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**Reproductive Health: A Literature Review on Reducing Maternal Mortality Rates
Among Afghan Women Using a Tiered Process of Interventions**

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MPH 683: Integrated Learning Experience

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Abstract

This literature review examines the risk factors associated with pregnancy that contribute to high maternal mortality rates in Afghanistan and women's limited access to adequate health services and education. Some of the factors contributing to high maternal mortality rates are political instability/civil conflict, current policies and legislation, workforce shortages in the healthcare field, as well as socioeconomic levels. The underlying theme which influences each of these factors are Afghanistan's culture and religion. To reduce the rising maternal mortality rates for Afghan women and girls, there must be a shift in mindset from within the culture. A three-layered tiered intervention which first targets rural Afghan communities through a community-based intervention highlighting passages from the Quran that speak to the importance of women and girls in their society. Following this would be the facilitation of diplomatic immersion trips to other Islamic countries for Taliban and community leaders to expose Afghan leaders to how women's rights can be aligned with Islamic law. The United States and the international community can also enlist sanctions against Afghanistan unless they were to meet specified benchmarks before receiving economic aid. This three-tiered intervention will help set the groundwork and build the foundation for reconstructing Afghanistan's healthcare workforce, increasing access to reproductive healthcare services, increasing education rates amongst girls and women, reducing the rate of unwanted pregnancy, while subsequently lowering the maternal mortality rates.

Keywords: reproductive rights, maternal mortality rate, religious influence, culture, civil conflict, Taliban, Afghanistan, women, reproductive health, pregnancy, essential health, human rights, women's rights, quality, empowerment, education

Introduction

This literature review examines the social, cultural, political, and structural factors that contribute to high maternal mortality rates in Afghanistan and women's severe lack of access to adequate reproductive health care services and education. The research question for this literature review is: How can the heavy cultural and religious influences on current policies and legislations regarding women's reproductive health be addressed? In the following sections, there will be three steps to ascertain the answer to this question.

1. To identify risk factors associated with pregnancy in Afghanistan.
2. To examine the depth of how culture and religion heavily influence current policies and legislation for women seeking reproductive healthcare services.
3. To explore potential solutions to address and mitigate this issue impacting Afghan women's ability to seek and access reproductive healthcare services.

The necessity of identifying and addressing the issues surrounding the high maternal mortality for Afghan women is of great importance as correct identification and understanding of the associated risks will allow for appropriate implementation of prevention efforts. The topic of reproductive health is at the forefront of society. Every woman should have the choice, options, and resources available to her to make the best choice possible for her; having a child or deciding to not have a child should not be a risk in a woman's life that affects her well-being. Access to high-quality maternal healthcare irrespective of economic position and social group is the right of every woman around the globe. To make this a reality for Afghan women and girls, the overall recommendation would be a three-layer tiered process targeting the community, then leaders and prominent stakeholders, and then the country of Afghanistan as a whole. This would begin with a community-based intervention in rural communities elucidating and highlighting

the importance of women and girls and their roles in society referenced by teachings from the Quran. Following this would be facilitation of travel of Taliban and community leaders to other countries, particularly Islamic countries to expose Afghan leaders to how women's rights can be consistent with Islamic law. The last component of recommendations would have the United States and the international community enlist sanctions against Afghanistan which would require Afghanistan to meet specific standards to maintain the economic aid to the country.

Background

Afghanistan is a landlocked multiethnic country located in the heart of south-central Asia inhabited by approximately 38.93 million people, with rural communities accounting for approximately 80-85% of the entire population (*see Appendix A*). Afghanistan is considered a low-income country that has been overwhelmed by wars for decades and is well known for poverty, political instability, a devastated health infrastructure, conflicts, violence, and geographical barriers. This country is also home to some of the most restrictive abortion laws in the world. Complicit in sustaining an imperialist system, Afghan men have derived power from family honor codes allowing them to dominate political positions, tribal councils, and family units. Husbands often restrict women from attaining maternal care from a proper healthcare facility. Afghan women lack autonomy and have restricted abilities to access and/or receive maternal and child healthcare (Ahmed-Ghosh, 2003). Most women do not have permission to go outside, and most are forbidden to be alone when in public (Barr, 2020). Husbands and in-laws are mostly the decision-makers.

The World Health Organization (WHO) characterizes reproductive health as a state of complete physical, mental, and social well-being and not merely the absence of diseases or infirmity in all matters relating to the reproductive system and to its functions and processes.

Reproductive health implies that people are able to have a satisfying and safe sex life with the capability to reproduce and the freedom to decide if, when, and how often to do so. This would indicate the availability of contraceptives such as birth control, intrauterine devices, abortions, and other family planning services for women. However, not all countries offer such resources as each country and territory is subject to their prerogative in establishing laws regarding women's reproductive health.

Epidemiology and Trends

Afghanistan had a maternal mortality rate (MMR) of 1,600-2,200 per 100,000 live births (Bristol, 2005). The Badakhshan Province within Afghanistan has the highest MMR ever recorded in the world—6,500 per 100,000 (Bristol, 2005). In more recent years, Afghanistan still has a high MMR of 400 per 100,000 live births, compared to 320 regionally and 280 globally (Najafizada et al., 2017). MMR has declined over the years from 1,340 in 1990 to 396 in 2016, however Afghanistan remains among the three countries outside the Sub-Saharan African region with the highest MMR in the world (Mumtaz et al., 2019). While the MMR has decreased dramatically since 2000, there is still a significant burden of maternal morbidity and mortality in Afghanistan. The high number of maternal deaths reflect inequalities in access to quality health services. Women in less developed countries, such as Afghanistan, on average more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher (WHO, 2019). Women die as a result of complications during and following pregnancy and childbirth. In Afghanistan, the maternal morbidity and mortality are mainly attributed to hemorrhage, obstructed labor, infections, high blood pressure, and unsafe abortions (Najafizada et al., 2017). Most of these complications develop during pregnancy and most are preventable or treatable. All women need access to high quality care in pregnancy, and during and after

childbirth. All births attended by a skilled health professional provide timely management and treatment which can make the difference between life and death for the mother as well as for the baby (WHO, 2019).

According to United Nations Children's Fund (UNICEF), Afghanistan remains one of the most dangerous places in the world to be a baby, a child or a mother, and access to a hospital or health facility is beyond the reach of most. Afghanistan has one of the highest infant mortality rates in the world and thousands of Afghan women die every year from pregnancy-related causes, a majority of which are easily preventable. In 2018, the United Nations (UN) estimated that Afghanistan witnessed about a 50% reduction in maternal deaths between 1990 and 2017. Despite these achievements, Afghan mothers' mortality remains among the highest in the region (WHO, 2022).

Afghanistan also has an infant mortality rate of 115 per 1,000 live births and an under five years mortality rate of 257 per 1,000 livebirths. There is little recorded statistical data specific to Afghanistan regarding unintended pregnancy, however regionally the unintended pregnancy and abortion rate in Central and Southern Asia is 64 per 1,000 women and 46 per 1,000 women (Guttmacher Institute, 2020). In addition, the Guttmacher Institute reported in 2019, 3.1 million women aged 15-49 wanted to avoid pregnancy and 68% of women who wanted to avoid pregnancy and had an unmet need for modern contraception (Guttmacher Institute, 2020).

Political Instability and Civil Conflict

One of the most significant risk factors affecting the reproductive health of women in Afghanistan are political instability and civil conflict that impacts the security for reproductive aged women and girls. Afghanistan's armed conflicts have undermined women's access to health

for decades and have continued to do so. WHO estimates that up to three million Afghans were deprived of essential health services in 2020 alone due to closures of health facilities by parties to the conflict, including the Taliban, groups affiliated with the Islamic State of Khorasan Province (also known as ISIS), and Afghan government forces (UNAMA & OHCHR, 2021). Violence has left the country with thousands of unqualified, uncertified, and underpaid health workers. In May 2020, a hospital maternity ward operated by Médecins San Frontières (MSF, Doctors Without Borders) was systematically attacked and resulted with 24 people killed, including mothers, women in labor, newborns, a midwife, and two children under ten, leading MSF to close the ward (BBC News, 2020). In 2020, the United Nations Assistance Mission in Afghanistan (UNAMA) verified 90 attacks impacting healthcare delivery, 71 of which they attributed to the Taliban and nine to pro-government forces—eight health personnel were killed, 11 injured, and 36 abducted in these attacks. The Taliban has forced the closure of dozens of health facilities after health providers refused to comply with Taliban demands for assistance for their fighters (UNAMA & OHCHR, 2021).

