. The Valley, 200 kilometres north of Kabul, was difficult to access. At that time there were few roads, no electricity and no sanitation system. About 200,000 people were living there on subsistence agriculture and grazing. Additionally, a new Taliban offensive had brought another 50,000 displaced people to the region. It became clear that a hospital was needed to support the population living in this area.[19]
EMERGENCY opened a **Surgical Centre for War Victims in Anabah**.
At the same time, **a number of First Aid Posts (FAPs) and Primary Health Centres (PHCs)** were created in order to reach the most inaccessible areas, guarantee basic healthcare services and stabilise the wounded before they were to be transported to the hospital. This network within the region has then expanded from the initial 5 to the current 18.
From 2001, as the war entered a new phase, the number of wounded civilians in the region began to decrease. However, the medical needs of the population were still significant, especially for women and children.
In 2003, EMERGENCY opened a Maternity Centre beside the existing Paediatric and Surgical Centre. As of today, the Maternity Centre remains the only specialist, free-of-charge facility in the area. It offers gynaecological, obstetrical and neonatal care, as well as family planning and contraception services. Furthermore, the hospital serves as a training centre, accredited by the Ministries of Public Health and Education, for Afghan staff, exclusively made up of over 100 women who receive theoretical and practical training from international health professionals. To date, hundreds of nurses and midwives, and several medical doctors have been trained there.

The FAPs and PHCs also play an important role in maternal healthcare. They provide services for pregnant women and follow-up for hospital patients.

18 FAPs and PHCs operate in the areas surrounding the Anabah Maternity Centre and cover four provinces (Panjshir, Parwan, Kapisa and Badakhshan). Six of these facilities have a permanent midwife presence, while the midwives at the Maternity Centre take turns to visit the clinics on a rotational basis. They offer free-of-charge 24/7 referrals to women in labour or with complications. The main point of contact with the Maternity Centre is the PHC in Anabah. For six days a week, two midwives and a gynaecologist from the hospital work at this clinic, referring women to the Maternity Centre in case of complications or when a secondary-level consultation is required, such as an ultrasound.

As of 30 June 2019, the Anabah Maternity Centre had performed over 351,520 medical consultations and delivered 56,329 babies. The Centre has become the reference point for neonatal and maternal care in both the Panjshir Valley and neighbouring provinces.
With ever-increasing demand, **EMERGENCY inaugurated a larger building in 2016, with 56 beds for women, 44 for newborns, four delivery rooms, and two operating theatres for both emergencies and ordinary elective surgery. An observation semi-intensive care unit allows for the treatment of more serious complications. The neonatal unit includes intensive and semi-intensive care units, an isolation room, an observation area, and a 'Kangaroo Mother Care' room for premature babies**. **The new structure has the capacity for 650 deliveries per month**, which includes dealing with numerous complicated pregnancies resulting from the difficult living conditions that many mothers in Afghanistan encounter, and the deficiencies in the national health system, especially when it comes to the needs of pregnant women.

The new hospital was dedicated to Valeria Solesin, an EMERGENCY volunteer who was tragically murdered during the Bataclan terrorist attack in Paris on 13 November 2015.

TECHNICAL DATA 2018

TOT DELIVERIES **7,560**	TOT BORN ALIVE **7,139**	
CS RATE **6.2%**	VBAC **85%**	EPISIOTOMY **8%**
0.4% 3RD/4TH DEGREE TEARS		
6% OPERATIVE VAGINALLY DELIVERIES (VACUUM)		
91.5% BREECH DELIVERED VAGINALLY		
93.7% TWINS DELIVERED VAGINALLY		

4. BEING MOTHERS IN AFGHANISTAN: A VIEW FROM THE FIELD

This chapter is based on semi-structured interviews of EMERGENCY's international health workers, who recalled their experiences of working at the Anabah Maternity Centre and the patients they had treated there.

Afghanistan can be termed a land of mothers: a primary concern for women in society has been to become mothers and give birth several times. This crucial role in Afghan society is not protected as it should be. Despite the declared success of public investments in this sector, the situation does not seem to have improved enough when maternal mortality data is considered (see *Background Reading*). Maternal survival relies on the availability of skilled assistance at birth. Therefore, the provision of skilled healthcare workers working in well-equipped and organised facilities is crucial. However, efforts to build a comprehensive system seem still far from succeeding.

a. TRADITIONAL PRACTICES VERSUS INTENSE MEDICALISATION

Afghan population displays a combination of two extreme approaches towards the experience of pregnancy.
On the one hand, traditional practices and low education rates mean that, for some women, pregnancy – at all stages – is a private, domestic event; whilst for others, the wide availability of drugs, new technologies, and medical treatments feed the anxiety to try and ensure a healthy and successful pregnancy. This combination of extremes shows specific asymmetries between urban and rural areas, as well as between the wealthiest and the poorest strata of the population.

According to AfDHS (Afghanistan Demographic and Health Survey) 2015, **half of Afghan women give birth at home**. However, this figure becomes more complex when moving from the general picture to the local reality. **Women living in rural areas, who are some of the least educated and poorest people in the country, are most likely to have a home delivery.**
The gap between rural and urban home deliveries cannot simply be attributed to a lack of education and awareness alone. There may also be serious challenges in reaching medical facilities due to a lack of transportation, costs or security concerns. Many public facilities, require patients to pay, and they are often underequipped and understaffed.

> *During the night I was called for an emergency: a woman with convulsions. She had suffered 18 episodes of fits since the morning, but the family had not been able to reach the hospital sooner as the AOGs were blocking the roads. I diagnosed her with a very severe case of complicated hypertension (eclampsia) and treated her immediately. The baby was born premature with breathing difficulties, and died almost immediately, while the mother survived: she had a stroke that impaired her movement, but she went back home on her own feet. It was a miracle.*
>
> Laura | obstetrician

Furthermore, a previous bad experience in a health facility can discouraged women and their relatives from making a long and arduous trip unless the situation became dangerous or complicated. Home birth attendants are an alternative to hospitalisation. They are known in the community and, furthermore, allow the birth to remain a domestic, intimate event, but with the addition of some basic skilled support.

The Afghan government is aware of the barriers to hospitalisation for pregnant women, especially in remote areas. For this reason, rural assistants, most of whom lack specific training, are a makeshift solution to compensate for the widespread absence of a national health system.
For women who give birth at home, especially in remote areas, the chances of reaching a proper facility in a reasonable timeframe in case of complications are low. Complications are unpredictable and can quickly reach a stage that puts the mother, child, or both, in danger. At the Anabah Maternity Centre, patients often arrive in a life-threatening condition, some of them arising from simple problems that could be solved straightforwardly and without harm if treated promptly in the right place. Our experience has shown that domestic management of birth also accounts for a good share of pathologies in newborns: from in utero death to neonatal death or long-lasting neurological impairment due to delays in appropriate interventions. **Risks that can arise from the presence of unskilled birth attendants include the use of dangerous drugs, which are available on the market or even distributed by the Afghan Ministry of Public Health.**[20] Due to significant gaps in the implementation of the law, the drug market is *de facto* unregulated: all that is needed to access drugs that, in other countries, are only permitted for hospital use, is cash.

> *A lot of women, during labour, ask for an injection referred to as "*pichkary*": they want us to speed up the birth. We found out what they mean: oxytocin! It seems that it is common practice for this drug to be administered by home attendants. The WHO has declared Oxytocin as one of the most dangerous drugs in the world. We use it in hospitals under very strict surveillance. It is shocking, but it is the reality of what happens outside these walls.*
>
> Manuela | midwife

Recent years have seen a proliferation in the types and number of drugs, medical treatments and facilities that are easily accessible for people who are able to pay for them. As childbearing is such an important aspect of life, it is becoming an expanding frontier in the market economy. Time and time again, EMERGENCY staff have heard from patients that family and social pressures are the primary causes of two main concerns for Afghan women: to get pregnant and to deliver a healthy baby.
Many women undergo multiple C-sections. While safe caesarean sections are rarely available in rural areas, the procedure is carried out at an alarmingly high rate in major urban hospitals.
Caesarean sections can be dangerous and are only justified when strictly necessary: a scar on the uterus can be a risk for future pregnancies.
An additional complicating factor is that when a woman undergoes surgery she may obscure this information when seeking care in later pregnancies. Most patients seem to understand pregnancy and birth as natural events that shouldn't require medical intervention, and thus fear having to undergo a surgical operation. This often pushes those who have already experienced a previous surgery not to cooperate with doctors, or even to stay away from hospitals.

> *We received a patient in shock, bleeding: we rushed her into the operating theatre and found a ruptured uterus and a dead baby. It was not possible to repair the uterus, so I had to remove it. Once she recovered completely, she said that she had received a caesarean section in a previous pregnancy. She had started to develop strong pain and bleeding for hours, but her mother-in-law had refused to give her permission to go to the hospital: the family wanted her to deliver normally, and they were scared of the hospital. Nonetheless, the patient was happy, as she realised that she could have died.*
>
> Keren | obstetrician

b. ANTENATAL CARE

A growing number of women are beginning to use the antenatal care services provided by the Ministry of Health and NGOs. Nevertheless, **many women arrive at the Anabah Maternity Centre for antenatal visits late in their pregnancy: in these cases, preventive measures and early diagnosis of most diseases are not possible.** Nonetheless, this at least offers an opportunity to meet with the patient and ask them about their health and previous pregnancies. However, there are other challenges faced when gathering information. **Often, women are not sure of their own age**, especially those who live in rural areas. **Likewise, gathering information on previous pregnancies and births can be a long and complex exercise**, and the information can be imprecise and change during the in-patient period.

Women already receiving treatment for chronic diseases may often not have medical papers and be unaware of the names of medication they have been taking. Not rarely women decide to stop taking prescribed medication due to fears of potential harm to their child.

Dating pregnancies often proves difficult, if not impossible: many women are unable to pinpoint the time of their last menstruation and access antenatal care services too late. Examinations that are common in countries with better resources are unavailable in Afghanistan and if it is almost impossible to estimate the age of the foetus, the detection of malformations or congenital problems. It is not rare for a mother of twins to discover this fact in the delivery room.

c. MATERNAL FACILITIES

There are several types of facilities that offer birth assistance, ranging from district hospitals to small private clinics. They offer a wide array of care levels, both for mothers and children: **a woman may find herself in a facility run by midwives or health assistants that can facilitate basic care, but will not be able to provide the specialist doctors and technical resources required if complications occur. Newborns will often be unable to receive even basic primary care. At the other end of the spectrum, comprehensive maternal and neonatal emergency centres are places where, in theory, most urgent situations can be treated successfully: they are able to offer enough skilled staff and specific resources to manage both normal and complicated situations. However, not all of these facilities can guarantee all treatments 24/7. Often, there are shortages of drugs and disposables** (which the patient and her relatives may be forced to buy), but **the most concerning trend across the country is the lack of staff**, especially during night shifts and festivities. One of the consequences is delayed treatment, even for conditions that should be treated promptly. Often, patients and their relatives discover, after a prolonged period in the waiting room, that nobody is going to treat them, so they have to make a new trip to another facility, in the hope of finding someone there.

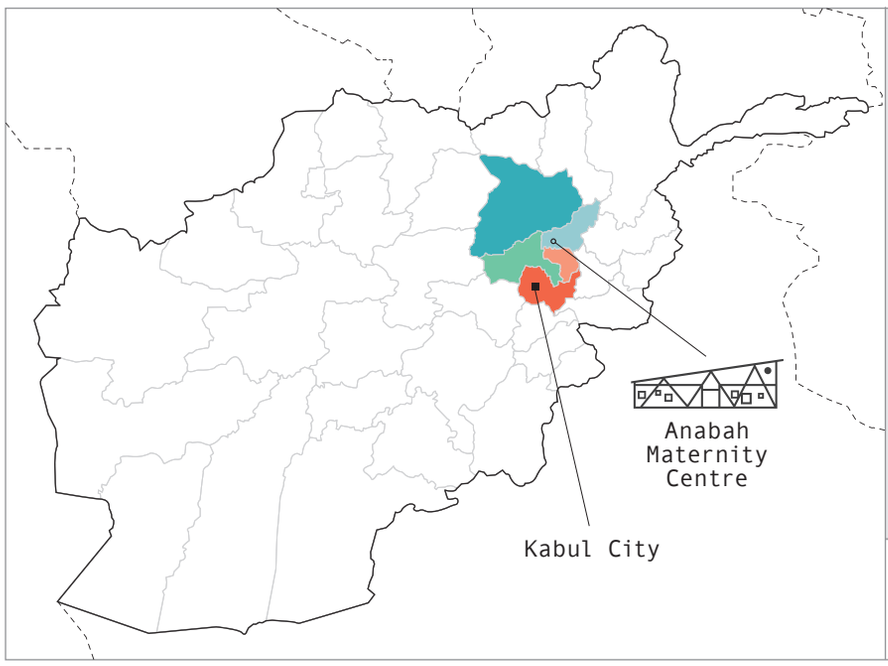
> *It was around 8.30pm, in June. They called "code 5" in the outpatient department: it's a code we use for emergencies that can develop into immediate death. We arrived immediately and she was not breathing, no pulse present. We tried resuscitation for 20 minutes, but there was no way. Her relatives told us that she had been bleeding since the morning: they came from far away in the mountains, from the Salang Pass. After some time, they had decided to bring her to another hospital where they had to wait for a long time without being seen by anyone. After a few hours, a woman told them that there were no doctors in the facility and sent them to us. But it was too late. She looked young, and had five other babies at home.*
>
> Eleonora | midwife

