AN ASSESSMENT OF THE POLICY CONTEXT ON WOMEN'S REPRODUCTIVE HEALTH RIGHTS IN AFGHANISTAN

BY

MOHAMMAD YAQOOB MUSLIH

AN INDEPENDENT STUDY SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH IN GLOBAL HEALTH FACULTY OF PUBLIC HEALTH THAMMASAT UNIVERSITY THE ACADEMIC YEAR 2020

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ABSTRACT

Afghanistan faces a high burden of maternal mortality. Sexual and reproductive health rights are vital for sustainable development, while social determinants of women's reproductive health play a key role in advancing the uptake of health services and preventing avoidable deaths. It was unclear to what extent public policy in Afghanistan addresses the social determinants of women's reproductive health rights.

This study applied a documentary review to (i) describe social determinants of women's reproductive health rights relevant to Afghanistan; (ii) explore communities' engagement in policy development; (iii) explore Afghan policy or lack thereof across government sectors affecting women's reproductive health rights; and (iv) determine policy deficiencies. A Boolean search in 4 databases yielded 178 sources. A PRISMA was employed, which produced 165 sources for inclusion in this study.

Social determinants were identified across governance; macroeconomics; socio-cultural values; social cohesion and social capital; living and working conditions; behavioural factors; and health system: quality, access and utilization. Civic engagement was described in terms of policy development, policy implementation and monitoring and evaluation. Current public policies affecting women's reproductive health rights across 7 Afghan line ministries were explored against identified social determinants. For each of the social determinants, sectoral policies were classified into directly, indirectly, or not addressed or conflicting law sources. Policy deficiencies were identified in terms of women's participation in governance and development, in terms of protection for adverse socio-cultural norms and values, in terms of social cohesion and social capital, and terms of the health system.

In broad terms, current Afghan public policies do address key social determinants of women's reproductive health. However, what was often not available was the translation of policy into action plans. In absence of action plans and resources and barriers created by persistent social-cultural norms, policies are at risk of being unable to achieve their full potential.

Keywords: Social Determinants, Health Policy, Values, Reproductive Health Right, Gender Inequality

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AfDHS	Afghanistan Demographic and Health Survey
CDC	Community Development Council
CDD	Community Driven Development
POC	Project Oversight Committees
CBOs	Community-Based Organizations
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSDH	Commission on Social Determinants of Health
EPD	Equity for Peace and Democracy
GDP	Gross Domestic Product
ICPD	International Conference on Population and Development
IO	International Organizations
LDCs	Least Developed Countries
LMIC	Low- and Middle-Income Countries
MDGs	Millennium Development Goals
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MMR	Maternal Mortality Rate
MoPH	Ministry of Public Health
MoUs	Memorandum of Understandings
NGO	Non-Government Organization
PHC	Primary Health Care
RAMOS	Reproductive Age Mortality Survey
RHC	Reproductive Health Care
RHCS	Reproductive Health Care Services
RHS	Reproductive Health Services
SD	Social Determinants
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SRHS	Sexual and Reproductive Health Services
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WB	World Bank
WHO	World Health Organization

CHAPTER 1
INTRODUCTION

1.1 Maternal mortality

The literature reports maternal mortality in various ways. Common measures used are: (a) "maternal mortality ratio (MMR), the most widely used measure, defined as maternal deaths/100,000 live births in the same period; and (b) maternal mortality rate (MMR) defined as the number of maternal deaths within a given period/population of women of reproductive age" (Roback-Morse, 2014).

The World Health Organization (WHO) estimated in 2017 that globally 295,000 women lose their lives annually due to pregnancy and childbirth. This is happening frequently from preventable causes. Amongst these maternal deaths, about 94% happen in countries where they suffer from poverty and insufficient income for daily life. Among which Asia, Sub-Saharan Africa and Southern Asia were reported to present about 86% (254,000) of the projected worldwide maternal deaths (World Health Organization, 2019). The limited availability of health staff and obstetric complications during childbirth are the contributory factors resulting in these deaths among women (Namasivayam et al., 2012a).