Conflict in Afghanistan has severely compromised the provision of services by the public and private sectors. The regions of conflict impact health facilities and workers are often caught in the crossfire of the conflict (*see Appendix B*). According to a government official, “the Taliban use health centers as safe areas...health workers can’t travel across battle lines because then they are suspected of being infiltrators...” (Human Rights Watch, 2021). Civil conflict generates insecurity between the government and insurgents thus creating risks for health workers, contributes to understaffing, especially by female workers, and deters women and girls from seeking care. Afghan women are concerned regarding their safety in accessing healthcare services; the insecurity within these regions deter people from working in clinics which then

leads to greater staffing gaps, especially among female staff who are the only ones able to help assist women in hospitals and clinics. Not only does the civil conflict impact Afghan women, but it also creates hesitancy in the involvement and investment from other countries to support Afghanistan.

Health care funding in Afghanistan mainly comes from outside sources such as the European Commission, World Bank, and United States Agency International Development (USAID) (Acerra et al., 2009). In the years after U.S.-led military invasion and the defeat of the Taliban in 2001, the Afghan government and international donors gave priority to developing an effective health system, including extending access to basic health care to all parts of the country. The effort led to important achievements, including significant declines in maternal mortality, and increases in provision of prenatal care, use of modern contraception, and attended births (Human Rights Watch, 2021). However, even with two decades of effort and the expenditures of hundreds of millions of dollars, delivery of healthcare services for women remains far below international standards set by WHO, and the progress that has been achieved is being eroded. International aid in Afghanistan has been dwindling in recent years, in part due to the deteriorating security and relentless violence, but also because increasing demands of funds have been further exacerbated by the COVID-19 pandemic (Gannon, 2021). External funding has unpredictable availability, frequent policy shifts, and the potential to end without warning (Health and Human Sector Strategy, 2008).

Current Policies and Legislation

During the previous reign of the Taliban (1996-2001), the maternal and neonatal death rates worsened because of the complex synergy of social, demographic, medical, economic, and cultural factors. Afghan societal norms dictate that only women can provide medical care for

women. During the Taliban regime, women were forbidden from going to school; thus, virtually no female doctors or nurses were trained during this period (Barr, 2021). Restrictions to women's lives included allowing only female health workers to examine them and limited access to quality health services—particularly obstetric care and minimal opportunities for education and work.

Many of those seeking women's health care are girls. Despite Afghanistan ratifying the United Nations Convention on the Rights of a Child (UNCRC) in 1994, millions of children are still being deprived of their basic rights. This includes their right to survival, to protection, to health, to learn, to play, to participate, to grow and to develop to reach their full potential (UNICEF, n.d.). Afghan law sets the minimum age of marriage as young as 15 for girls, which violates international human rights law prohibitions on discrimination based on gender. Child marriage is associated with early and closely spaced pregnancies, which can have serious health consequences, including the risk of death, for pregnant girls, and their babies (UNFPA, n.d.).

After the collapse of the Taliban in 2001, the Ministry of Public Health (MOPH) inherited a devastated health system and some of the worst health statistics in the world. The health system was rebuilt with an Essential Package of Health Services (EPHS) defined as the package of services that the Afghan government would be providing or would aspire to provide to its citizens in an equitable manner (Wright, 2015). Afghanistan has a defined EPHS which includes a Basic Package of Health Services (BPHS) designed for the purpose of ensuring all primary health care facilities deliver a standardized package of basic services (Acera et al., 2009). The BPHS includes verbiage concerning maternal and newborn health, child health, immunization, public nutrition, communicable diseases, mental health, disability, and regular supply of essential drugs (Newbrander et al., 2014). However, the BPHS implicitly excluded:

safe abortion, social support during childbirth, home visits for women and children across the continuum of care (USAID, Essential package of Health Services Country Snapshot: Afghanistan, 2015).

The former Minister of Public Health Suraya Dalil created a report for the National Reproductive Health Policy that was revised and ready to be implemented between 2012 and 2016. Based on the revised policy, all Afghan families were to have the right to access the highest reproductive health standards. The four main priorities of the National Reproductive Health Policy included maternal and child health, family planning/birth spacing, sexually transmitted infections (STIs) and breast and cervical cancers (Reproductive Health Task Force, 2012). However, the execution of such policies and health packages designed for the sole purpose of improving the health and well-being of Afghan women and girls significantly fall short. These policies lack comprehension and acknowledgement that the contributing components to the high maternal morbidity and mortality rate in Afghanistan are attributed to hemorrhage, obstructed labor, infections, high blood pressure, and unsafe abortions. Unsafe abortions are one of the three leading causes of maternal mortality in Afghanistan, despite abortions being against the law.

Although, the MPOH created the EPHS, BPHS, and the National Reproductive Health Policy, the current policies surrounding abortion remain highly restrictive. A “legal abortion” in the Islamic Republic of Afghanistan is only offered when the mother’s life is in danger or there is a risk of the child being born with severe disabilities. However, many Afghan women will perform unsafe abortions themselves for countless various reasons and if caught are sentenced with prison terms of up to five years and fines which are the standard punishments for abortion (Barr, 2020).

Workforce Shortages

Access to abortion clinics and services poses another risk factor to Afghan women's reproductive health. The unintended pregnancy and abortion rate in Central and Southern Asia is 64 per 1,000 women and 46 per 1,000 women (Guttmacher Institute, 2020). As seen in Appendix C, this percentage of unsafe abortions in South-central Asia is much higher than all other areas of the world studied, including a slight lead over Africa (Ganatra et al., 2017). In this study by Ganatra et al., WHO's definition of unsafe abortion is stated as "...a procedure for termination of a pregnancy done by an individual who does not have the necessary training or in an environment not conforming to minimal medical standards" (pp. 2372). Increasing access to legal abortion will ultimately decrease the amount of dangerous, unsafe abortions and the many health risks associated with them.

In Afghanistan, despite high knowledge of contraceptive methods (95% amongst married women), contraceptive prevalence is low fluctuating between 10% and 20% (Ezadi et al., 2021). Currently, women and girls struggle to access even the most basic information about health and treatment as it is largely nonexistent. Routine preventative care such as pap smears and mammograms are almost unheard of, and a large proportion of births are still unattended by a professional (Human Rights Watch, 2021). Many women are unable to access health care and can only be examined by female health professionals as male doctors are not allowed to visit them. In a society where women seek care only from female providers, lack of qualified female health workers is certainly an obstacle. The Community Midwifery Education (CME) program aimed to train more midwives as well as ensure their initial deployment in remote health facilities as well as good retention rates. The CME program began training rural midwives in 2002 and began scaling up nationally in 2005. The CME program has contributed to consistently

positive indicators including up to a 1,273 per 100,000 reductions in MMR, up to a 28% increase in skilled deliveries, and a six-fold increase in qualified midwives since 2002 (Speakman et al., 2014). Begun as a small pilot, CME has gained support of international donors, the Afghan government, and civil society (Speakman et al., 2014). However, it is unknown at this time whether this program has continued throughout the escalated conflict-torn areas of Afghanistan alongside the COVID-19 pandemic.

WHO considers 23 medical professionals to 10,000 people a critical shortage; Afghanistan currently stands with 4.6 medical professionals to 10,000 people (Gannon, 2021). In 2014, WHO reported that the number of doctors per 10,000 people varied from a high of 7.2 to a low of 0.6 in the least served areas (Human Rights Watch, 2021). Rural facilities are often understaffed or have few or no female staff.