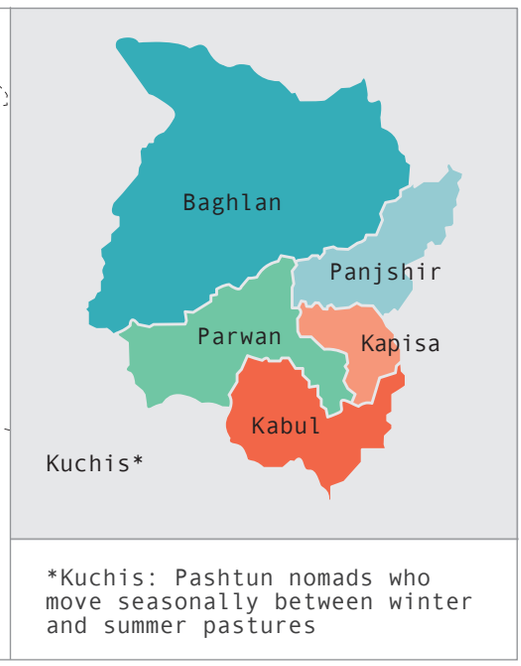

EMERGENCY
EMERGENCY
EMERGENCY

5. THE PATIENTS AND THE STAFF

The Anabah Maternity Centre serves a number of core provinces in central Afghanistan, namely Panjshir itself, neighbouring Parwan and Kapisa and, increasingly in recent years, Kabul Province.
Given the provinces' central location and their comparative internal diversity, including in terms of social and ethno-linguistic composition and of economic and security trends, patients coming from these areas offer a representative sample of Afghanistan as a whole.
The research involved 300 patients and 50 members of staff. All the patients who responded had given birth recently, ranging from a few hours to a few weeks before the interview.

The staff interviewed largely consist of midwives and nurses. A broad majority of them (75%) earned a midwifery or nursing degree after a 2 to 3-year course. Others (20%) received their training with EMERGENCY and started working at its hospital; after a period of two years they received their professional qualification by passing the state exam.
Among those interviewed there are also four of the resident doctors who are currently specialising in gynaecology at the Anabah Maternity Centre. They joined EMERGENCY after a 7-year medical degree and are specialising in Obstetrics and Gynaecology (4 years). Most of them come from Kabul, although their families are originally from Panjshir.



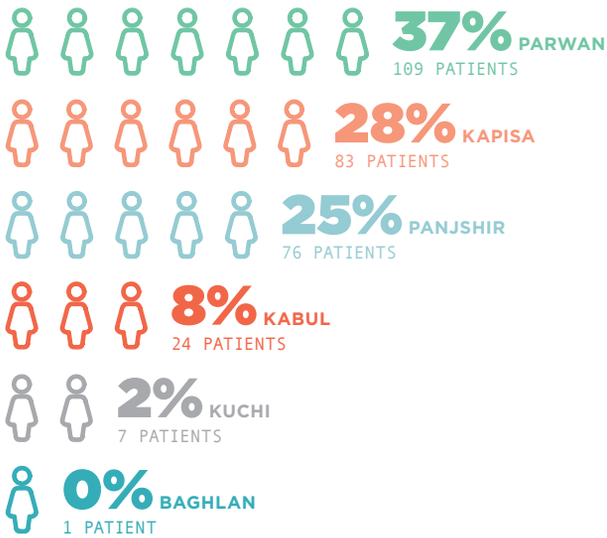


*Kuchis: Pashtun nomads who move seasonally between winter and summer pastures

a. PATIENTS PROFILE

ORIGIN

Most of the women interviewed are of rural origins. Just 36 out of 300 respondents come from an urban background – most of these come from Kabul province, and 15 women come from Charikar town in Parwan.

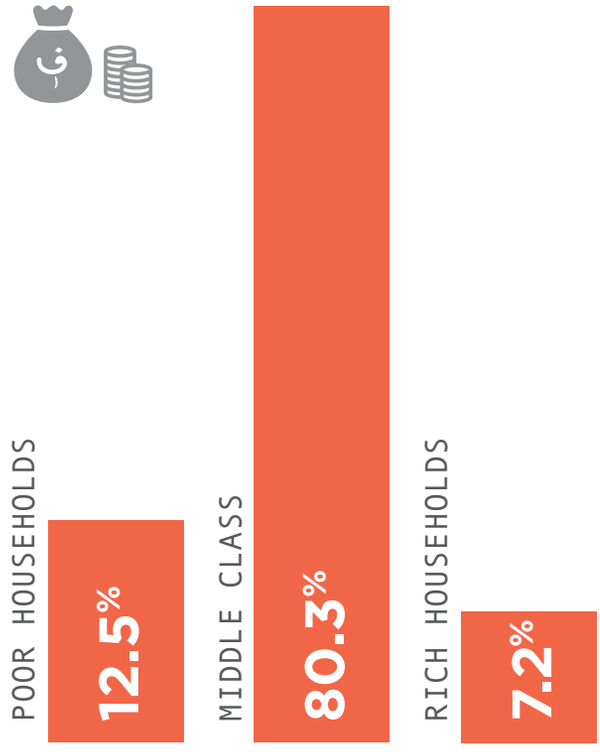


AGE

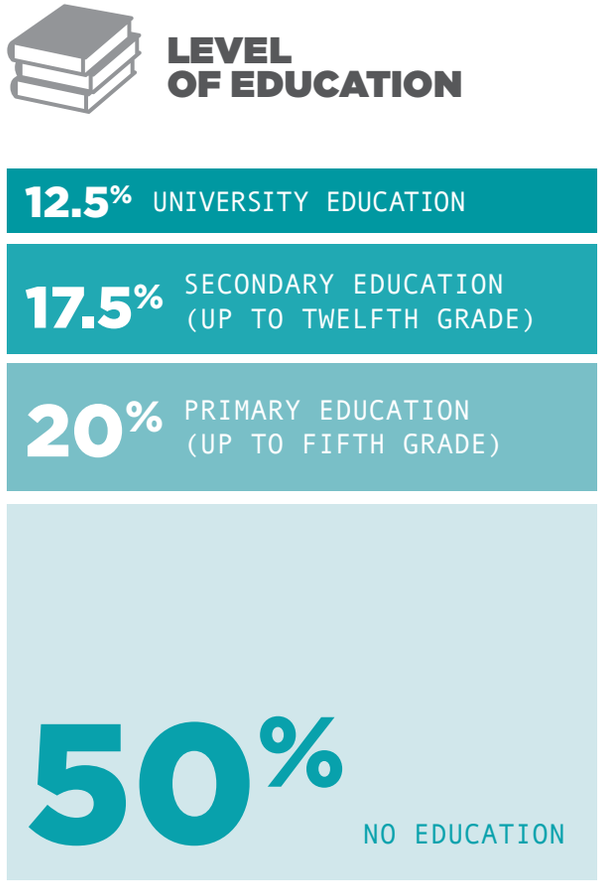
78% OF PATIENTS ARE BETWEEN THE AGES OF **18** AND **35**

15.3% of patients are over the age of 35, and 6.6% are under the age of 18. The latter come mostly from Parwan and from some districts of Kapisa, in particular Tagab, which, of all the districts included in the research, is the one most affected by conflict, lack of education and conservative customs surrounding women.

ECONOMIC BACKGROUND[21]

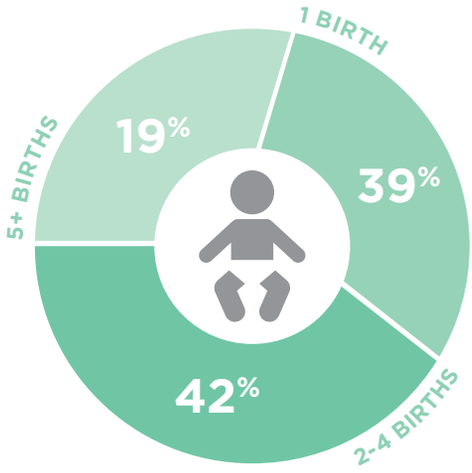


LEVEL OF EDUCATION



The three main provinces of origin of the respondents share similar socio-economic indicators and, to some extent, ethno-linguistic make-ups. Differences are more marked in relation to Kabul, where two-thirds of the women interviewed had at least a secondary education. Among those living in urban areas, 55.5% have at least a secondary education, while 27.7% have received no education at all.[22] At the opposite end of the spectrum, all Kuchi women reported having received no education at all, and a majority of them (5 out of 7) reported being poor.

BIRTHS PER WOMEN



71.7% OF THOSE OVER THE AGE OF 35 HAD GIVEN BIRTH 5 OR MORE TIMES

RURAL RESIDENTS WERE MORE LIKELY TO HAVE GIVEN BIRTH 5 OR MORE TIMES COMPARED TO URBAN RESIDENTS

20.6% VS **11.1%**

AGE AT FIRST PREGNANCY

68.6% BETWEEN THE AGES OF **17** AND **22**

b. STAFF PROFILE

ORIGIN

Respondents among the healthcare workers come from the same four provinces as the vast majority of the patients. 70% of those coming from Kabul are originally from Kapisa or Panjshir and moved to the city only recently. Some of them commute to the Anabah Maternity Centre on a daily basis while others are able to stay overnight in Panjshir.

34% KABUL
17 STAFF

30% KAPISA
15 STAFF

18% PARWAN
9 STAFF

18% PANJSHIR
9 STAFF

AVERAGE AGE

25.7 YEARS OLD

AMONG MARRIED WOMEN, THE AVERAGE AGE IS **28.8**

UNMARRIED FEMALE WORKERS ARE **23.6** YEARS OLD ON AVERAGE

TIME SPENT WITH EMERGENCY

Nearly half of the 50 healthcare workers interviewed have been working with EMERGENCY for a period of

1 TO 5 YEARS

Around two thirds of EMERGENCY's female staff are unmarried. The position of unmarried women in Afghan families is different to that of married women. Unmarried women live at home under the authority of their parents, but after marriage they tend to move in with their in-laws. For this reason, these two groups will be evaluated separately in the section on decision-making inside the household.

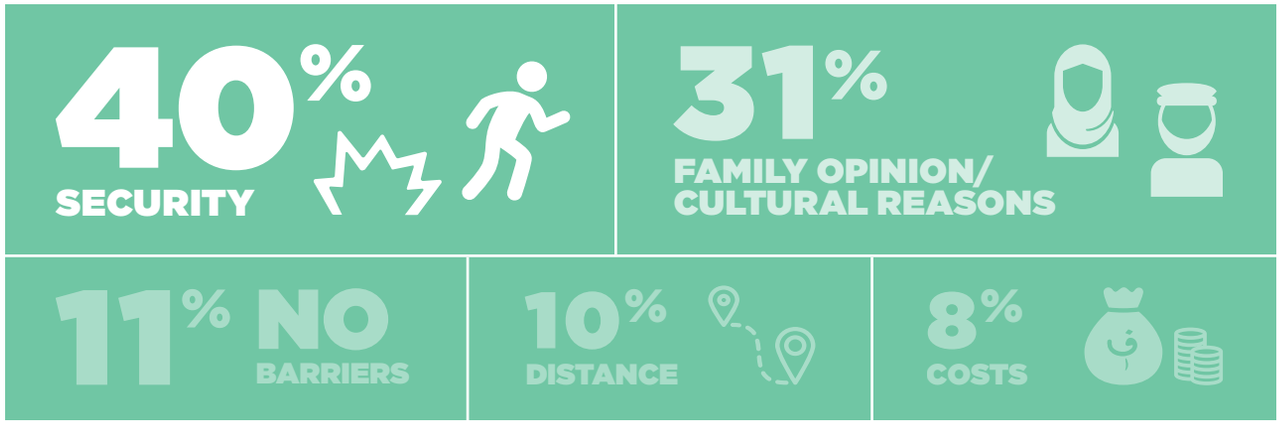
6. CONSTRAINTS IN ACCESSING HEALTHCARE

The regions surrounding the Anabah Maternity Centre present considerable differences in terms of women's ability to access healthcare.
Beside the major public hospitals near provincial capitals, there are villages dotted with small private clinics. Communities who live in remote mountain areas, however, have to walk for hours before reaching a tarmac road leading to a hospital.
There are also other types of distance to be considered: in some districts, high-intensity conflict prevent from moving. In particular, places like the Tagab, Alasay and Nejrab districts in Kapisa, or the Ghorband and Koh-e Safi districts in Parwan province are either largely controlled by AOGs or bitterly contested between AOGs and the government.

In these areas, residents are often discouraged from making all but the most necessary trips to hospital due to fighting, landmines and Improvised Explosive Devices (IEDs) along the roads, the risk of being stopped and harassed at checkpoints, or the suspicion that people who move across the frontlines are acting as spies for one of the parties in the conflict.
Cultural restraints play a major role in keeping women at home, hugely so in some cases. One of the most widespread cultural traits among Afghan communities is for the so-called "women's modesty" to be considered the repository of family honour. This, often results in attempts at reducing all female movements outside the house.