In Afghanistan, annually 638 women per 100,000 live births lose due to pregnancy or delivery complications (WHO UNICEF UNFPA WB and UNDP, 2019). Poverty, shortage of health providers and low access to health facilities are factors, resulting in high maternal death in the country.

1.2 Sexual and reproductive health

The 4th International Conference on Population and Development (ICPD), held in Cairo in 1994, recognized the sexual and reproductive needs and rights of individuals and called for universal access to sexual and reproductive health services by 2015.

> "*Sexual and reproductive health (SRH) is an essential component of the universal right to the highest attainable standard of physical and mental health, enshrined in the Universal Declaration of Human Rights and other international human rights conventions, declarations, and consensus agreements. Sexual and reproductive health needs must be met for both men and women. Human rights standards require states to respect, protect, and fulfil the right to sexual and reproductive health, and states must also ensure that individuals have the opportunity to actively participate in the development of health care policy and in individual care decisions —including determining whether and when to have children and in protecting the rights of others to sexual and reproductive health, including through ensuring violence-free relationships and homes and in seeking information, education, and care for one's children*" (Amnesty International USA, n.d., para. 1).

It has been documented that insufficient attention was given to issues concerning women's reproductive health rights (RHR). Moreover, reproductive health (RH) was often framed as a narrow set of health issues with less acknowledgement of its importance to individuals' wellbeing and overall health. This approach is rooted in the cultural and political sensitivities related to sexuality, reproductive choice, and gender inequality. For all individuals to live healthy and satisfying lives and to achieve their full potential, their sexual and reproductive health rights (SRHR) must be fulfilled and respected (Starrs et al., 2018).

The Afghan Ministry of Public Health has developed a comprehensive National Reproductive Health Strategy for lowering maternal mortality. The strategy aims to provide well-organized antenatal care, labour and childbirth, and postnatal care for all. This is expected to be achieved by focusing on increasing the availability of skilled birth attendants (community-based midwives) and expanding the coverage, quality, and use of emergency obstetric care, particularly in rural areas (Bartlett, Mawji, Whitehead, Crouse, Dalil, Ionete, & Salama, 2005).

Nevertheless, in the context of Afghanistan, the term sexual and reproductive health is somehow sensitive. For different cultural reasons, people in rural Afghanistan remain uncomfortable talking openly about sex or sexual and reproductive health. According to experts (Najafizada et al., 2017b), most females in Afghanistan have little or no access to their rights to health and other basic needs, including schooling, participation in the workforce and the political sphere of life. Being an Afghan man and medical doctor who has worked in different rural areas, I know the obstacles females in this country face just to fulfil their health rights. Furthermore, the literature indicates that in Afghan society, customary responsibilities given to women and men prevent spouses from talking about issues associated with their RH needs, which often results in poor SRH for spouses. In customary families, where women have to be obedient and men have the authority of decision-making without involving their wives, there may be little or no discussion on aspects of sexual and reproductive health (SRH), including antenatal care, safe delivery, and postnatal care (Safi & Doneys, 2020).

1.3 Determinants of health

In 1948 the WHO defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. However, several root precursors of health lay outside the health system and involve the social domain (Huber et al., 2011; World Health Organization, 1948). The WHO definition of health is consistent with the biopsychosocial model of health, which considers physiological, psychological, and social factors in health and illness, and interactions between these factors.

In 2005, WHO set up the Commission on Social Determinants of Health (CSDH). One of the objectives of this Commission was to fill the disparity in the scientific evidence about the social determinants of health (SDH) and to build and execute efficient policies and procedures to address social factors of ill health and health inequities. Also, the commission intended to attract the interest of authorities and society to the social factors of health, in establishing healthier social conditions for health, especially among the most susceptible classes. The Commission provided a conceptual framework (see Fig. 1.1) for the action of member nations suggesting the relations between social

determinants and their impacts on societies and persons (Marmot & Bell, 2009; Solar & Irwin, 2007). The SDH structure provides guidance for policy makers in addressing inequities in health.