Socioeconomic Factors

Socioeconomic status, or social standing, are often measured as a combination of education, income, and occupation. Afghan women's socioeconomic status reveal clear inequities in access to resources, plus issues related to privilege which contributes to the high MMR in the country. During the Taliban regime, women were forbidden from going to school thus negatively impacting their workforce capacity, but also preventing Afghan women from receiving or seeking care during pregnancy and childbirth. In a study, it was reported that 93% of women who died to maternity-related causes were illiterate (Najafizada et al., 2017). In the capital city of Kabul, 64% of women participating in the reproductive health survey never attended a regular school and 62% were illiterate (Egmond et al., 2004). Women's education irrespective of other socioeconomic factors, have positive contributions to improved reproductive health. Studies have found that educated women recognize emergency obstetric

complications and seek medical care immediately, receive antenatal care, use skilled birth attendants, use contraceptives, and have lower rates of adolescent pregnancies (Khorrami et al., 2008).

In addition, women with socioeconomic disadvantages are less likely to communicate with a healthcare professional during two critical times in their lives: pregnancy and childbirth. Poor women have less access across the continuum of antenatal visits and birth attendance and have very low levels of health care utilization around the time of birth (Mishra, 2018). Many women and girls cannot afford health care as poverty is alarmingly high in Afghanistan and is rising dramatically. Healthcare is increasingly unaffordable to the estimated 61% to 72% of Afghan women who live in extreme poverty (Gannon, 2021). Without sufficient resources or finances to access high quality healthcare services in pregnancy, Afghan women are vulnerable to severe bleeding, infection, and pre-eclampsia/eclampsia all of which are preventable if properly treated, however if left unattended could be life-threatening for both mother and baby.

Women also have difficulty accessing healthcare services due to the high costs in transportation and medicines. A poor road network and near complete absence of railways makes some rural areas inaccessible during heavy winter snowfalls (Accera et al., 2009). Almost 10% of people cannot reach a health facility within two hours and 43% must travel more than half an hour (Human Rights Watch, 2021). Most women cannot afford the increasingly costly medicine they need or even the cost of a taxi ride to a clinic as most Afghans live on less than \$1.90 a day.

Economic Implications from Prior Interventions

Many of the current policies and interventions are at least a decade old and it is unclear if these policies still exist. Past interventions have addressed either the demand side or supply side of programs, but neither addressed both at the same time. Supply side interventions address the

implementation of services and facilities, while demand side interventions “are particularly designed to reduce access barriers for poor and vulnerable groups” (MATIND, 2013). For example, if a free health clinic opens in a rural Afghan region that distributes birth control, but there is no health education or promotion for the citizens of this region on the safety or potential importance of birth control, the supply side intervention will not be successful. If services are available, but communities are not empowered to access them it will increase health inequalities. If communities are empowered, but there are no facilities there will be no impact. The demand side and supply side must be integrated together in order to implement programs that are successful and meet the needs of the communities they are aimed towards, especially with consideration for the country’s culture and religion.

Influence of Culture & Religion on Reproductive Health Care Access

Developing nations have many challenges to the growth of their society and healthcare systems, and Afghanistan is no exception to this. Progress has been made in Afghanistan with the implementation of the BPHS and the CME, however the maternal morbidity and mortality rates are still staggeringly high in comparison to other countries in the region. Reproductive health care access in Afghanistan is complicated by many factors that plague post-conflict countries including an unstable political system, poor economy, poor baseline health indices and ongoing violence and instability. Intertwined with these factors is the underlying denominator that influences all spheres and realms in Afghanistan and that is its culture and religion.

Almost all expressions of Afghan culture are shaped by a deeply rooted belief in the Islamic religion. These beliefs drive everything from the way someone dresses, greets others, uses the bathroom, eats, sleeps, and works. Islam is practiced by 99% of Afghans and governs much of their personal, political, economic, and legal lives (Commisceo Global Consulting Ltd,

2020). Islam underpins many of the customs and tribal codes that condition numerous aspects of political and social life in the country. Islam, therefore, has a profound influence on the identity and social structure of the rural Afghans who compose an overwhelming majority of the population. The religion of Islam provides an organizing framework for rough justice and a justification for its implementation. As the Taliban are the leaders and local enforcers of the rules and culture, they are more likely to be perceived as legitimate by local communities, especially those in rural communities. Islam constitutes a critical factor in legitimizing Afghan national leadership and remains an essential force in preserving the unity and independence of Afghanistan (HPCR Central Asia, 2001).

In a society heavily influenced by culture and religion in dictating policies and legislations regarding women's reproductive health, it is clear a different, perhaps a more inward approach, intervention must be made. As history has shown, ignoring the religious aspects of Afghan society risks the establishment of illegitimate institutions, antagonizing the Afghan population and generating resilient opposition against modern reforms. Addressing issues internally rather than externally might be the path forward and an opportunity for women and girls to contribute and live in a thriving, sustainable and growing Afghanistan.

Methods

This literature review was conducted using the University of San Francisco's online search engines, specifically through The Lancet Global Health, The Lancet, Guttmacher Institute, Journal of American Medical Association (JAMA), International Journal of Gynecology & Obstetrics, BMC Public Health, BMC Women's Health, PLOS ONE, Central Asian Journal of Global Nature, Nature, and the National Library of Medicine: PubMed. Other databases used were World Health Organization (WHO), United Nations (UN), United Nations

Population Fund (UNFPA), United States Agency for International Development (USAID), United States Institute of Peace, United States of America Department of State, Human Rights Watch (HRW), United Nations Children’s Fund (UNICEF), Atlantic Council, World Health Organization Regional Office for the Eastern Mediterranean, the New York Times, BBC News, CNN, and National Geographic. Keywords that were used include reproductive rights, abortion, contraceptives, unsafe abortions, self-managed abortion, maternal death, religious influence, religion, culture, empowerment, education, family, inequalities in access, civil conflict, Taliban, Afghanistan, women, female, girls, children, child, youth, reproductive health, sexual health, maternal health risk factors, predisposing factors, socioeconomic factors, urban, rural, health consequences, health impacts, pregnancy, prenatal, maternal, perinatal, unintended pregnancy, morbidity, mortality, death rate, birth control, mifepristone, misoprostol, disparity, interventions, equity, equality, health, essential health, human rights, women’s rights, quality, care, policy, barriers, gender, agency, basic package of health services, and services. There were 62 relevant articles from 1998 to 2022 that were chosen to assess the current risk factors, restrictions associated with pregnancy/unwanted pregnancy, unsafe abortions, reproductive and sexual health in Afghanistan.

Recommendations

Recommendation 1: Community-Based Intervention (CBI)

The United States’ involvement in Afghanistan centered on the idea that constructing a strong centralized authority would be the answer to Afghanistan’s problems. The new constitution created a top-heavy system that gave the president “nearly the same power that Afghan kings exercised” (Hamid, 2021). This concentration of power inevitably alienated other stakeholders, particularly those on local and regional levels. The risks of the presidential system

were heightened in divided societies, and Afghanistan being divided along ethnic, religious, tribal, linguistic, and ideological lines—was just that in almost every way possible. Ultimately this plan fell apart and invited resentment by pushing programs that were meant to reengineer Afghan culture and gender norms (Hamid, 2021). The assistance and advice from international communities focused on a top-down approach in terms of implementing changes; however, this proved to not be as successful or sustainable for any party involved. Many of the choices made reflected the hubris of Western powers that saw Afghan traditions as an obstacle to overcome when, it turns out they were the lifeblood of the country’s political culture (Hamid, 2021). In the end, few Afghans believed in a government that they never felt was theirs or wished to wade through its bureaucratic red tape. Afghans kept turning to informal and community-driven dispute resolution and local figures they trusted, which left the door open for the slow return of the Taliban.

Rather than utilizing a top-down approach, a community-based intervention (CBI) in rural communities elucidating the importance of women and girls in their society referenced by teachings from the Quran about women’s roles might be a strategy that will help build the foundation of change in Afghanistan. Beginning in rural communities is a crucial component to this intervention as rural communities are of utmost importance and priority as they account for 80-85% of the total population of Afghanistan (European Commissions’ Directorate – General for European Civil Protection and Humanitarian Aid Operations, 2002). In recent years, the Taliban has been gaining ground and establishing deeper roots in local communities. Rural communities have more influence with the Taliban as they are the local enforcers of the rules. When the Taliban entered new territory, they provided a “rough and ready” dispute resolution and often outperformed the local court system. According to Vanda Felbab-Brown, Harold

Trinkunas, and Shadi Hamid, “Afghans report a great degree of satisfaction with Taliban verdicts, unlike those from the official justice system, where petitions for justice frequently have to pay considerable bribes” (Hamid, 2021). This is one major reason why religion—particularly Islam—matters. It provides an organizing framework for rough justice and a justification for its implementation and is more likely to be perceived as legitimate by local communities (Hamid, 2021).