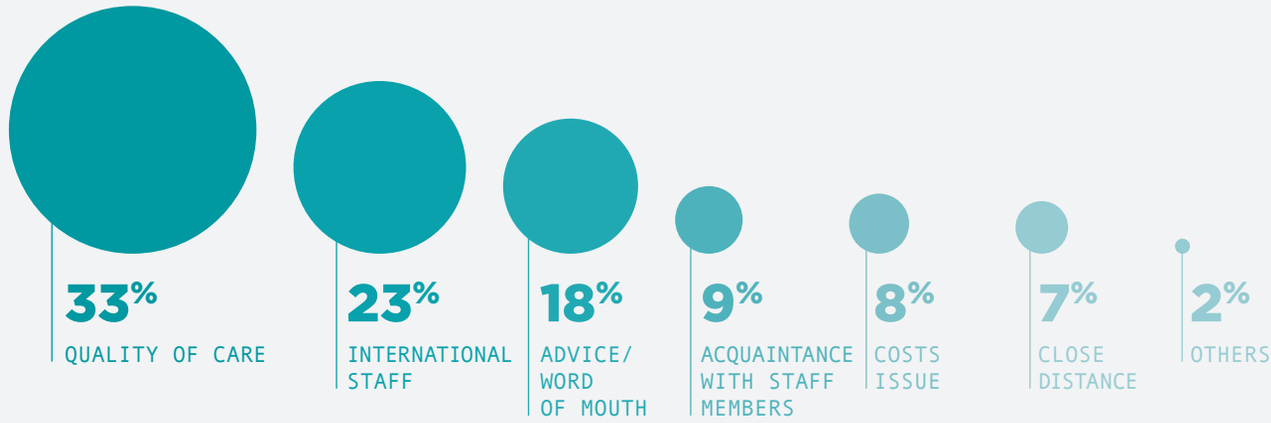
> *A lot of people think it's unnecessary for women to go to the hospital during pregnancy or childbirth; even elderly women say 'What's wrong with you? We didn't go to the hospital when it was our turn to give birth'.*
>
> Afghan midwife
> from Kapisa Province

ACCESS TO HEALTHCARE (for rural and urban women)



Security is the main issue affecting access to healthcare. According to respondents, physical distance is only a secondary issue when access to healthcare, accounting for just 10% of their responses. For residents of urban areas in particular, distance was no issue at all (2.7%) and family opinion and cultural issues presented a minor obstacle in accessing healthcare (16.6% and 9.5% if only those from Kabul city are considered).

CHOICE OF MEDICAL FACILITY



Once a decision is made to visit a healthcare facility, the choice of where to go is informed by many factors. **Respondents identified the most important criteria as being the high quality of healthcare provided; another important factor included the presence of international staff, seen as a guarantee of such quality.** Some factors were not originally included in the list of suggested options but were cited by patients; the most frequent were the availability of high-quality medications, a recurrent concern in a country swarmed with low-quality drugs, and the presence of an all-female staff.

Considerations of cost and distance, though obviously playing a role, were deemed less important. Naturally, their relevance is greater among respondents from poor households (the frequency of responses related to financial considerations doubles, from 8 to 16%).

a. THE COSTS OF ACCESSING HEALTHCARE

Cultural biases may have caused respondents to downplay the importance of costs, which certainly play a major role in informing decisions about healthcare, especially in cash-strapped rural areas. **The costs of accessing healthcare in Afghanistan are multi-layered, comprising transportation, medical fees (in private hospitals only), food, accommodation, and all tests and medications.**

Before arriving at the Anabah Maternity Centre, respondents reported having spent sums ranging from 250 AFS to 22,000 AFS (between 3 USD and 272 USD) on that pregnancy or during a previous experience, with an average per-capita expense of 2,425 AFS (32 USD). This is no small expense in a country where the annual percapita income is around 550 USD and many government workers such as teachers or policemen are paid a little over 100 USD per month.[23]

On average, women who delivered at the Anabah Maternity Centre had spent 1,050 AFS (13 USD) on transportation to reach the hospital.

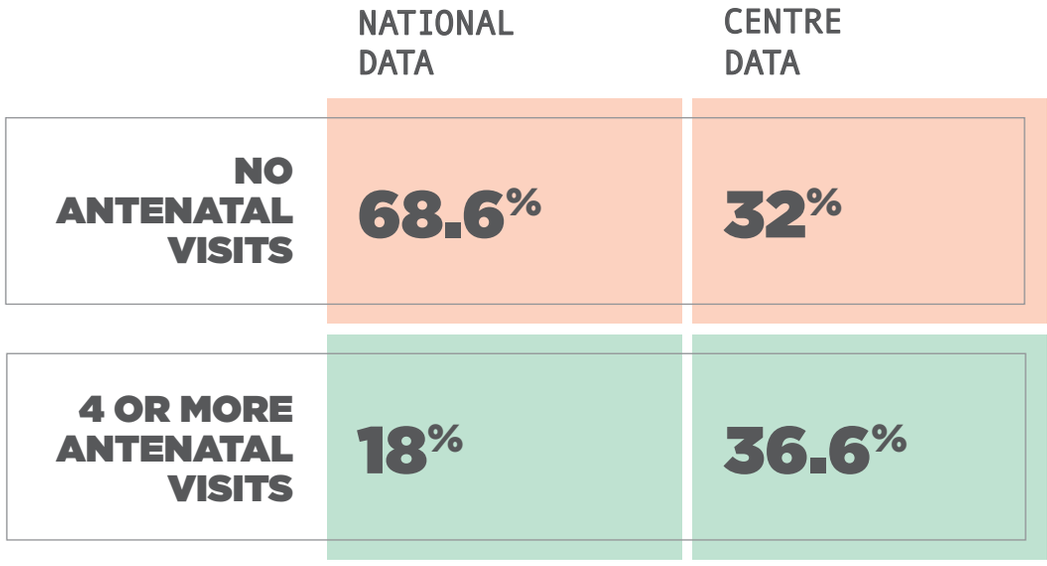
Only 26 women out of 300 had travelled by private cars and were therefore unable to quantify the cost. Residents of remote or mountainous districts like Salang or Ghorband in Parwan Province or the Tagab, Nejrab and Alasay districts in Kapisa often reported very harsh travelling conditions. They had travelled on mountain tracks, to the nearest road and had then hired a taxi. While for a majority of the patients (53.4%) the trip to the hospital or to the FAP/PHC had lasted less than one hour, for some it had been considerably longer, in some cases up to 8-9 hours.
On average, women who came to the Anabah Maternity Centre had spent 1.5 hours travelling.

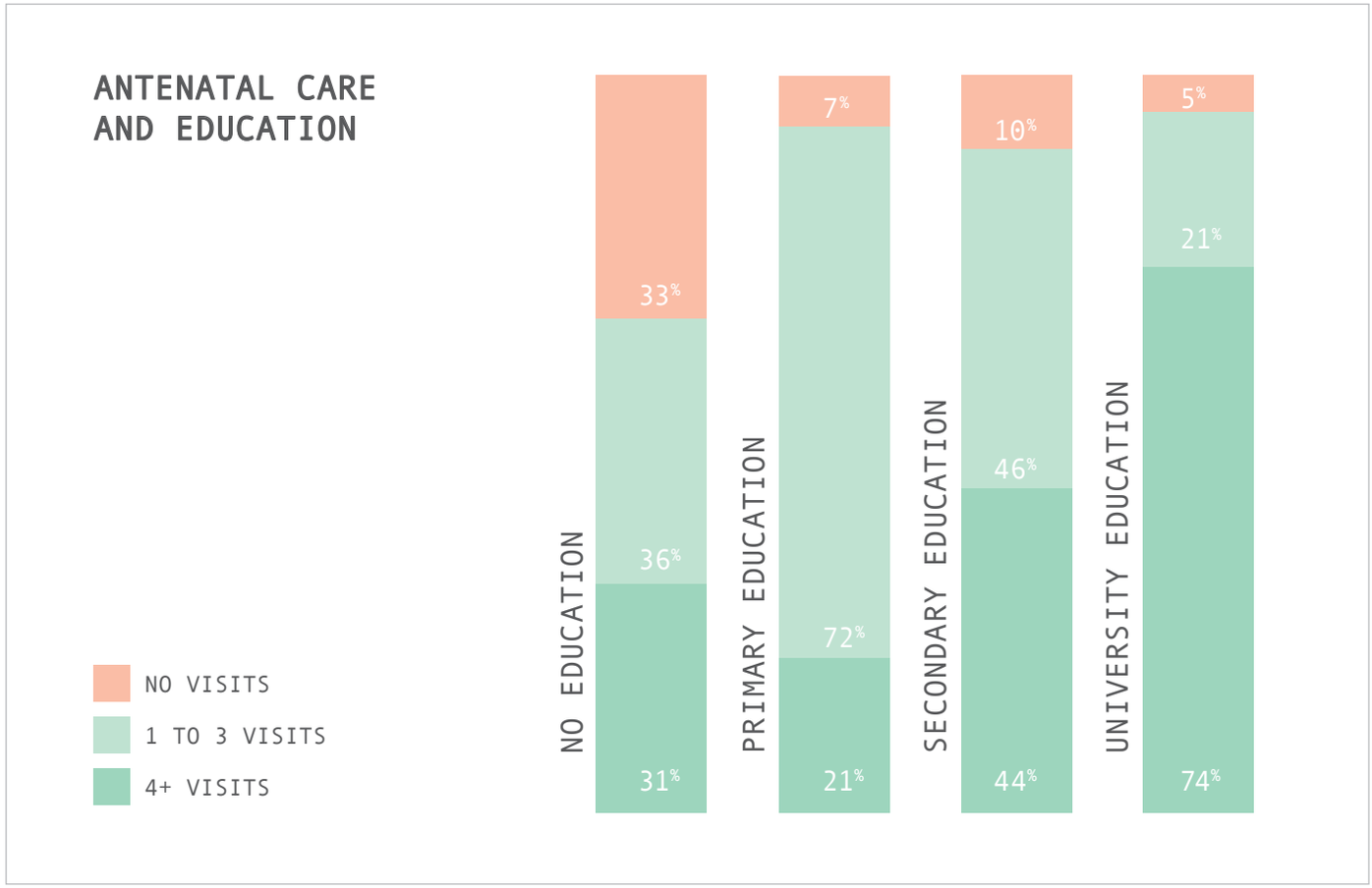
b. DIFFICULTIES IN ACCESSING ANTENATAL CARE

In terms of antenatal care, patients who came to EMERGENCY fared well compared to official national trends.

Rural areas, do show disparities, with districts showing specific trends according to conditions: Anabah in Panjshir recorded an outstanding 86.6% of women who had completed four or more ANC visits, a feature that is not surprising given it is the district that hosts the EMERGENCY FAPs and hospital. Tagab in Kapisa, at the other end of the spectrum, recorded only 11%.

Despite ratios above the national average, one fifth of the women who came to deliver at the Anabah Maternity Centre had not completed any ANC visits at all. **Education and wealth are also considerable influences on women's decisions and ability to complete ANC visits.**



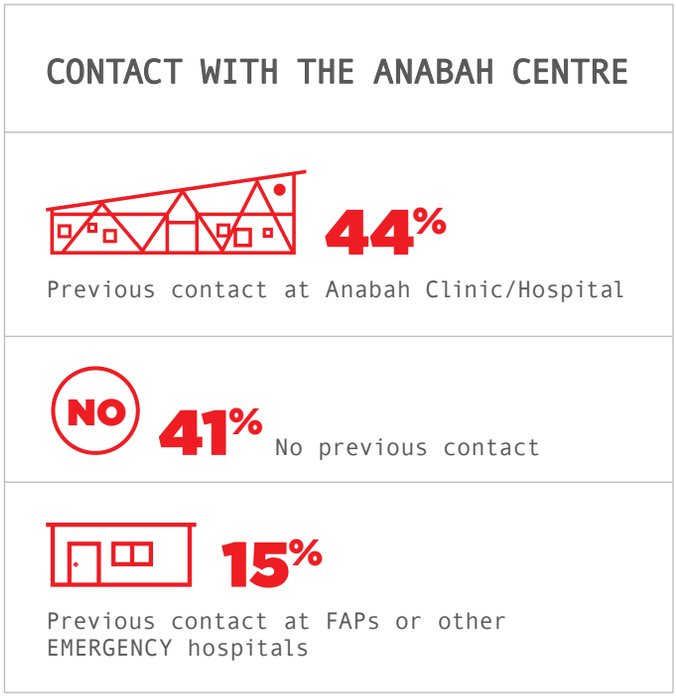


Many of the women who came to deliver at the Maternity Centre in Anabah had already contacted EMERGENCY during their pregnancy for ANC visits; this was true for 43% of those who received ANC visits).

In some cases women came to EMERGENCY after having first approached a health centre or a private clinic closer to their homes and having had a negative experience there, or after discovering complications in pregnancy.