Social determinants include structural and intermediate determinants. The structural determinants are the political and socioeconomic circumstances that create socioeconomic differences and are mainly accountable for creating injustices. An individual's social status is identified by economic position, level of schooling, background, religion, etc. Intermediate determinants contain the individual and community situation and health system factors, in the case of this study, impacting the maternal health outcomes (Hamal et al., 2018).

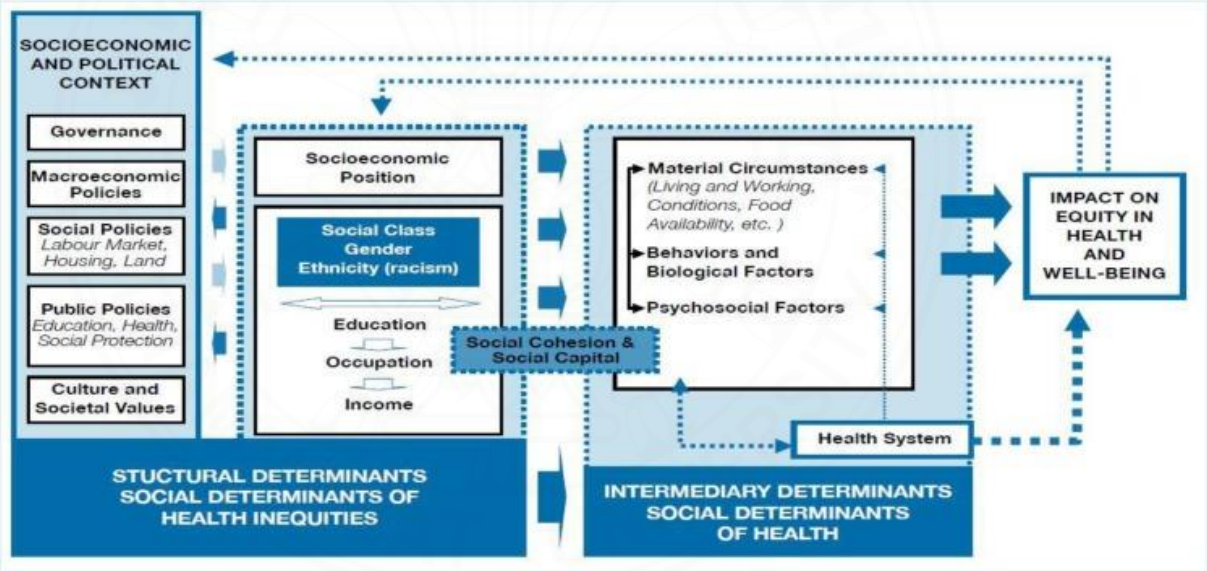


Figure 1.1: Conceptual Framework Social Determinants of Health
Source: WHO (Commission on Social Determinants of Health), 2010

Inequity in health implies a failure to avoid or overcome inequalities in health that infringe on human rights or are otherwise unfair. Health inequities have their roots in the SDH or social stratification and the living conditions of the individual. The SDH can be understood as social conditions in which people are born, live, and work. In addition, SDH can indicate specific features of the social conditions that affect people's health status and its outcome, as well as the pathways by which they are seeking to access health care (Ranson et al., 2007). This is in line with the core principle of the

2030 agenda for sustainable development and the sustainable development goals (SDGs), to ‘leave no one behind, which puts equity at the centre of national and international policy agendas (Buzeti et al., 2020).