The CBI would be delivered in small group settings with women and men together to relearn and be exposed to passages in the Quran in a different perspective. As in many traditional societies, adults of both sexes recognize that each play relevant and important roles, albeit in different spheres. However, Islam is not necessarily the force that has led to women’s subordination. Not only does the Quran emphasize that righteousness is identical in the case of man or woman, but it affirms clearly and consistently, women’s equality with men and their fundamental rights to actualize their human potential; this is what the anticipated outcome this intervention would deliver (Amiri et al., 2004).

Al-Hibri, an expert in Islamic jurisprudence noted that for many years, Islam was used in Afghanistan as the justification for policies that inflicted serious harm (dharar) on women (Amiri et al., 2004). During the Transition within Tradition Conference, Al-Hibri said,

The Afghan woman was denied the right to education despite the fact that, according to the Prophet, seeking an education is the duty of every Muslim, male or female. She was denied the right to earn a respectable living despite the fact that the Qur’an states that every person is allotted what they earn. She was also denied participation in the political process, despite the fact that the Qur’an itself recognized her right to such participation. This state of affairs shocks the conscience, given the explicit Qur’anic stand in support of women. The overarching Qur’anic view of gender relations is rooted in the basic assertion that God created us all from a single soul.

The teachings in the CBI would be based entirely from passages in the Quran as well as acknowledgements and proper understanding of the country’s sociopolitical and religious

history. While women in Afghanistan and other parts of the Muslim world face many obstacles, there are also, within Islam and Afghan history, important precedents of women playing active roles in politics, business, healthcare, education, the media, and the military, among others (Amiri et al., 2004). Many modern Afghan leaders say the foundation of Islamic religion affords women protection, including the right to education, property, and civic participation (Amiri et al., 2004). The reconstruction of Afghanistan can build upon these beliefs and past experiences. To create sustainable progress, support for women's rights and roles must be couched within Afghan culture, history, and religion. The change in the mindsets and perspectives in how women are viewed in Afghan society must come first as it sets up the foundation for other programs and interventions to succeed. If successful, this intervention could open a variety of avenues that could lead to the opportunity for girls and women to gain an education, to help increase the workforce in healthcare, and then to help increase the use of reproductive health services and ultimately the reduction in the maternal mortality rate for Afghan women.

Recommendation 2: Diplomatic Immersion Trips

In addition to the CBI, the United States should promote the appointment of a third-party mediator (ideally by the United Nations) to facilitate the travel of Taliban and community leaders to other countries, particularly Islamic countries such as Indonesia, Malaysia, Egypt, and Turkey, where women enjoy significant freedoms (Allen & Felbab-Brown, 2020). This will expose the Taliban to how women's rights can be consistent with Islamic laws. Neighboring countries offer valuable lessons for women in Afghanistan as Muslim women strive to develop an understanding of their rights within the Islamic tradition (Amiri et al., 2004). A prerevolution minister in neighboring Iran Mahnaz Afkhami believed that

As Muslim women activists, it is necessary for us to reinterpret and redefine our cultures and to seek indigenous roots for our rights—to change when we must, to search out what

is authentically supportive of our rights, and to replace what has been shaped to uphold patriarchal social structures. Change will mean transformation. Change will require improving our condition by taking an active role in administration, practice, expression, and definition of culture, tradition, and religion. (Afkhami, noted during Transition within Tradition Conference, December 2001).

The United States Department of State, under the instruction of the Secretary of State, can assist with the logistics and assist as a liaison with the UN along with the Special Representative for Afghanistan Reconciliation as well as the Office of Global Women's Issues. The expertise of each office, combined with the collaborative efforts to help enable the travel of Taliban and community leaders to other Islamic countries could help reveal a potential future that involves women's rights aligned with Islamic law and help bring a more stable and prosperous Afghanistan. In addition, the exposure to other Islamic countries would also allow for the Taliban to understand what laws and governance systems could be implemented that would increase the chance that the U.S. and western aid is preserved for Afghanistan.

Recommendation 3: Economic Sanctions & Benchmarks

Along with the facilitation of travel for Afghan leaders, the United States and the international community can enlist economic sanctions against Afghanistan unless specific standards and benchmarks are met to maintain economic aid to the country. As mentioned in previous sections, most of the economic funds come from international sources. According to the Organization for Economic Cooperation and Development the top five donors in Afghanistan are USAID, European Union Institutions, Germany, the United Kingdom, and the World Bank. The top sectors where the monetary funds are being designated to categories such as government and civil society (\$369.2M) and emergency response (\$163.4M), while basic education (\$54.48M), maternal and child health, family planning (\$41.96M) fall short on the list of priorities (*see Appendix D*). The U.S. and other international partners retain some leverage with the Taliban

such as maintaining economic aid to the country. For that reason, the Taliban are keenly aware they need to cater—at least to some extent—not only to the preferences of the Afghan population, but also to the United States and the international community.

The interconnectedness and relationship between the Afghan people, the Taliban, and the international community can be seen as a three-legged stool, each party representing one leg (*see Figure 1*). The Afghan people need assistance and programs created to better serve them and their communities, the Taliban must accommodate the needs of their people and must serve them in order to remain in power; and to help the Afghan people, the Taliban will need the aid of the international community. The Taliban are still reliant on the international community, and they are still in the process of gaining recognition and legitimacy on the international stage.



Figure 1. Diagram of Relationship Between the Afghan Society, the Taliban, and the International Community

The economic sanctions would be created and implemented through the United States Department of State as well as the United States Department of Treasury. Both departments would be responsible for collaborating with one another to come to terms and agreements on what benchmarks must be met before the disbursement of any monetary amount to Afghanistan. There are also considerations to be made on any sanctions that the United Nations or the European Union could create as they too are major financial contributors to Afghanistan. Examples of what certain benchmarks could be implemented would be setting minimal standards of women's rights that would allow girls and women to gain an education. This could be gaining a general education or being as specific as gaining an education to pursue a career in the healthcare field to address the workforce shortage that Afghanistan faces, but particularly for women when seeking reproductive healthcare services. This would still be consistent with Islamic law on how Afghan women can only be treated by female health workers, while still helping to reduce the maternal mortality rates, increasing the usage of healthcare services and being able to afford it, and helping bolster the Afghan economy.

There are also other benchmarks on the opposite end of the spectrum the United States and international community could consider. The United States could make clear that a systematic failure to uphold minimal rights as defined by the Afghan constitution, or as set by minimal international human rights standards, would disqualify Afghanistan or a part of it from the majority of United States economic and humanitarian assistance. The United States can insist to the Taliban and Afghan powerbrokers that women's rights are crucial qualifications for United States and international aid and that would require preserving maximum freedom and human rights protection of Afghan women that the Afghan society would be prepared to accept (Allen & Felbab-Brown, 2020). Revisiting and reallocating funds to sufficiently support sectors such as

education, maternal and child health, family planning, as well as building infrastructure and economic growth should be considered as part of the sanctions. Further research by the United States Department of State and Department of Treasury should aim attention at which inducements, sanctions and benchmarks would yield the greatest results where the Taliban are willing to comply, and Afghan women are supported and empowered in their right to seek reproductive healthcare services.

Implications and Discussion

To achieve improved conditions where Afghan women and girls can access reproductive health care and to ultimately lower the maternal mortality rates, new strategies and knowledge is crucial. Availability of reproductive health care services often does not guarantee their utilization. However, improvement in sociocultural beliefs, socioeconomic factors, and educational opportunities has a great potential to improve utilization of reproductive health services.

With the implementation of the aforementioned community-based intervention, there is a greater chance that rural Afghan women will have the blessings from the men in their families and communities to seek reproductive health care services during their pregnancies; thus, reducing the maternal mortality rate in Afghanistan. With the enlisted sanctions requiring Afghanistan to meet certain benchmarks to maintain economic aid to their country, this will also help to address some of the socioeconomic impacts that women face. This has the potential to open the path for women to gain the opportunity to pursue an education and join the workforce in the healthcare field. This would also help to uplift women out of poverty, while subsequently decreasing the rate of unintended pregnancies.