7. WHY CHOOSE THE ANABAH CENTRE

A majority of the women who gave birth at the Anabah Maternity Centre had already got in touch with EMERGENCY healthcare workers beforehand (58.5%).



Patients' first contact with EMERGENCY was usually made at the Anabah PHC or Maternity Centre (this was true for 73.5% of those who had such contact) or at those FAPs/PHCs which offer midwifery services. In a few cases, the first point of contact had been EMERGENCY's Surgical Centre for War Victims in Kabul. Women coming from Anabah or the neighbouring districts – like Rokha and Bazarak in Panjshir, Kohistan 1 in Kapisa, or Jabal ul-Seraj in Parwan – were most likely to have had previous contact with EMERGENCY. In comparison, fewer of those coming from more distant districts – like Tagab in Kapisa, or Ghorband in Parwan – had previously had contact with EMERGENCY, and some even expressed their hope that FAPs/PHCs be established in their home districts to allow local women to complete ANC visits. Because of the costs and the risks associated with traveling, residents from those districts generally make the trip to Anabah or to an EMERGENCY FAP or PHC only for delivery, or in case of complications.

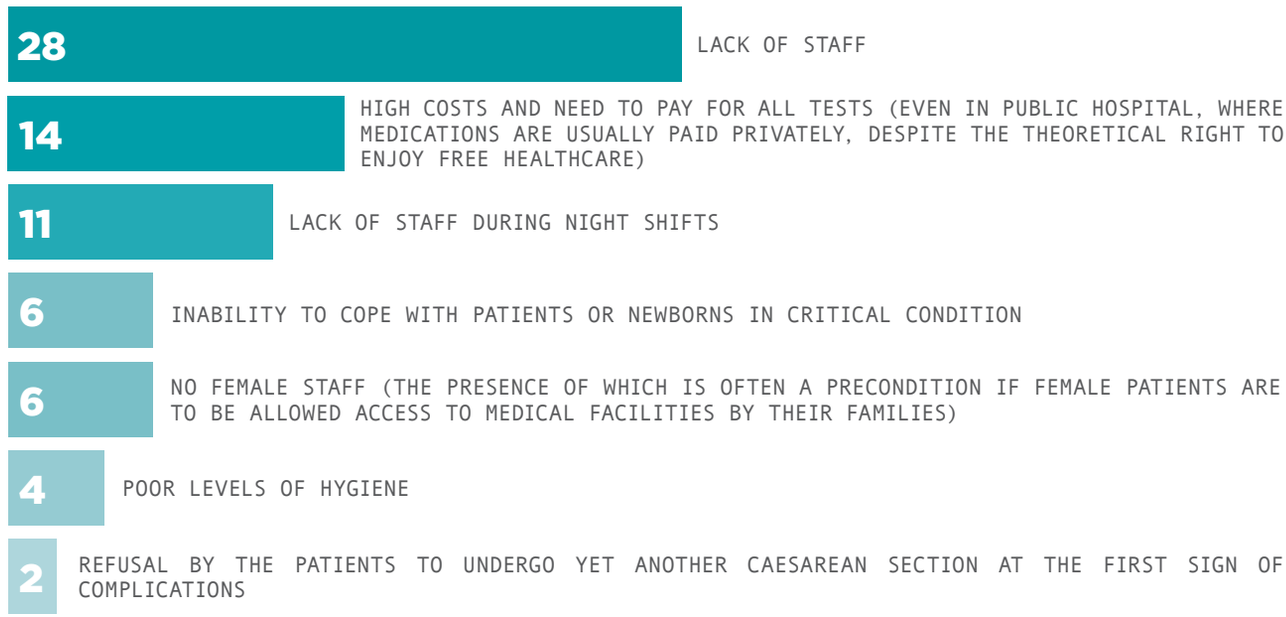
When asked about the reasons for choosing EMERGENCY in particular as a maternal healthcare provider, 70% of respondents cited the high-quality healthcare offered by EMERGENCY as their primary reason. Only 13% of respondents cited the free of charge care as their primary reason, while even smaller numbers cited proximity, word of mouth, acquaintance with a staff member or lack of other facilities as their primary motive. Patients do not fail to recognise the benefits of EMERGENCY's free provision of good-quality food and medicines, although this only ranked third in the list of the things the respondents appreciated the most. More generally, **word of mouth seems to have played a very important role in establishing EMERGENCY's reputation in this part of Afghanistan.**

When the Anabah Maternity Centre was built, many local families did not want their wives and daughters to work there, because of the perceived moral corruption associated with the presence of international staff. It took some time for people to accept the presence of the Centre, and several of EMERGENCY's female healthcare workers reported that even nowadays their intermingling with foreigners is sometimes criticised. However, patients generally consider the presence of international staff to be an asset capable of greatly enhancing medical performance: at the beginning of the activities the hospital was able to deliver around 20 babies per month, and today it has reached the capacity to deliver more than 650 babies each month.

a. DIFFERENCES WITH OTHER MEDICAL FACILITIES

Around one-third of respondents mentioned dissatisfaction with other medical facilities as a reason for choosing EMERGENCY.

Complaints (based on the number of answers) about the treatment received in other hospitals mainly referred to private clinics, and revolved around:



Two-thirds of patients described the differences between the Anabah Maternity Centre and other hospitals: again, the guarantee of round-the-clock care for patients was considered the single most important difference, after the more generic appraisal of the superior quality of healthcare available. Indeed, the 24/7 presence of medical staff at the Anabah Maternity Centre contrasts positively with the majority of nearby clinics, where few staff members – except for perhaps a doorkeeper or a nurse – stay overnight, and many commuters leave the facility by mid-afternoon to avoid the risks of travelling in the dark. Free-of-charge care was also considered an important difference, followed by the presence of an all-female staff and high levels of hygiene.

REASONS FOR RETURNING TO ANABAH CENTRE

> *It's clean here, and the midwives stay with their patients and check up on them all the time.*
>
> Woman from Kapisa

> *People feel that here, anything is possible. As the Centre has the capacity to receive and provide full treatment to any number of patients, no one is turned away.*
>
> EMERGENCY midwife

> *In private hospitals we have to buy everything, from the medicines to the food. Here, everything is free.*
>
> Woman from Kabul

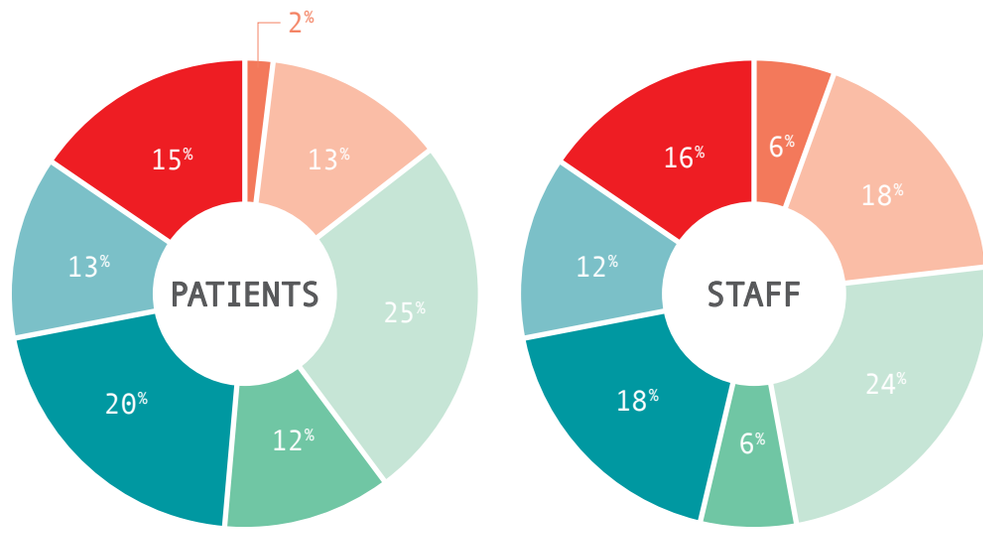
PATIENTS' PERCEPTION OF THE ANABAH MATERNITY CENTRE

The continuous and attentive presence of qualified and highly-experienced staff, both local and international, and the availability of high-quality medications and technology, give patients confidence that with EMERGENCY, even the most difficult pregnancies can have a positive outcome. Also, free medicines, accommodation and food increase the range of possible therapies available to patients, whereas elsewhere their options could be strongly limited by economic considerations.

When asked to motivate the reasons why they would return to the Anabah Maternity Centre in case of a future pregnancy, choosing as many as three out of seven possible answers, patients' preferences pointed to the importance of being in a safe environment and to the positive attitude of the staff as the two most important aspects of their experience. These two answers each represented one-fifth of the total answers given.
Safety does not consist solely of security, though this is an important factor. Notwithstanding the almost total absence of insurgent activity in Panjshir, the province has a high incidence of armed confrontations between private individuals or families, due in part to the large number of weapons among the population. **The total ban on arms inside the premises of the Anabah Maternity Centre has a calming effect on the patients. Furthermore, women coming to the Centre find themselves in a women-only space where no men are allowed, which might provide a break from the social constraints regulating women's behaviour in the male-dominated public sphere.**

The above answers correspond, to some extent, with the opinions expressed by EMERGENCY's healthcare workers, despite slightly different sets of possible answers. According to the obstetricians, midwives and nurses working at the Anabah Maternity Centre, the single most important aspect that leads patients to favour EMERGENCY over other healthcare providers is the economic factor, i.e. the provision of free healthcare and food. This is followed by the attitude of the staff, and then by the presence of international medical staff, though some of the staff argued that the latter can act as a double-edged sword: for patients coming from Kabul, the presence of international staff is generally seen as a plus, but for those coming from conflict-stricken or more socially conservative areas, it can be a reason for mistrust. The provision of round-the-clock care and patient-oriented care are also considered assets according to the staff at the Centre.

THE ANABAH CENTRE'S STRENGTHS ACCORDING TO PATIENTS AND STAFF



8. WOMEN'S DECISION-MAKING POWER

a. FAMILY PLANNING AND USE OF CONTRACEPTION

50% **OF RESPONDENTS HAD NOT RECEIVED ANY INFORMATION ON FAMILY PLANNING BEFORE THEIR LATEST PREGNANCY**

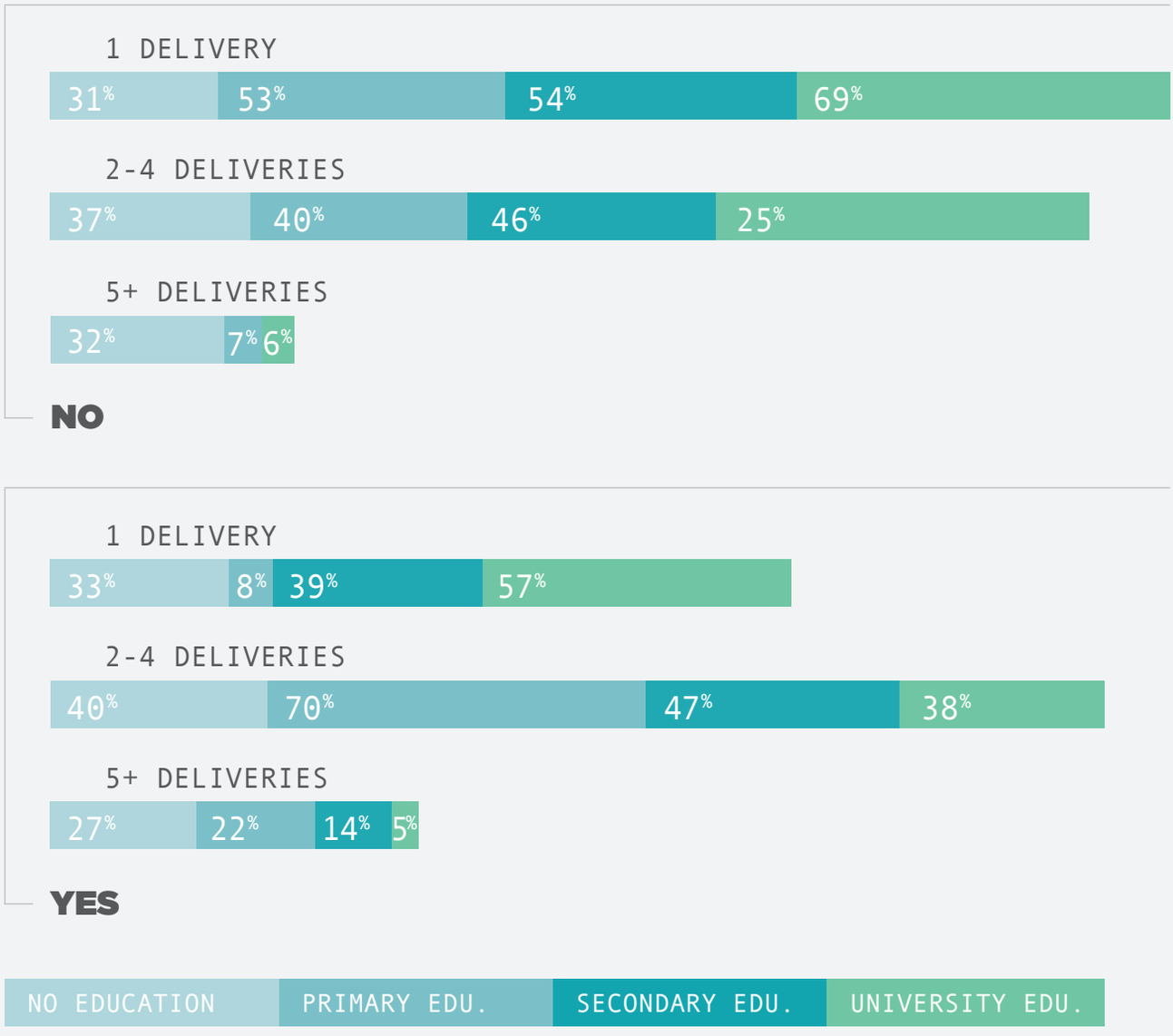
Particularly amongst rural families, a combination of traditional cultural attitudes and economic considerations mean that the benefits of spacing out pregnancies are not widely appreciated. When it comes to family planning and the use of contraception, **women's answers revealed a prevalent lack of awareness about the issue**.