Social factors that influence maternal health have been researched in Afghanistan. For instance, studies included the lack of skilled female health personnel, local cultural and traditional practices such as young age marriage and pregnancy, the need for women to get approval from males to visit a health facility, the low level of women schooling and their low position in the family. SDH also encompasses transportation systems including safe public transport, better road connectivity and the delivery of timely transportation when needed, which affect the uptake of RH services in a timely fashion. Further, the affordability of RH services and low power of decision making among Afghan women also impact their access to SRH services (Najafizada et al., 2017b; Safi & Doneys, 2020).

Afghan society has been affected by conflicts for over three decades. Also, the country has been rated 170 out of 181 countries for Gross Domestic Income (GDI) during 2019 (United Nations Development Programme[UNDP], 2019). The literacy rate for adult women and adult men is (18%) and (45%) respectively, illustrating gender inequality (UNESCO, 2014). Based on the report released by the Equality for Peace and Democracy (2015), women account for 28% of the National Parliament, 21% of Provincial Council members, and 35% of Community Development Council (CDC) members. Though Afghanistan’s Constitution recognizes the equality of men and women, there is limited participation of women in the labour force, women are missing from political activities and decision-making at all levels of public life. In Afghanistan, gender relationships are influenced by socio-cultural customs and norms that create hierarchical relations, in which males have an influential status and females have inferior status. While the extent of these relations differs across urban-rural areas, ethnic groups, and provinces. In general, Afghan society requires women to be mothers and wives doing (unpaid) household duties and child-rearing. Men are supposed to be primary breadwinners and making the decisions, earning income through participating

in formal employment or entrepreneurship, and take part in the public sphere and public life (Equality for Peace and Democracy [EPD], 2015).

1.4 Reproductive health services

RH *"includes the reproductive processes, functions, and systems at all stages of life". "It is also acknowledged within the framework of the WHO definition of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes*" (World Health Organization [WHO], 2000). RHC is *defined as the set of methods, techniques, and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems.* Access to safe, effective, affordable, and acceptable Reproductive Health Care Services (RHCS) will improve couples' reproductive wellbeing and enable them to have a responsible, safe, and satisfying reproductive and sexual life (Becker, 1996; Becker & Robinson, 1998).

The strategy on reproductive health on a national level is formed to guarantee that all Afghan inhabitants get access to basic reproductive health services. Also, the national RH strategy aims to improve women's health and reduce illness and death and achieve comprehensive access to RHCS (Ministry of Public Health [MoPH], 2012a). Despite the improving accessibility of RHC services in past years, inhabitants in rural Afghanistan continue to endure from the limited access to these vital services" (Hadi et al., 2005). The government of Afghanistan has promised to obtain comprehensive access to RHCS for all Afghan residents in the following of the SDGs and priority was put on enhancing the condition of and access to RHCS (United Nations[UN], 2014).

Solely for this study, the term RHCS is limited to the following services: antenatal care, delivery, and postnatal care. These services are essential for females in a conservative society such as Afghanistan. Women's access to these services will help them going safely through pregnancy or childbirth.

1.5 Sustainable development goals (SDGs)

Besides specifically addressing maternal mortality, various SDGs aim to foster gender fairness and empowerment of women. These create a nurturing context in addressing the reproductive health rights of women. SDG directly or indirectly impacting maternal mortality are portrayed in the sections below:

SDG3 ensures healthy lives and promote wellbeing for all at all ages. Target 3.1 specifically addresses global maternal mortality by reducing the ratio to less than 70 per 100,000 live births by 2030. Target 3.7 ensures universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030. Whereas target 3.8 promotes the achievement of universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

SDG4 quality education has several targets among which target 4.1 ensures that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes by 2030. Target 4.3 ensures equal access for all women and men to affordable and quality technical, vocational, and tertiary education, including university by 2030. Target 4.5 eliminates gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples, and children in vulnerable situations by 2030. Target 4.6 ensures that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy by 2030. Target 4.7 ensures that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and nonviolence, global citizenship and appreciation of cultural diversity and culture's contribution to sustainable development by 2030 (Ashley, 2016).