The Taliban are actively seeking and attempting to establish international recognition driven by the group's pressing economic needs and desire to see various forms of assistance be delivered (Bateman et al., 2021). The Taliban's willingness to enter negotiations with other Afghans, including the government, over a political settlement has offered both hope and fear to the Afghan people (Mashal, 2021). The Taliban's ambiguity on their ambitions for a post-peace settlement exacerbates some fear that the most difficult work has yet to come. However, if their desire to be recognized with a degree of legitimacy by Afghanistan's neighbors and on the world stage, the international community may have leverage and some ability to advocate for some concessions. If the Taliban are driven to support the Afghan people, they might be more open to the idea that women are allowed to pursue an education, either from the teachings in the community-based intervention, the facilitated travel to other Islamic countries, or even the economic sanctions and benchmarks placed. This would lock in education and employment initiatives for women and girls which is the key to transforming developing economies. Education is vital to the overall health of women as well as a significant proponent in reducing the MMR in Afghanistan. Education allows women the opportunity to pursue a career, to earn a wage, and to break the cycle of poverty; all of which helps to reduce the MMR in Afghanistan. This also shrinks gender gaps and provides the opportunity to receive critical reproductive health education as well. Addressing direct factors of maternal mortality will not reduce Afghanistan's ratio unless the overarching social factors are addressed too from being culturally and religiously competent and aligned with their beliefs.

However, the major limitation to this approach is the amount of time it will take to effect such change. It would be a multi-generational endeavor in a culture rooted in religion that is particularly resistant to change. This strategy would be no simple measure or easy path to

quickly addressing the rising maternal mortality rates in Afghanistan. Despite the difficulties, these are steps that could help open the pathway to a more open-minded relationship and discussion between Afghanistan and the international community. This could initiate creating long-term sustainable changes that could lead to a more prosperous, healthy future for women and girls in Afghanistan. Without creating an efficient, self-reliant, and sustainable healthcare system, Afghanistan and its government will continue to be reliant on international donors and development agencies to bolster and finance its healthcare system. Change from within the culture and religion of Afghanistan, although time-consuming, would be the best strategy for making an enduring and lasting impact for women in Afghanistan.

The impacts of this strategy would help set the foundation for investment in future research in identifying necessary steps for Afghanistan to begin building a sustainable healthcare framework with consistent financial means. A shifting mindset and view on women from within the culture could help to pave the way for women to hold higher governmental positions that would allow them to have their voices heard in policies. The change in perspective and interpretation of the Quran could lead to directed-policy changes that could alter the way Afghan women seek and receive reproductive healthcare services. In prior interventions addressing maternal mortality rates in Afghanistan, there was a focus on addressing either the demand side or supply side of interventions, however neither addressed the barrier that the influence of culture and religion has on the impact on the utilization of the demand and supply of interventions. Implementation of services and facilities providing birth control (i.e., supply side) has been utilized, however without the cultural and familial acceptance and understanding of the use of services and importance of birth control, neither intervention would be successful. The demand and supply side must be integrated to implement programs that are successful and meet

the needs of communities they are aimed towards. Nevertheless, that cannot occur until there is a change in mindset and reconstruction of Afghanistan that is built on their cultural beliefs and past experiences that advocate on behalf of women with proper understanding of the country's sociopolitical and religious history.

Recommendations for future studies include completing needs assessments in various rural Afghan communities to tailor each community-based intervention to best suit the needs of those communities as well as identifying potential non-governmental organizations (NGOs). The NGOs would then conduct the community-based intervention. The offices within the U.S. Department of State, the Special Representative for Afghanistan Reconciliation as well as the Office of Global Women's Issues, should reach out to other Islamic countries and their foreign ministers and ambassadors to gauge the likelihood and level of interests in potentially hosting Taliban leaders and their prominent community stakeholders for diplomatic immersion trips. In addition, the U.S. Department of State and Department of Treasury should evaluate which benchmarks concerning women's rights would be most likely to be accepted by the Taliban, but still serve the U.S.'s primary interest in women's empowerment as women are vectors of both peace and economic progress in Afghanistan.

Conclusion

Maternal mortality rates in Afghanistan remain startlingly high in comparison to other countries in the region, despite the implementation of the BPHS and the CME. Afghanistan has many risk factors affecting reproductive health of adolescent girls and women. Political instability and civil conflict, policies and legislations surrounding reproductive healthcare, workforce shortages and socioeconomic status are main components preventing reproductive healthcare access for women (*see Figure 2*). The underlying common denominator for all these

components is the depth and reach of Afghanistan's culture and religion and how to address this major proponent influencing each sector.

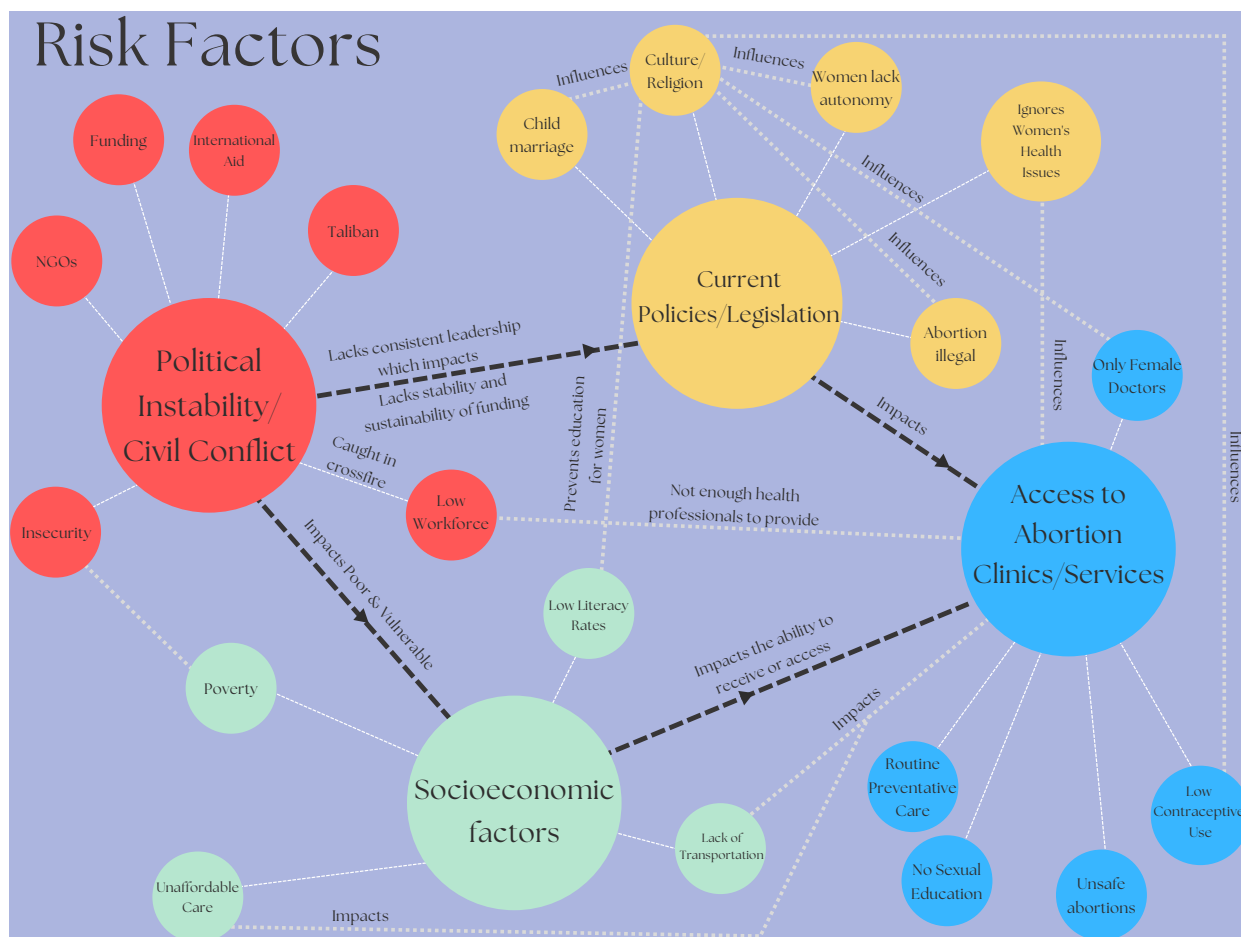


Figure 2 Diagram of Factors Associated with Pregnancy in Afghanistan

Utilizing a method which focuses on an inward cultural shift in mindset and view on women would help reduce the maternal mortality rates and help set the stage for lasting change in Afghanistan. A strategy to accomplish this would be with a three-layer tiered process beginning with targeting rural Afghan communities, then the Taliban leaders and prominent community stakeholders and then Afghanistan as a whole (*see Appendix E*).