This lack of awareness is higher among respondents who were delivering for the first time, who constituted 39% of respondents. Among women experiencing their first pregnancy, 57.7% had received no information on family planning, but percentages were remarkably high even among those who had had 2 to 4 deliveries (47.5%) and even more so among those who delivered 5 times or more (51.7%).

Respondents from urban areas showed a higher level of awareness in this respect, with a clear majority (64%) having received information on family planning. Among those with a rural background, this figure was just 45.5%.

EDUCATION AND FAMILY PLANNING

Women who have received information on family planning and contraception before this pregnancy, **by number of deliveries and level of education.**



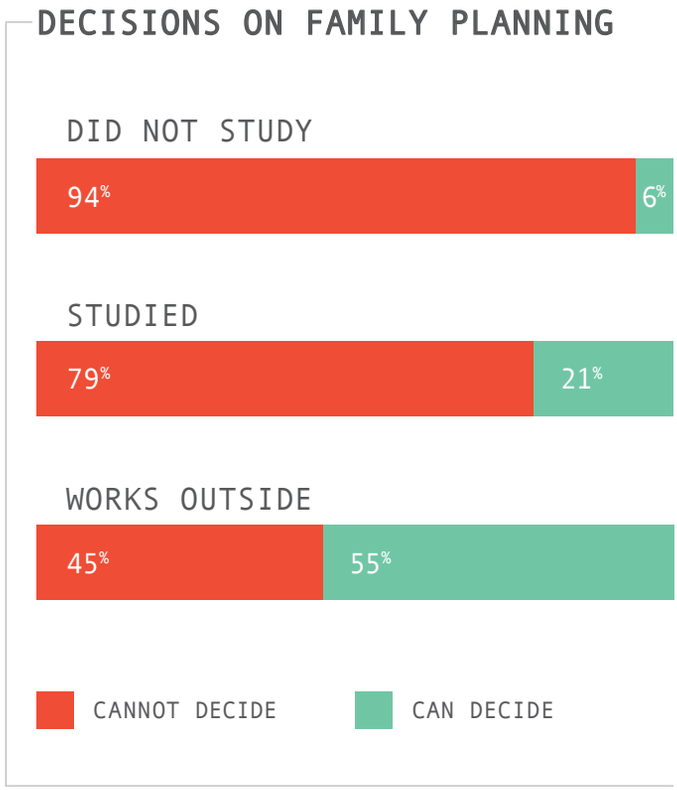
The lack of education also plays a role in the issue of family planning: women who had no awareness about family planning – even those who had given birth multiple times – were most likely to be completely uneducated.
Among respondents who had had no previous contact with EMERGENCY, 69.4% had not received any information on family planning, while this number drops to 42.3% among those who had previously been in contact with EMERGENCY.

It is therefore no surprise that a majority of respondents **(66%) reported never having used contraceptive methods before**.
It is to be expected that women experiencing their first pregnancy report low levels of contraceptive use, as Afghan society does not condone pre-marital sex and considers the procreation of offspring as a prime duty of the married couple. The percentage of non-use among this group is the highest, at 76.7%, but that figure is nonetheless remarkably high among women who have had 2-4 babies (63.7%) and 5+ babies (41.3%).
These percentages do not show a significant divide between people from rural and urban backgrounds, or people with differing levels of education. When only women experiencing their first pregnancy are considered, the use of contraceptive methods is more frequent among those who have received either secondary or university-level education (22.9%) compared to those with a primary education or none at all (16.4%).

b. WOMEN'S HEALTH

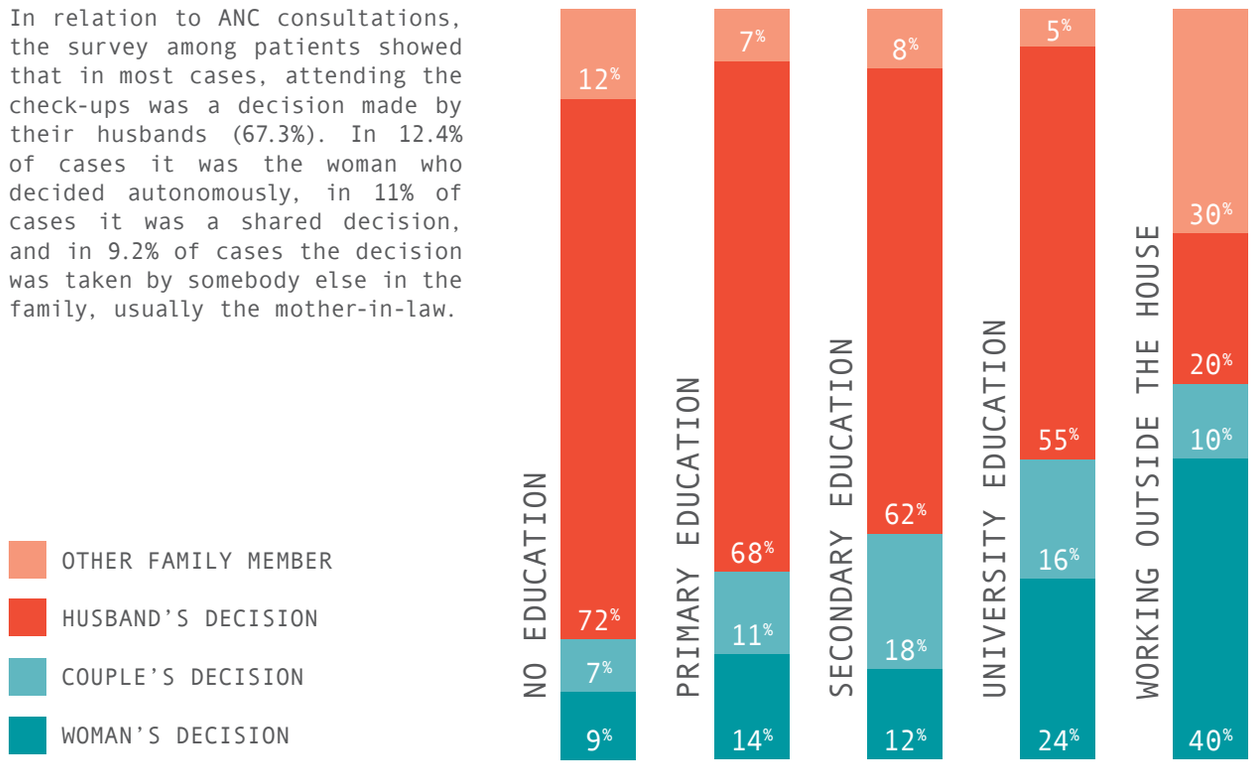
Only 12.7% of respondents claimed to be able to decide autonomously on family planning, while the other 87.3% could not.

The low proportion of women capable of making decisions about family planning poses questions about what factors grant women autonomy over their bodies and lives. It seems this is dependent neither on the family's economic situation nor on whether a woman comes from an urban or a rural background.
Education, on the other hand, seems to make a difference: only 6.3% of uneducated women claimed to be capable of making their own decisions, compared to 21.1% of those who had attended school. However, this alone is not enough to explain the situation.
Among those women who work outside the home, more than 50% claimed that they can decide autonomously about family planning. Women working either inside the home (embroidering, sewing, etc.) or in agricultural-pastoral activities did not show any significant difference in autonomy compared to unemployed women (housewives). For women working in these fields, there are only minor differences in decision-making capacity depending on their level of education. The same situation is to be found in relation to other decisions on reproductive issues.



DECISIONS ON ANTENATAL CARE

In relation to ANC consultations, the survey among patients showed that in most cases, attending the check-ups was a decision made by their husbands (67.3%). In 12.4% of cases it was the woman who decided autonomously, in 11% of cases it was a shared decision, and in 9.2% of cases the decision was taken by somebody else in the family, usually the mother-in-law.



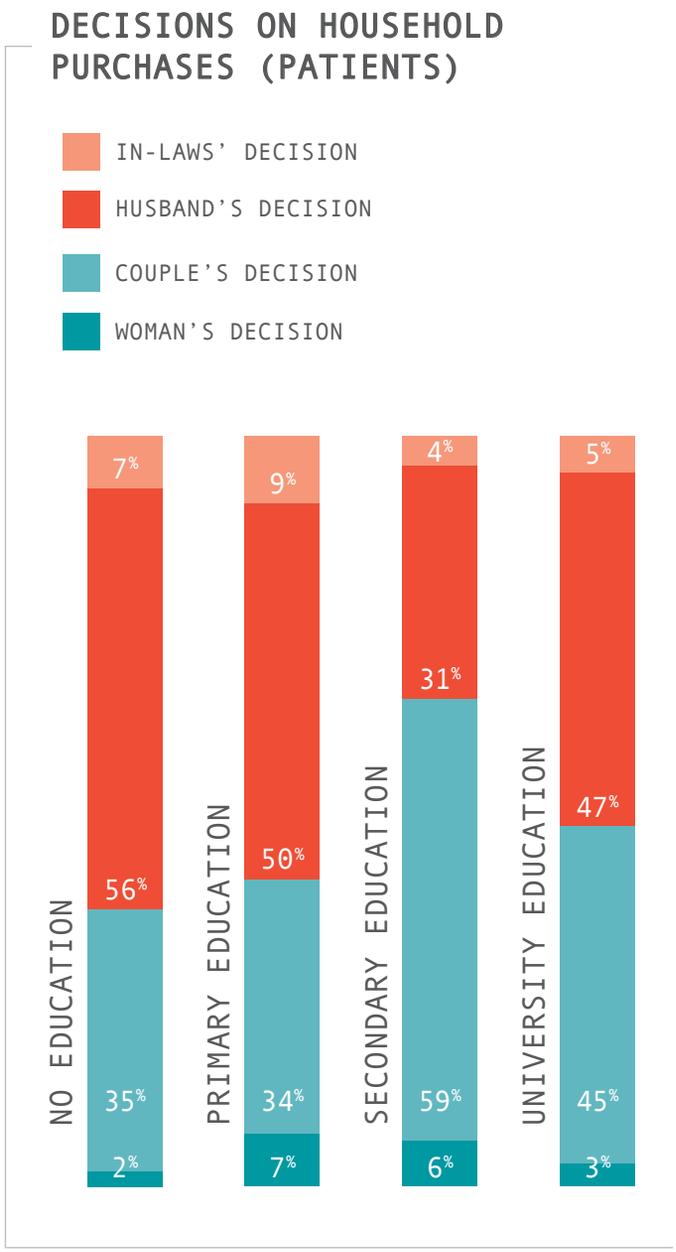
Trends regarding antenatal care also seem unconnected to the family's economic situation and to whether a woman comes from an urban or a rural background.
On the other hand, education is once again the main factor affecting women's capability of deciding autonomously whether to attend ANC consultations: 8.8% of uneducated women, 13.1% of those with primary or secondary education, and 23.6% of those who attended university reported having autonomy in this area.
In particular, a high proportion of professional women who work outside the home reported having autonomy in making decisions about ANC consultations.
Unlike the more sensitive issue of contraception, being exposed to a wide array of media seems to have a beneficial effect on the capacity of women to push for ANC consultations[24]: women who have access to more than one medium of mass communication at home are more likely be capable of making decisions about ANC consultations, with 17.9% able to do so alone and 21.3% able to do so alongside their partner. These percentages increase further, to 36.6% and 43.3%, when considering women who have access to more than two media sources.

c. DOMESTIC MATTERS

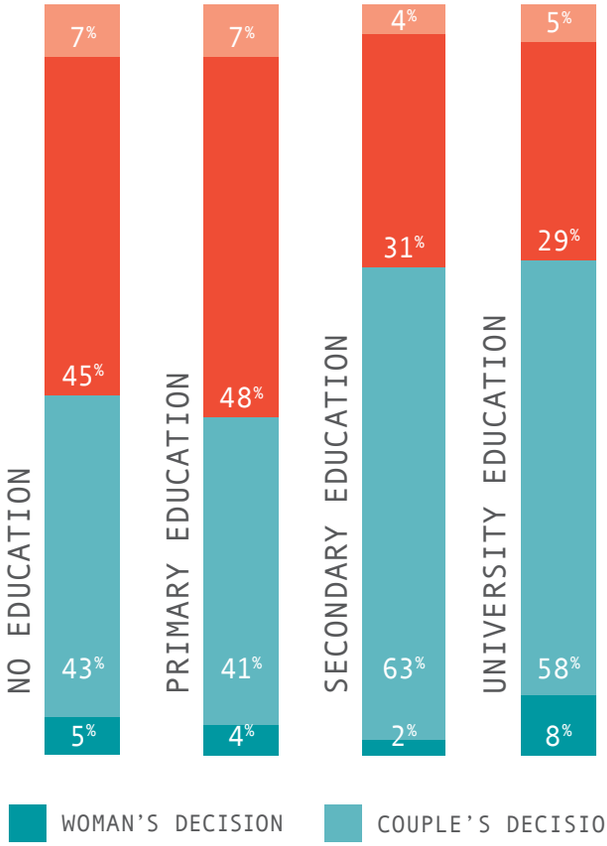
In Afghanistan, prospects for women wishing to attain a high level of education have increased at a significantly faster pace than those for women wishing to pursue a professional career. Coming from an urban or wealthy background no longer presupposes liberal, more secular worldviews: some well-to-do families with conservative attitudes towards the role of women in society might allow their daughters to complete high levels of education, as a sort of status symbol. There is a sufficiently broad range of educational facilities available, at least in Kabul and the areas covered by this research, for women to find facilities that comply with any requirements of religious strictness and respectability.
After completing their studies, however, many women find it impossible or indeed unnecessary to find a job, and therefore fall back into a traditional social role limited to the private sphere.