SDG5 focuses on achieving gender equality and empower all women and girls gender inequalities intersect with other forms of discrimination, contributing to inequities in

income, living conditions, social and human capital, work, and employment. Addressing these inequities is a prerequisite for achieving universal health coverage (Buzeti et al., 2020). Target 5.1 focuses on achieving gender equality and empower all women and girls. Target 5. 2 eliminates all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. Target 5.3 eliminates all harmful practices, such as child, early and forced marriage and female genital mutilation. Target 5.5 ensures women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life. Target 5.6 ensures universal access to sexual and reproductive health and reproductive rights as agreed by the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (Esquivel, 2016, p. 11).

SDG 16 focuses on peace, justice, and strong institutions and it is in line with the human rights framework, as most of the 12 targets and 23 indicators of SDG 16 reflect rights enshrined within the International Covenant on Civil and Political Rights (Ivanovic et al., 2018). Some of the targets are relevant to improving maternal health. For instance, significantly reduce all forms of violence and related death rates everywhere by 2030; provide legal identity for all, including birth registration; ensure public access to information and protect fundamental freedoms by national legislation and international agreements; strengthen relevant national institutions, including through international cooperation, for building capacity at all levels, in particular in developing countries, to prevent violence and combat terrorism and crime and; and promote and enforce non-discriminatory laws and policies for sustainable development (UNDP, 2016b).

SDG 17 focuses on partnerships about all goals. It acknowledges the need for developing 'an integrated, holistic, multi-stakeholder approach which is an expression of systemic sensibility; and an appreciation that implementing any one of the SDGs will have effects on other SDGs (MacDonald et al., 2018). Target 17.9 enhances international support for implementing effective and targeted capacity-building in developing countries to support national plans to implement all the Sustainable

Development Goals, including through North-South, South-South and triangular cooperation. Whereas target 17.16 enhances the Global Partnership for Sustainable Development, complemented by multi-stakeholder partnerships that mobilize and share knowledge, expertise, technology and financial resources, to support the achievement of the SDGs in all countries, in particular developing countries (United Nations, 2016).

1.6 Problem statement

Though the WHO SDH and the UN SDGs address inequities, including other relevant global conventions, maternal mortality remains a challenge worldwide. About 99% of these deaths occur in low resource countries, and almost one third occur in the South Asia region (WHO, 2014). As mentioned in the introduction section, in Afghanistan, for every 100,000 live births, annually 638 women die due to pregnancy complications or childbirth (WHO UNICEF UNFPA WB and UNDP, 2019). Various factors attribute to high maternal deaths amongst Afghan women. Though the government of Afghanistan invested in RHCS to increase women's access to these services, evidence shows that Afghan women's access to skilled birth attendance and ANC was only 21% and 43% respectively (UNICEF, 2015).

1.7 Importance of the study

1.7.1 Relevance to global health

Women's wellbeing and health are closely linked to both global and national development. Leading causes of maternal mortality in resource-poor Afghanistan are preventable. The solution relies on receiving essential RHCS to the individuals who require them along with tackling underlying injustice. To realize this, political will and funds must be in place to building a tailored cross-sectoral approach in addressing gender inequality, support community-based initiatives and strengthen health systems. The SDGs have emphasized the significance of tackling maternal health and advocating gender fairness for overall global and national advancement.

A focus on social determinants of women's RH contributes to reaching SDGs over the coming decade. Because women everywhere want and need RH services to monitor

pregnancies, deliver babies safely, monitor their recovery from giving birth and ensure their newborns are doing well (Barot, 2015).

The study focuses on Afghan women, triggered by maternal mortality, which not only contributes to SDG-3 but through an appreciation of the SD of maternal health expands its attention to SDG4, SDG5, SDG16 and SDG17 to create the conditions in which women of reproductive age can live a healthy life. This study capitalizes on the momentum created by the United Nations' SDGs and other global agendas to promote broad policies to support women's health in Afghanistan and situates at the global-local interface of health and development.