Through this strategy, the outcomes and impacts could be transformational for Afghanistan. With a changed perspective on the role of women in society, there is a greater chance that rural Afghan women will have the blessings and approval from the men in their

families and communities to seek reproductive health care services during their pregnancies, thus lowering the maternal mortality rate in Afghanistan. The facilitation of travel to other Islamic countries for Taliban and community leaders and enlisted sanctions would also help to address some of the socioeconomic impacts women currently face. Women may have the opportunity to pursue an education, join the workforce in the healthcare field, rise out of poverty with the increased income, all while subsequently decreasing the rate of unintended pregnancies and lowering the maternal mortality rate in their country.

This approach has the potential to reduce the maternal mortality rates, increase the rate of girls and women pursuing education, reduce the rate of unwanted pregnancy, increase the healthcare workforce, increase the access to reproductive health care services, and help rebuild Afghanistan after decades of conflict. These are the necessary steps to set the groundwork and foundation for reconstructing Afghanistan's healthcare workforce and economic standing. Although this strategy is no simple feat and will most likely take a significant amount of time to effect change, this strategy is a multifaceted approach targeting various levels of engagement in Afghanistan from within and has the potential to create a lasting and enduring impact for Afghan women and the country.

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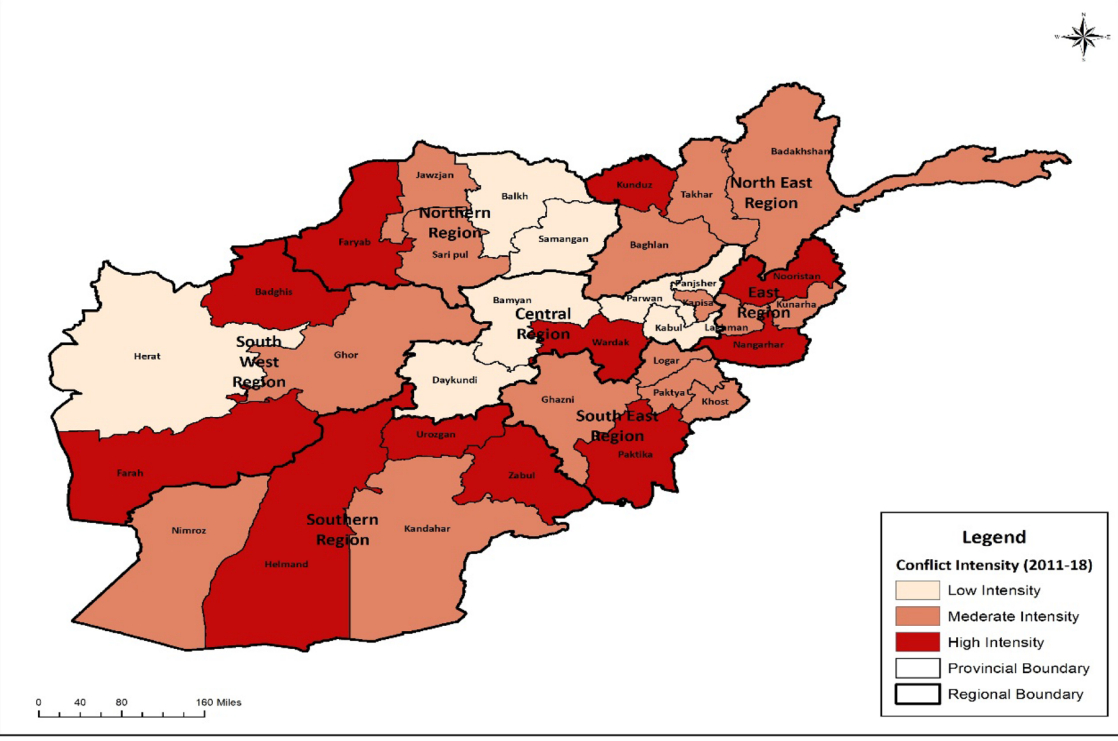
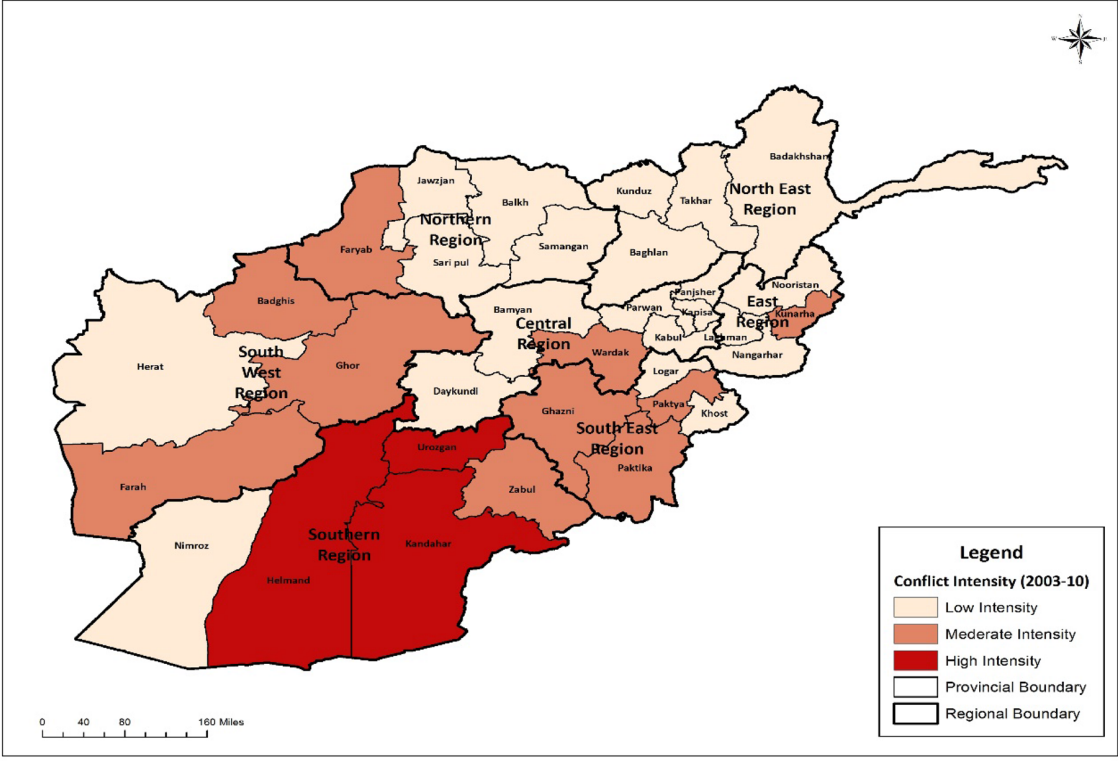
Appendices

Appendix A: Map of Afghanistan and Its Neighbors



(Accera et al., 2008)

Appendix B: Map of Conflict Intensities in Afghanistan



(Mirzazada et al., 2020)