Women who seek a high level of education in order to enter into a professional career are more of an exception, across all economic backgrounds. This decision can be made as a result of strong individual desire to do so, the attitude of parents, or the need for every member of the family to bring in a salary.
Educated women who pursue a professional career appear to have the potential to change their role inside Afghan society.

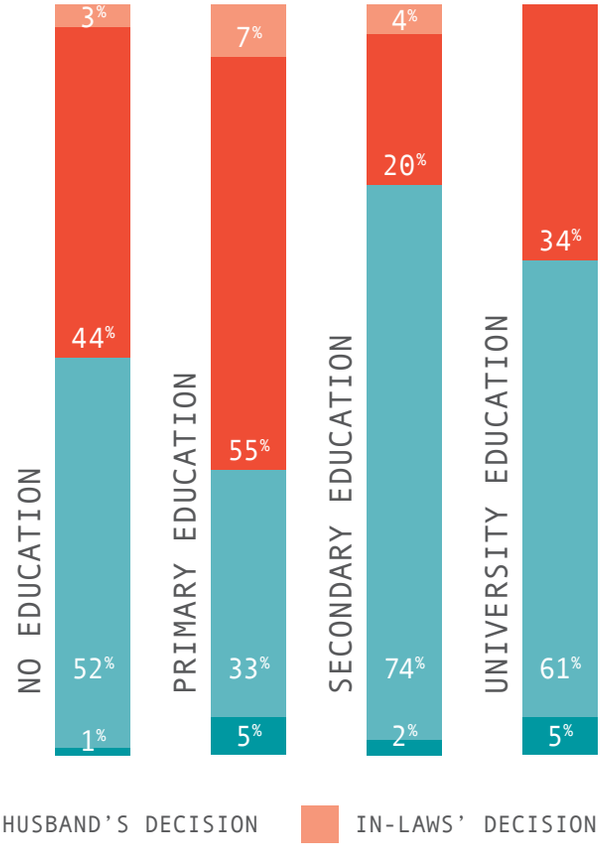
Moving to other realms of decision-making inside the household, educated women once again show a greater capacity to make decisions.
For example, they have a greater say on household purchases: a majority of respondents (52.8%) from the two higher education categories report household purchase decisions being taken by both partners together, compared to a minority among the less educated (34.4%).



DECISIONS ON CHILDREN'S HEALTHCARE (PATIENTS)

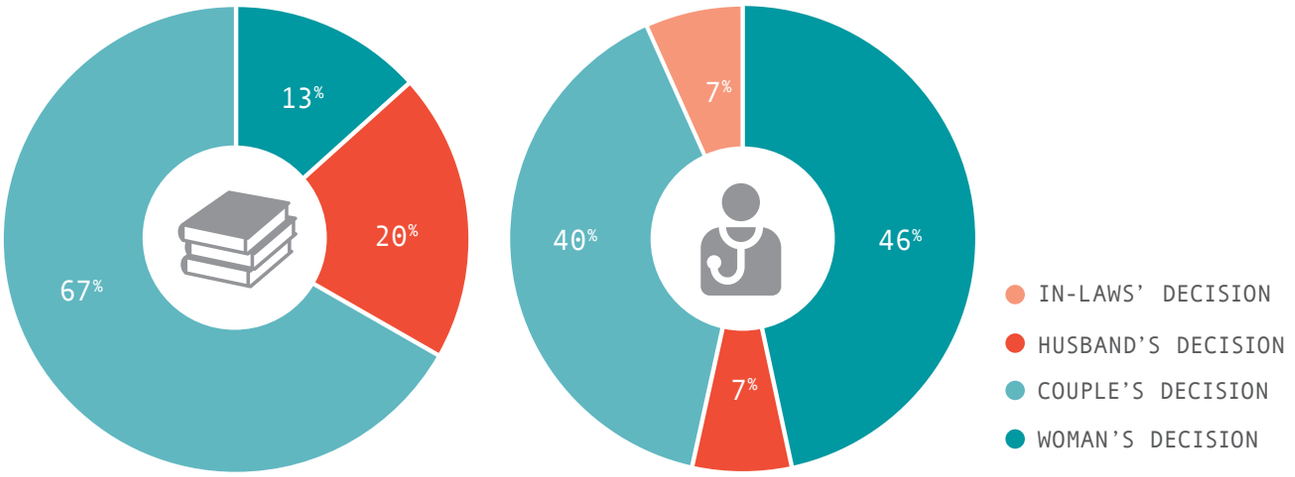


DECISIONS ON CHILDREN'S EDUCATION (PATIENTS)

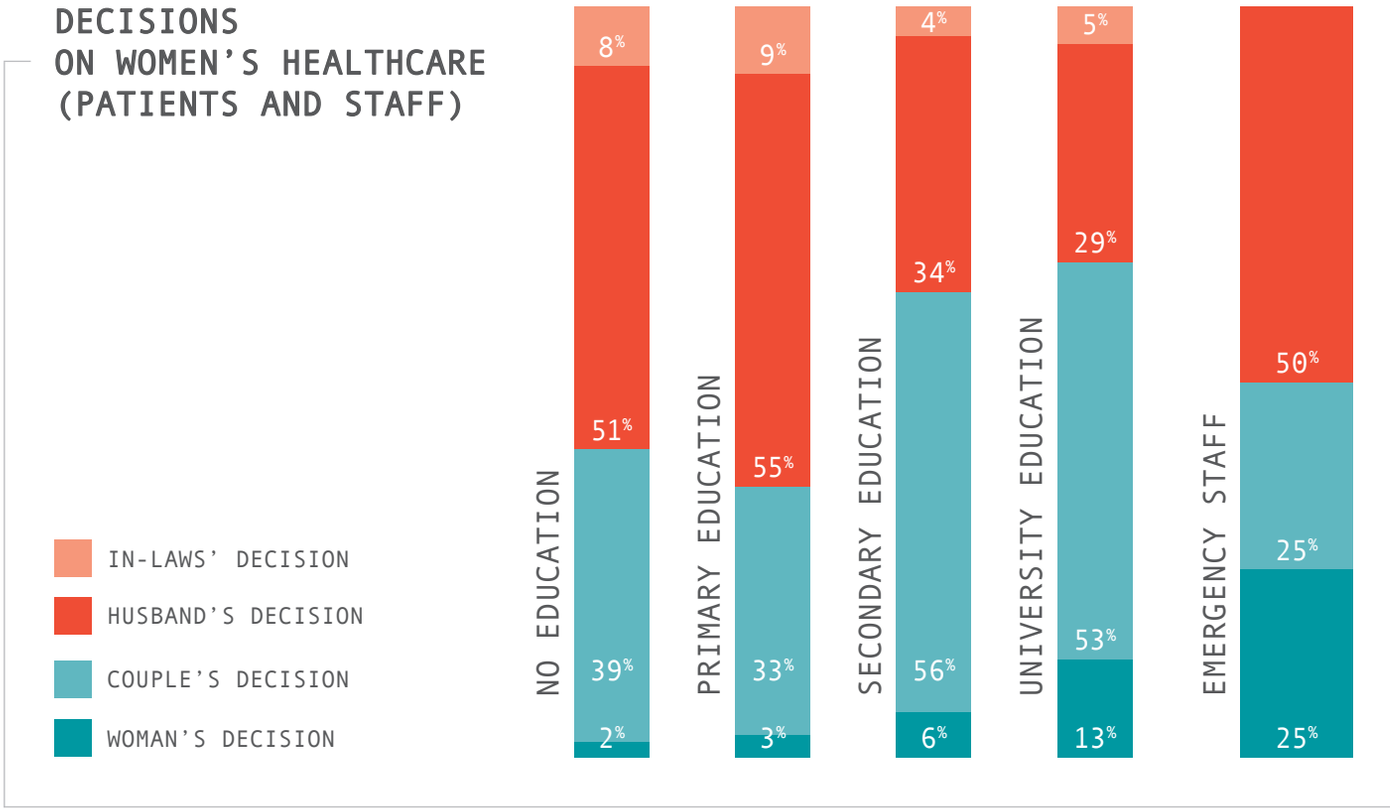


The same thing holds true for other decisions that involve all family members, such as those regarding children's healthcare (61.1% vs. 42.2%), their education (68.5 % vs. 46.3%), visits to relatives (43.8% vs. 32.1%) or whether to borrow money (55.5% vs. 35.9%).

DECISIONS ON CHILDREN'S EDUCATION AND HEALTHCARE (STAFF)

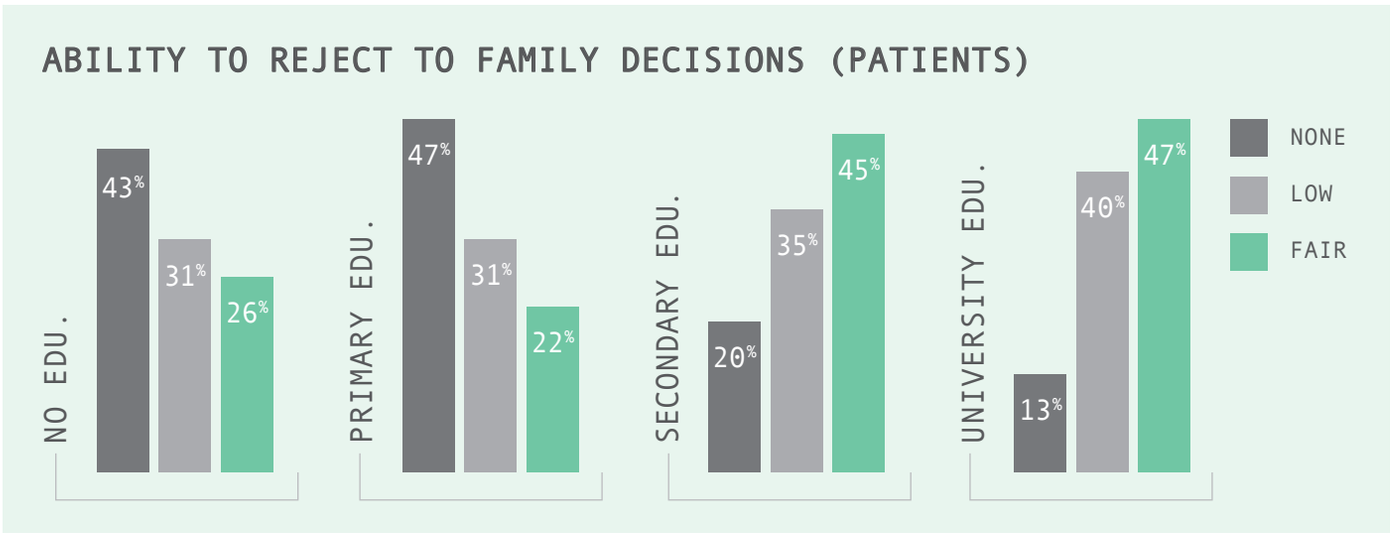


Answers given by EMERGENCY's female healthcare workers in this respect show that a similarly high proportion are able to make shared decisions with a partner, but also point to a higher level of self-confidence in the ability to make decisions autonomously, especially on issues regarding healthcare.



Decisions on women's healthcare are indicative of a broader issue, as they ultimately revolve around women's freedom of movement beyond the house and other 'scheduled' appointments, like going to the doctor. Surprisingly, it is in this area that EMERGENCY healthcare workers, despite their medical background, reported a higher level of control exercised by their husbands, whose permission is needed for them to move without making relatives and neighbours 'raise their eyebrows'.

Village societies are particularly sensitive to this issue, while residents of central areas of Kabul are more relaxed about it, accounting for slightly different attitudes among female staff depending on whether they come from a rural or an urban background: 41% of those in Kabul report being able to decide autonomously about their healthcare consultations compared to 33% of those in other provinces.