1.7.2 Afghan peace deal

The peace agreement for Afghanistan, negotiated among the USA and the Taliban, illustrates both the urgency and the importance of contributing to advocacy within Afghanistan on women's right to reproductive health.

1.8 Expected outcomes

- Independent study report
- A Ministry of Public Health 'green paper' to facilitate an inter-sectoral dialogue on the need for an integrated plan of action on creating the conditions that enable women's access to RH services in Afghanistan.

CHAPTER 2
REVIEW OF LITERATURE

2.1 Introduction

This chapter presents a synopsis of the literature on the challenges in measuring maternal mortality; RH rights and global commitments on women's reproductive health in support of global development; and sustainable development and health equity. The review enables the formulation of the inquiry problem and the related question and study objectives. Finally, the interactions between core values, SDH, SDGs, health equity and women's access to RHCS, ultimately impacting maternal mortality are presented in the study's conceptual frame including the scope of the study.

2.2 Maternal mortality

Maternal mortality is challenging to measure because of the problems with differentiating between deaths due to the pregnancy as opposed to entirely happening during the pregnancy or being measured by the pregnancy-related mortality ratio. Another problem is finding deaths, particularly in settings such as Afghanistan, where geography and security can severely limit access to household surveys. Despite these challenges, Afghanistan is among the highest-burden countries for maternal morality (Alba et al., 2020). For instance, the first MMR estimates produced for Afghanistan came from the 2002 Reproductive Age Mortality Survey (RAMOS) with an estimate of 1,600 deaths per 100,000 live births. The same survey's official publication in 2005 only presented four subnational estimates, ranging from 418 in Kabul to 6,507 in the Raghu district of Badakhshan province. These widely quoted estimates resulted in the key focus on maternal mortality in policy and planning for Afghanistan. Although another primary survey estimated the MMR to be 327 per 100,000 live births in 2010. This result was controversial and criticized as implausibly low and potentially jeopardizing future investments in maternal health in the country (Afghanistan Ministry of Public Health, 2011; Alba et al., 2020; Azimi et al., 2015). Later, in 2015, the Afghanistan Demography Health Survey (AfDHS) stated that the MMR was 1,291

annually per 100,000 live births. The AfDHS 2015 estimations with an MMR of 1291 was likewise criticized for being too high. Finally, an interagency report stated that in every 100,000 live births annually 638 women die due to pregnancy complications or childbirth in Afghanistan (WHO UNICEF UNFPA WB and UNDP, 2019). Though reports suggest that MMR is declining in Afghanistan, maternal deaths are somehow hard to measure and survey methodologies failed to yield reliable findings due to challenges in civil registration. In absence of a functional civil registration system, measures of uptake and use of RH services for Afghan women might be a more reliable measure (Alba et al., 2020).

The maternal death in Afghan women is the result of a complex interrelated causal web, including low uptake of RH services (Safi & Doneys, 2020), a large number of children, early marriage, and frequent child birth at close intervals (Azimi et al., 2015), low income, low level of awareness/ illiteracy, lack of information on women health and lack of delivery by skilled birth attendance, social norms, and poor health (Tappis et al., 2016; World Bank, 2005c). Common limitations on schooling and participating in the workforce results in a shortage of female health staff and reduce women's ability to seek healthcare. The lack of ability to leave their homes without the approval of a male relative is also a limitation. These factors are more dominant in rural areas and combined with the direct effects of conflict on travel safety result in a delay in seeking care (Bartlett, Mawji, Whitehead, Crouse, Dalil, Ionete, Salama, et al., 2005; Van Egmond et al., 2004).