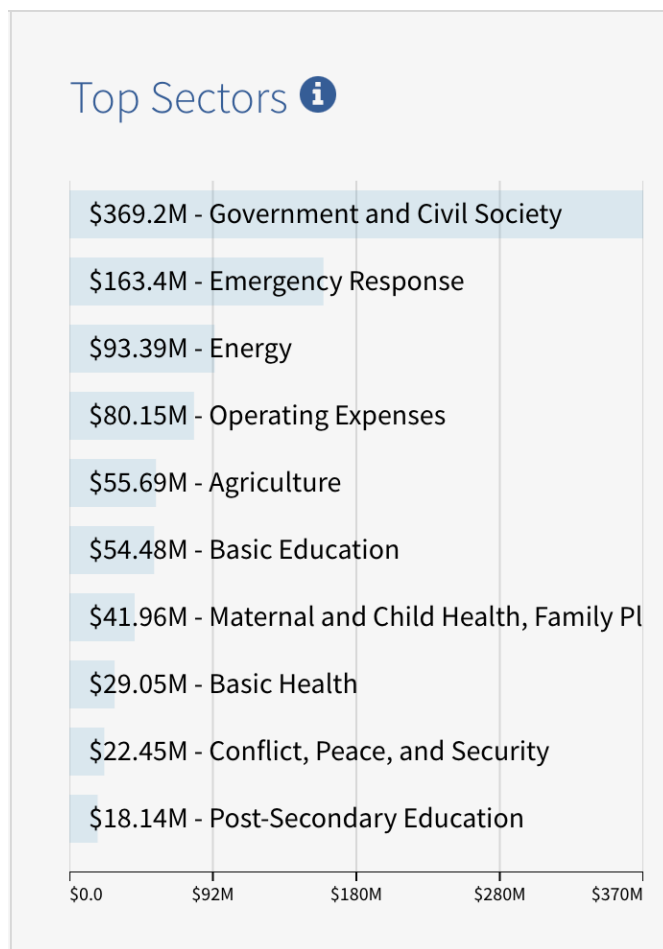
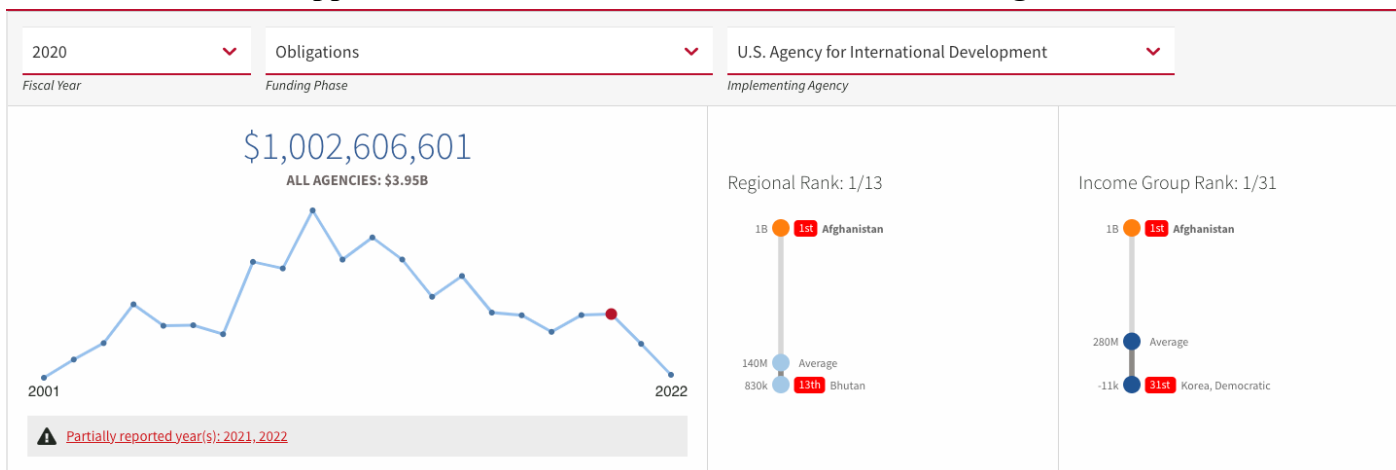
Appendix C: Table of Distributions of Number of Abortions

	Total abortions per year*	Safe abortions		Less-safe abortions		Least-safe abortions		Unsafe abortions (sum of less-safe and least-safe abortions)	
		n	% (90% UI)	n	% (90% UI)	n	% (90% UI)	n	% (90% UI)
Worldwide	55 700 000	30 600 000	54.9% (49.9–59.4)	17 100 000	30.7 (25.5–35.6)	8 010 000	14.4 (11.5–18.1)	25 100 000	45.1 (40.6–50.1)
Developed countries	6 580 000	5 760 000	87.5% (81.9–89.6)	818 000	12.4 (10.2–17.9)	5180	0.08 (0.0–1.36)	823 000	12.5 (10.4–18.1)
Developing countries	49 100 000	24 800 000	50.5% (45.2–55.9)	16 300 000	33.2 (27–38.3)	8 010 000	16.3 (13.1–20.7)	24 300 000	49.5 (44.1–54.9)
Northern America	1 190 000	1 180 000	99.0% (97.7–99.8)	11 200	0.9 (0.2–2.3)	†	0.0 (0.0–0.03)	11 200	0.9 (0.2–2.3)
Europe	4 290 000	3 800 000	88.8% (80.3–91.7)	480 000	11.2 (7.8–19.3)	3 770	0.0 (0.0–0.02)	483 000	11.2 (8.3–19.7)
Southern	750 000	684 000	91.2% (85.6–92.9)	65 400	8.7 (6–13.9)	820	0.11 (0.0–2.9)	66 200	8.8 (7.0–14.5)
Western	562 000	525 000	93.5% (90.6–96.1)	36 500	6.5 (3.9–9.4)	†	0.0 (0.0–0.03)	36 500	6.5 (3.9–9.4)
Northern	349 000	341 000	97.9% (92.8–99.6)	7 370	2.1 (0.4–6.8)	†	0.03 (0.0–0.9)	7 370	2.1 (0.4–7.2)
Eastern	2 630 000	2 250 000	85.8% (73.3–91.1)	370 000	14.1 (8.4–26.5)	2 950	0.11 (0.2–4)	373 000	14.2 (8.8–26.7)
Asia	34 500 000	21 000 000	62.1% (54.8–67.2)	10 500 000	29.7 (23.5–36.6)	2 950 000	8.3 (4.9–13.3)	13 500 000	37.8 (32.8–45.2)
Eastern	12 800 000	11 300 000	88.9% (78.3–95.7)	1 410 000	11.1 (4.1–21.3)	5 730	0.04 (0.0–0.6)	1 420 000	11.1 (4.3–21.7)
South-eastern	5 140 000	3 070 000	59.6% (38.4–77.7)	1 380 000	26.9 (10.8–45.9)	694 000	13.5 (2.3–30)	2 080 000	40.4 (12.3–61.6)
South-central	15 700 000	6 620 000	42.2% (34.1–49.6)	7 040 000	44.9 (35.1–53.3)	2 020 000	12.9 (7–19.2)	9 060 000	57.8 (50.3–65.9)
Western	1 870 000	962 000	51.5% (40.9–66.4)	678 000	36.3 (19.2–48.5)	229 000	12.3 (1.2–23.4)	907 000	48.5 (33.7–59.1)
Latin America	6 420 000	1 510 000	23.6% (8.8–47.0)	3 830 000	59.7 (32.7–72.2)	1 070 000	16.7 (8.8–33.4)	4 900 000	76.4 (53.0–91.3)
Caribbean	519 000	132 000	25.4% (6.7–47.6)	258 000	49.6 (23.8–64.9)	129 000	24.9 (15.1–40.8)	387 000	74.6 (52.4–93.3)
Central America	1 310 000	241 000	18.4% (10.6–28.9)	684 000	52.1 (37.7–63.5)	388 000	29.6 (16.9–40.3)	1 070 000	81.6 (71.1–89.5)
South America	4 590 000	1 140 000	24.9% (4.7–53.7)	2 890 000	63 (28.9–79.3)	555 000	12.1 (3–31.9)	3 440 000	75.1 (46.3–95.4)
Africa	6 860 000	2 010 000	24.4% (18.6–33.6)	2 280 000	27.6 (21.2–37.0)	3 950 000	48.0 (36.5–52.9)	6 230 000	75.6 (66.4–81.4)
Eastern	2 650 000	634 000	23.9% (17.0–33.0)	774 000	29.2 (19.9–37.6)	1 240 000	46.9 (36.5–54.9)	2 020 000	76.1 (66.9–83.0)
Middle	1 020 000	120 000	11.8% (5.5–30.4)	195 000	19.2 (6.7–40.7)	702 000	69.0 (38.0–81.2)	897 000	88.2 (69.6–94.6)
Northern	1 920 000	557 000	29.0% (11.0–49.9)	510 000	26.6 (10–46.3)	852 000	44.4 (19.5–58.9)	1 360 000	71.0 (50.1–89.0)
Western	2 140 000	327 000	15.3% (10.4–24.1)	698 000	32.6 (24.1–42.8)	1 120 000	52.1 (40–59.8)	1 820 000	84.7 (75.9–89.6)
Southern	510 000	375 000	73.5% (27.7–93.2)	98 800	19.4 (1.5–62.1)	36 400	7.1 (2.6–11.1)	135 000	26.5 (6.7–72.3)
Oceania	144 000	95 700	66.3% (61.4–77.7)	11 200	7.8 (3.5–17.9)	37 400	25.9 (11.5–31.1)	48 600	33.7 (22.3–38.6)