EMERGENCY female workers, both married and unmarried, seem to be better positioned than many patients to resist decisions by their families made against their will. **While among the patients, only those with a higher level of education reported in significant numbers having fair chances of rejecting such decisions (46%), among EMERGENCY staff they represent a clear majority (61.5%).**

SALARY MANAGEMENT

While the small number of working women among patients are likely to be left with only a small share of their salary for personal use, the habit of putting one's salary in the hands of the wife for her to administer, once common among urban white collar workers, seems to be still widespread. A total of 32.5% of respondents reported this practice, although it is most common among salaried workers: 45.3% of the women whose husbands have a regular, paid job reported managing their husband's entire salary, compared to 13.3% of those whose husbands had low-skilled, occasional jobs; 9.7% of those whose husbands are farmers, and none of those whose husbands are shopkeepers or traders. On the other hand, among the female staff of EMERGENCY's Anabah Maternity Centre, a majority stated they manage directly either small or large parts of their salary and only in one case reported handing it over to their parents or husband. In most cases, they were also the main breadwinners of the household.

9. THE KEY TO WOMEN'S EMPOWERMENT

a. BREAKING TABOOS

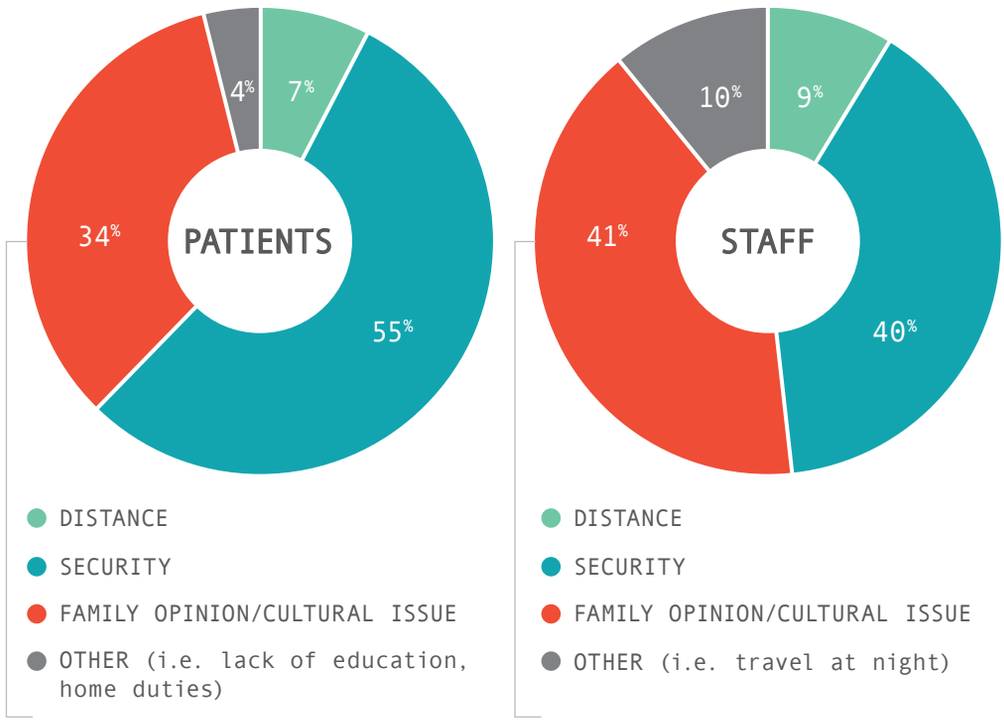
In rural Afghan communities, it is a taboo for women to work outside the home or its immediate premises, such as fields and pastures. The women working at the Anabah Maternity Centre and the surrounding FAPs often come from the same rural background that they work in, meaning that they had to fight hard to attain their position.

Even studying presents its own complications. Costs and distance present a difficult choice to families. Public educational facilities can only be found in major cities like Kabul or Charikar, while the few private institutes located in other districts of the region, though physically closer, are more expensive. A 2-year midwifery course at a private institution in Kapisa or Panjshir can easily cost up to 100,000 AFS (1,350$) in fees alone. Young women admitted to public institutions like Ghazanfar avoid paying fees, but have to move to Kabul or Charikar, and unless they live close enough to commute daily, they take up residence in the dormitory of the institute. This represents both an opportunity and a challenge for families, as sending a girl to the city to live on her own is likely to raise suspicion and resentment back at the village.

When respondents were asked why they strived to get a higher education and chose this career, motivations were usually evenly split between the idealistic and the pragmatic. On the one hand, many Afghan girls consider women's lack of access to healthcare and the high maternal mortality rate as the topmost social ills in their country, and grow up with the idea of combating them. On the other, through personal experience and family advice they also correctly come to identify the medical profession, and maternal care in particular, as one of the few careers that are socially viable for women in Afghanistan, and one where the demand for trained staff is growing. Entering this career path, however, means overcoming no small number of obstacles.

> *My father is illiterate but not close-minded. He would always tell me: "Until you say 'Enough!', you can keep studying.*
>
> Midwife from Anabah

OBSTACLES FACING WORKING WOMEN (PATIENTS AND STAFF)



> *In Afghanistan, families do not easily allow women to study and work, so we should take advantage of every chance we have: if we're allowed to be nurses, we should strive to become midwives; if we're allowed to become midwives, we should try to study as doctors, and so on...*
>
> Nurse from Anabah, now studying midwifery

The graphs above clearly show that for EMERGENCY staff, issues related to familial approval and cultural taboos represent one of the main obstacles they face when it comes to their career, along with security concerns. Apart from situations of dire need where purely economic motivations force all family members to help make ends meet, families must often be convinced that the benefits of female family members pursuing a professional career exceed the risks that these women and their families become exposed to. In Afghan society, a woman working outside the home may be perceived as a potential liability that may jeopardise the family's honour.
Therefore, even when close family members are supportive, other relatives may raise objections. Some respondents described situations in which a supportive mother had to argue against a father or an uncle who opposed the idea. Younger generations are not necessarily more open to the idea of women working: several women reported that it was their brothers, reluctant to give up their role as 'custodians' of family honour, who tried to prevent them from pursuing a career, and that they had managed to go ahead only through the intervention of their parents. Marriage is also seen as a 'leap in the dark', as in-laws may have different ideas about the role of a wife within the family.

Furthermore, the presence of a 'career woman' within the family is often unprecedented: **58% of EMERGENCY staff surveyed were the first women in their family to have ever worked outside the home**.
These women could not benefit from the experience of mothers and sisters who had taken a similar path, but are now able to provide an example, guidance and in some cases material support to sisters or other young women from their extended family who might follow in their footsteps.

Families can thus be an asset or a liability; while a majority of women working for EMERGENCY recalled that their families had played a supportive role during their studies and when they started work, several others had to struggle to gain familial approval, and it took some time before relatives came to see the positive aspects choices made by their wives or daughters. Considering that all those involved in this study were able to become trained medical professionals, it is remarkable that as many as **one-third of the respondents reported having faced some pressure from family members to change their working habits or stop working entirely**.

b. THE ANABAH CENTRE AS A GAME-CHANGER

REASONS FOR WORKING AT ANABAH CENTRE

Security is also about how you feel in the workplace, the feeling of not having to worry about your every movement and action.

EMERGENCY administrator
from Rokha, Panjshir

After all the challenges women face in receiving an education and overcoming cultural barriers, the Anabah Maternity Centre represents a safe landing point and a good learning environment for freshly-graduated midwives and nurses. Among the reasons cited by respondents for choosing EMERGENCY, **the opportunity for rigorous training is prominent, particularly given the high volume of incoming patients – often presenting difficult cases – and respondents appreciated the possibility of gathering valuable experience and honing their professional skills.**

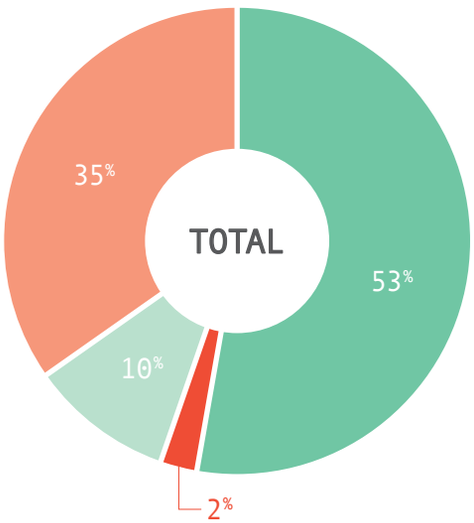
In the words of healthcare workers, standard protocols and the use of a reference system means that "you are not allowed to treat patients according to your whims"; on the other hand healthcare workers are "encouraged to deal with patients in first-person" and therefore one can "learn more here in one week than you'd learn in another hospital in a year". Some complained that in the public or private hospitals where they had previously worked or practiced "they would not let us deal with patients" and "there was no opportunity to improve our skills".

Training was also seen as a central part of working at the Anabah Maternity Centre, both the theoretical training sessions taking place periodically, as was the day-to-day training imparted through constant collaboration between local and international colleagues and the sharing of best practice.

53%

OF THE STAFF SURVEYED REPORTED BEING THE MAIN BREADWINNER WITHIN THEIR FAMILY
(NOTE THAT ONLY 16 OUT OF THE 50 RESPONDENTS ARE MARRIED)

BREADWINNERS IN THE FAMILY



Gaining professional experience and qualifications leads to an increase in social status. This, together with the salary that such women are able to contribute to their households, greatly enhances their role within the family.

An important part of the status granted to female EMERGENCY healthcare workers is the high degree of social acceptance that EMERGENCY enjoys within local communities, to the point that several female healthcare workers reported that their families would not let them work in other hospitals. The factors that contributed to this reputation are the presence of an all-female staff and the shuttle transport system that brings commuters back and forth safely, while allowing other workers to stay at the Centre's guest house.

This has not always been the case. As many veteran workers recalled, when the hospital was opened, families did not want to send their daughters to work there, due to the presence of international staff. The hospital's positive reputation is all the more remarkable given the taint of moral corruption that is usually associated with the presence of foreigners by conservative or less educated people.

This process of acceptance took many years, and there are still deep-rooted prejudices that can occasionally resurface, but thanks to its long-term presence and the undeniable beneficial effect on the health of local communities, EMERGENCY has gained much trust in the area. Even Mawlawi Yahya, one of the topmost clerics of Panjshir and a very conservative religious leader, stated during a visit by members of the provincial council in 2016 that "the EMERGENCY hospital is part of the history of Panjshir".[25]

This acceptance provides sustainability to the choice and livelihoods of the hospital's female staff and increases the possibilities of an expansion of this model, in which women's empowerment is achieved through the development of professional skills, to the neighbouring districts.

> *Before joining the Anabah Maternity Centre, I was fresh out of school without any experience, skill or self-confidence. But now, after two years of studying, practising, and having helped many people, my skills have developed and others respect me for that. I realise that I'm not 'just a girl' anymore but somebody who plays an important role in society.*
>
> Gynaecologist specialising at EMERGENCY

c. VILLAGE COMMUNITIES: FROM SUSPICION TO BENEFIT

In rural areas of Afghanistan, women working outside the home have always been the exception rather than the rule. Several members of staff at the Anabah Maternity Centre reported being gossiped about, harassed or even threatened by their fellow villagers. **However, there is at least one district that a considerable number of female EMERGENCY healthcare workers originate from. Out of 50 respondents, as many as 17 come from a tiny district of Kapisa province, Hisa-e Awal-e Kohistan, also known as Kohistan 1**.

Parwan, Kapisa and Panjshir are becoming trendsetters in making people accept female workers. Patients from all over Afghanistan come here and see that the system works.

Midwife from Kapisa, studying Medicine

Other than three women who moved to Kabul, all the other respondents still live in their home villages, commuting daily to their job in Panjshir. The number of workers from Kohistan 1 is remarkably high considering that the second largest group by district of origin consists of those from Charikar, of which there are just seven (despite Charikar having a population more than double that of Kohistan 1).

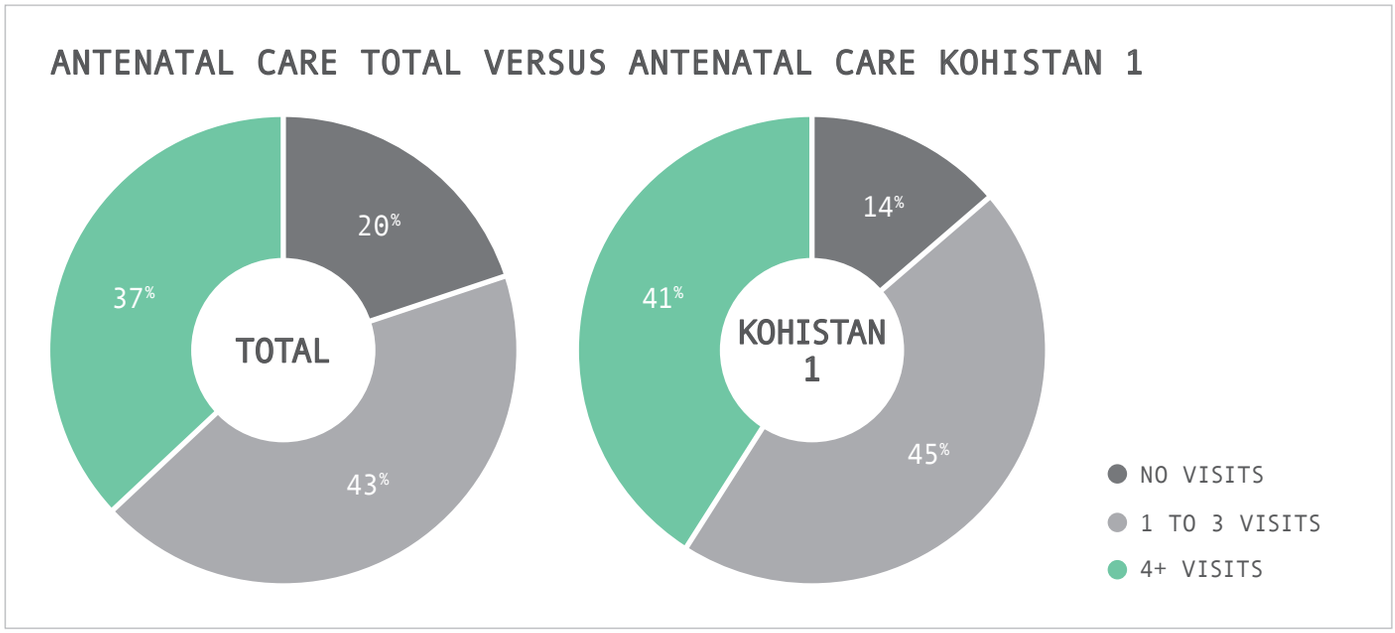
These women are younger on average than their colleagues at the Anabah Maternity Centre: **88% are below 26 years old, and therefore belong to the new generation of maternal care workers being trained at new Afghan educational facilities like the EMERGENCY hospital in Anabah**.

Their district does not host any such facility: to graduate as midwives or nurses they had to move to Kabul and Charikar and stay in dorms, or commute to a neighbouring district in order to attend classes at an expensive private institution. This 'anomaly' cannot be explained only in terms of proximity to Panjshir. Kohistan 1, according to statistics released by the Afghanistan Central Statistics Office, ranks first in Kapisa Province for both male and female literacy.[26]

Most importantly, the healthcare workers have consistently reported an improved social status within their communities, often following ostracism at the beginning of their career. This improvement in social status derives from the fact that they are asked to offer assistance to people with health problems in their villages.

Villagers can benefit from the double advantage of having not only a health consultant on their doorstep, but also a trusted contact inside the region's most advanced hospital.

The important role played by these healthcare workers in raising awareness and spreading best practice among the population of their home district is evident: women from Kohistan 1 make up almost 10% of the patients surveyed at the Anabah Maternity Centre, again representing the most common district of origin.



Mothers from Kohistan 1 also fare slightly better than average when considering the number of ANC consultations received.

Kohistan 1 has no single feature that has made it more receptive to female healthcare workers. Thus, there is a concrete possibility that this example, in which female employment has provided families with economic resources and rural communities with improved access to healthcare, could be replicated elsewhere.

> *Some relatives were opposed to the idea of me going to study far away and spending my nights there (at the college dorm in Charikar). So, to convince them, we explained that the objective was to one day start something really useful for our people, because in our area there were no midwives.*

Afghan midwife of FAP in Panjshir

> *There was a need for midwives in my village. Even now, I'm the only midwife there. My family was deeply concerned, and opposed my attempts at getting a higher education. … My uncle on my mother's side was opposed to the idea, as were my father and my brother. Only my mother supported me, and she argued with them a lot. The people of my village, on the other hand, were supportive of the idea of a local becoming a midwife and being able to help them. … they started to come to my home to ask for advice, and in time they developed a great respect for my skills. Seeing this, even my father started to respect me more.*

Afghan midwife from Kapisa

34% OUT OF 50 HEALTHCARE WORKERS SURVEYED

10% OUT OF 300 PATIENTS SURVEYED

COME FROM THE DISTRICT **KOHISTAN 1**

CONCLUSIONS

OBSTACLES TO HEALTHCARE

This research offers an in-depth look at the conditions in which Afghan women face a defining moment of their lives: childbirth.
Despite a noticeable influx of investment and medical technology, maternal care in Afghanistan remains far from satisfactory. Many women still lack awareness about the importance of receiving proper antenatal and natal maternal care. Even those who are aware are often **unable to access healthcare due to various constraints, first and foremost security issues (40%)**. Prescribed routine antenatal care check-ups, when carried out, seldom meet the required standards and are still seen as an 'optional' in many households, while lying beyond the reach of many others. Often, the use of contraception is only considered at a later stage of a couple's life, and women can rarely decide autonomously about it.

DIFFERENCES BETWEEN URBAN AND RURAL AREAS

The disparity between urban and rural areas is particularly concerning. Although the sample of women interviewed come from a relatively small part of Afghanistan, the data shows non-homogenous patterns of behaviour regarding maternal healthcare, clearly emerging from the two groups' already diverging demographic statistics.
The gap between these 'two Afghanistans' is at risk of widening rather than narrowing: in recent years, **insecurity has spread even to areas of the country which used to be relatively calm, and the new situation results in increased risks and costs for rural residents when it comes to accessing healthcare.**
The degenerating security situation has a negative impact on their will and their ability to access medical facilities. In insecure contexts, women's mobility is likely to be drastically reduced by their families. **The willingness of male family members to allow women access to clinics and hospitals depends on security issues as much as the perceived risk of jeopardising the family's honour by exposing women to unsafe or promiscuous environments.**
Costs also tend to affect rural inhabitants the most: generally, they have to spend more money to travel to medical facilities and their sources of revenue are more limited compared to their urban counterparts.
Despite these differences, **Afghan women share a common lack of autonomy when it comes to decision-making inside the household, especially on issues related to healthcare. An exception is partially made for those with a higher education and, more markedly so, for those who work outside the home, although they constitute a tiny minority of the patients.**

STRENGTHS OF THE ANABAH CENTRE

As described by the respondents, the position of the EMERGENCY's Anabah Maternity Centre makes it more easily accessible to residents of rural areas and even to those living in certain remote mountain areas, thanks to the referral system set up with FAPs/PHCs and government clinics. Uncharacteristically – compared to other major hospitals in this part of Afghanistan, all located in Kabul – those who spend the most money to reach the Anabah Maternity Centre are women from Kabul, who can arguably afford such a 'quality choice'. Travel expenses are furthermore balanced by the totally free-of-charge medical care and accommodation offered at the Centre. **The weapon-free environment, patient-oriented care, and 24/7 presence of an all-female staff all help to soothe families' concerns about sending their wives and daughters to the hospital. The presence of foreigners brings additional credit to the quality of the healthcare provided there, and has come to be accepted by locals.**

THE IMPORTANCE OF TRAINING

The training offered by foreign specialists and the high quality of procedures and medications are mentioned by patients and staff alike as the key reasons for the good reputation achieved by the Centre.
Two years of work at the EMERGENCY Maternity Centre are recognised by the Afghan government as a valid alternative to the midwifery courses at the university, and those with such experience need only pass the State Exam to receive their certification. Indeed, midwives and nurses who have 'graduated' from the Anabah Maternity Centre are greatly sought after by other hospitals in the region.
The possibility that an enhanced social and economic role for female healthcare workers may become more widely accepted across rural Afghanistan, facilitated by the training capacity and deep-rooted reputation that EMERGENCY possesses, could greatly improve future health outcomes and living conditions for Afghan women.
Today they are no longer a tolerated exception to the rule, they are quickly becoming respected members of their communities.


EMERGENCY

THE EXAMPLE OF KOHISTAN 1

Interestingly, this change seems to be taking place in rural areas around the Anabah Maternity Centre, like the Kohistan 1 district of Kapisa Province, where many young women have found employment with EMERGENCY. **A utilitarian approach on the part of local communities, who appreciate the importance of having women contributing to family economies and highly skilled healthcare workers at the disposal of the villagers, has proven stronger than cultural or religious restraints.** These professional women, in turn, contribute to spreading awareness about healthcare in their original communities, empowering other women by encouraging them to take a more proactive role when it comes to their health and even to defy social taboos and their familes' scepticism by committing to studies or a professional career.

THE EMERGENCY'S MODEL

The Anabah Maternity Centre has thus become a place where women can fulfil their social role, as mothers or as healthcare workers, in an assertive, autonomous and relaxed way. Defying male attitudes and expectations, they have managed to bring this newly acquired role into society at large.
A virtuous circle based on the replication of the Anabah Maternity Centre's model, namely access to health, professional training, and employment, is possible in other districts of the region across Afghanistan, and beyond. A referral system amongst small clinics and the establishment of additional FAPs and PHCs in remote areas could extend some of the effects of this model even to areas that have slipped out of government control, and thus help to prevent the collapse of the basic maternal and neonatal care standards that represented a fragile achievement for the reconstruction of Afghanistan's health system in recent years.

The experience of EMERGENCY's Anabah Maternity Centre reinforces recent evidence that strategies to reduce maternal and neonatal mortality rates must focus on quality of care. Over previous decades, global efforts have revolved around strategies to encourage delivery in health facilities and the attendance of skilled birth assistance, but they have proved insufficient to have a major impact on health outcomes. In fact, the rise in the number of deliveries occurring in health facilities, combined with the poor quality of care received in many of them, has actually contributed to negative outcomes in terms of morbidity and mortality.
The WHO has defined quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred". Furthermore, "the quality of care depends on the physical infrastructure, human resources, knowledge, skills and capacity to deal with both normal pregnancies and complications that require prompt, life-saving interventions." **The findings of our research highlight and strengthen the concept of quality of care as a central element in facilitating SBA and hospital deliveries, as well as positively impacting on maternal outcomes.**

ENDNOTES

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8. WHO, 'Afghanistan Attacks on healthcare', 24 June 2019 (https://reliefweb.int/sites/reliefweb.int/files/resources/Afg-Attacks-on-Health-Care-20190623.pdf)
9. The Islamic State in Afghanistan came to be known mainly as Daesh (from the acronym of its original Arabic name) or as ISKP, Islamic State Khorasan Province, the name of its branch in Afghanistan and Pakistan
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11. CDC/UNICEF/MOH 2002, MOH 2004, UNICEF MICS 2003
12. WHO, Essential Package of Hospital Services in Afghanistan, 2005, p. v (https://apps.who.int/medicinedocs/documents/s16169e/s16169e.pdf)
13. Valuable contributions to statistical knowledge of Afghan society have been given by the periodic surveys carried out by the Afghan Central Statistics Organization, such as the Afghanistan Mortality Survey 2010 (https://dhsprogram.com/pubs/pdf/fr248/fr248.pdf), Afghan Demographic and Health Survey 2015 (https://dhsprogram.com/pubs/pdf/FR323/FR323.pdf) and the Afghan Living Conditions Survey 2016-2017 (http://cso.gov.af/en/page/1500/1494/nrav-report). However, much data from insecure districts remain inaccessible
14. CSO/UNFPA, SDES Maternal Mortality monograph, 8 June 2017, p. 30 (https://afghanistan.unfpa.org/sites/default/files/pub-pdf/Maternal%20Mortality%204%20web_0.pdf)
15. Ministry of Public Health DHS Program, Afghan Demographic and Health Survey 2015, (January 2017), p. 248 (https://dhsprogram.com/pubs/pdf/FR323/FR323.pdf). According to some analysis, this data may be overestimated; for a discussion of maternal mortality indicators in Afghanistan see: Bartlett, L. Et al., 'Progress and Inequities in Maternal Mortality in Afghanistan', The Lancet, Vol 5 Issue 5, May 2017, (https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30139-0/fulltext)
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19. Archive EMERGENCY' magazine
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21. The economic situation of the households has been assessed also depending on the possession of the following house assets: refrigerator, stoves/gas cooker, generator, radio, TV, DVD player/VCR, satellite phone, mobile phone, motorcycle, car
22. It should be noted that women from Charikar town do not show marked differences in terms of education compared to the broader trends of rural areas of Parwan province
23. See the World Bank's data on Afghanistan at (https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=AF)
24. That is, more than one among radio, TV, internet or newspapers/magazines
25. Interview with Wafi Akbar Jan, Anabah, 20 August 2018
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GLOSSARY OF TERMS

AfDHS – Afghanistan Demographic and Health Survey

ANC – Antenatal Care

ANSF – Afghan National Security Forces

AOGs – Armed Opposition Groups

BPHS – Basic Package of Health Services

CS – Caesarean Section

EPHS – Essential Package of Hospital Services

FAP – First Aid Post

IEDs – Improvised Explosive Devices

ISKP – Islamic State Khorosan Province

MOWA – Ministry of Women's Affairs

OB&GYN – Obstetrics and Gynaecology

PHC – Primary Health Centre

SBA – Skilled Birth Attendants

UNFPA – United Nations Population Fund

VBAC – Vaginal Birth After Cesarean

WHO – World Health Organisation

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