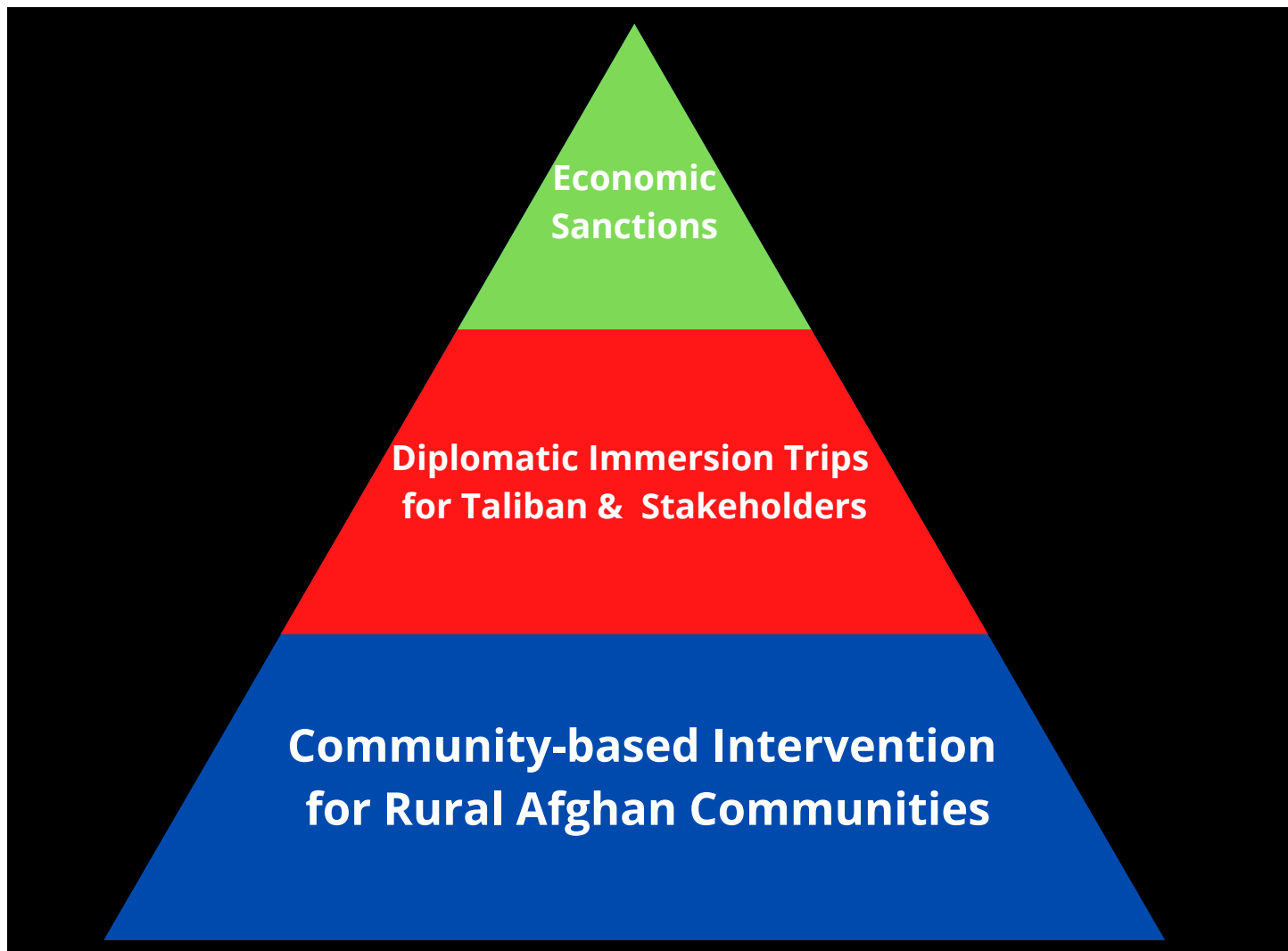
Numbers greater than 10 million are rounded to the nearest 100 000, greater than 1 million to the nearest 10 000, greater than 100 000 to the nearest 1000, greater than 10 000 to the nearest 100, greater than 1000 to the nearest 10, and numbers less than 1000 to the nearest 1. UI=uncertainty interval. UN DESA=UN Department of Economic and Social Affairs. *Data are median. †Estimated numbers were fewer than 200 abortions.

(Ganatra et al., 2017)

Appendix D: Distribution of International Aid for Afghanistan



(U.S. Foreign Assistance in Afghanistan for Fiscal Year 2020, ForeignAssistance.gov)

Appendix E: Diagram of 3-Tiered Intervention Model

(Diagram of the 3-tiered model intervention)

Appendix F: MPH Competencies



CEPH Foundational Competencies

Competency	Anticipated FW Activity
Evidence-based Approaches to Public Health	
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	Conducting a literature review of existing data pertaining to maternal mortality rates in Afghanistan
4. Interpret results of data analysis for public health research, policy and practice	Analyzing and interpreting existing literature to provide recommendations for improvement in policy and practice
Public Health & Health Care Systems	
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings	Analyzing the complex dynamic interactions between the Afghan society, the Taliban, the international community, and the previous Afghan government
Planning & Management to Promote Health	
7. Assess population needs, assets and capacities that affect communities' health	Recommendation for future research of conducting a needs assessment for each rural Afghan community before implementation of community-based interventions
8. Apply awareness of cultural values and practices to the design or implementation of public health policies or programs	Recommendation 1 which is applying awareness of cultural values and religious teachings to conduct a community-based interventions based on teachings and reinterpretations of the Quran to help assist with change from within the culture
9. Design a population-based policy, program, project or intervention	Community-based interventions based on teachings and interpretations of the Quran
Policy in Public Health	
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence	The three-legged stool evaluating the relationship between the Afghan society, Taliban leadership and the international community (i.e., U.S. and western countries)
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	Identification of Taliban leaders and community stakeholders to engage with for diplomatic immersion trips and strong ties with rural communities

14. Advocate for political, social and economic policies and programs that will improve health in diverse populations	The three-tiered recommendation targeting the community at the local level, the leaders of Afghanistan as well as the country as a whole
15. Evaluate policies for their impact on public health and health equity	Rural Afghans are the ones who are most deprived of healthcare services, community based-interventions will serve them first.
Leadership	
16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making	This is the 3-tiered recommendation; guiding change in a perspective for women; exposing Afghan leaders to a future that is inclusive of women in society as well as including sanctions that would help foster and encourage the fulfilment of women's education.
Communication	
19. Communicate audience-appropriate public health content, both in writing and through oral presentation	Community-based interventions would be done in writing and oral presentation in small groups settings
20. Describe the importance of cultural competence in communicating public health content	Community-based intervention is based on teachings within the Quran and the culture.

MPH – Health Policy Leadership Competencies

Competency	Anticipated FW Activity
1. Apply economic concepts to understand the effect of changes in policies at the government, health systems, and public health sectors	The economic aid that is supplied through international community towards Afghanistan
2. Synthesize economic concepts to assess equity and efficiency in making health policy recommendations in underserved communities	Supply and Demand interventions and the success of them is dependent on addressing both at the same time, but also addressing the cultural and religious aspect influencing both.
4. Develop recommendations to improve organizational strategies and capacity to implement health policy	Encouragement of girls and women to pursue an education specifically in the health field to address the workforce shortage