2.3 Reproductive health rights and global development

ICPD 1994 affirmed the link between population and development and introduced the concepts of SRH, reproductive rights, and women empowerment. However, globally SRH rights are neglected due to a lack of uniform understanding and opposing belief systems, which posed a barrier to the MDGs. The Cairo Conference achieved consensus on key issues such as universal access to education, reduction of infant, child, and maternal mortality, and access to reproductive and sexual health services, including family planning (Adewole & Gavira, 2018). ICPD described reproductive rights as

resting on, the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. However, globally SRH rights are neglected or have not been prioritized by many governments due to a lack of uniform understanding and opposing belief systems. For example, China's one-child policy was enacted in 1980 to restrict population growth and maximize gross domestic product (GDP) growth. The policy was relaxed in 2016, in response to its unintended social and economic consequences, including an ageing population and a sex ratio skewed towards men for Chinese nationals.

A government's dependence on foreign aid influences whether countries support or overlook HR issues. For example, the USA, as a major donor for universal health programs, exercised its influence over developing nations that obtained USAID funding (Starrs et al., 2018). The 2030 Agenda for Sustainable Development explicitly mentions sexual and reproductive health, with Sustainable Development Goal target 3.7. Universal access to SRHR services is expected to provide leverage for ensuring that no one is left behind. The universal access also focuses on comprehensive reproductive health care services such as family planning and sexual health; reducing child and maternal mortality; providing universal access to basic education, in particular for girls; and improving gender equity and women's empowerment (Adewole & Gavira, 2018).

Several universal authorized treaties highlight the rights to SRH. Table 2.1 below presents in chronological order an overview of important international agreements addressing reproductive health rights.

Table 2.1: International Legal Agreements Addressing Reproductive Health Rights

1948	The Universal Declaration of Human Rights (art. 25) Everyone has the right to a standard of living, adequate health and well-being of himself and his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
1974	At the World Conference on Population, the international community highlighted common concerns over emerging population issues by

	adopting the World Population Plan of Action, containing recommendations and guidelines aimed at a better quality of life and rapid socio-economic development" for all people.
1979	Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).
1984	International Conference on Population in Mexico. The Conference adopted the recommendations for the further implementation of the World Population Plan for Action.
1989	UN Convention on the Rights of the Child (art. 17, 23-25 and 27) The CRC has three optional protocols, of which two are related to SRHR. First, the prohibition of the sale of children, child prostitution and child pornography, and second, the right of children to file complaints when their rights have been violated.
1994	International Conference on Population and Development (ICPD). A total of 179 countries at ICDP agreed to set several independent goals to be attained by 2015. These goals consist of universal access to comprehensive reproductive health care services, such as family planning and sexual health; reducing child and maternal mortality; providing universal access to basic education, in particular for girls; and improving gender equity and women's empowerment.
1995	International Conference on Women in Beijing.
2000	Millennium Development Goals 2, 3, 4, 5 & 6.
2006	International Convention on the Rights of Persons with Disabilities (art. 9, 12, 16, 22-23, 25 & 32) The CRPD includes articles that promote the inclusion of disabled people in SRHR and stipulates that governments should guarantee access to SRHS and should protect the rights of people with disabilities in this regard.15.
2015	Sustainable Development Goals 3, 4, 5, 6,16 & 17.

Since 1948, international policies and agreements have placed attention on SRH needs and rights, with individuals' sexual direction and gender equality, aiming at enhancing the standard of care, improving access to safe SRH services, achieve desired reproductive health goals, including women's ability to exercise control over their reproductive and sexual lives, to improving maternal health and reducing maternal mortality; recognizing that these goals may be affected by gender power relations, norms, and roles applied to women and men. Therefore, understanding factors such as gender relations, norms, and roles applied for women and men within families and societies may help to understand how to increase women's access to reproductive health

care services, how to address sexual and gender-based violence, how to reduce health-related gender disparities, and justice for women (UNDP, 2016b, p. 16).

2.4 Reproductive Health in Afghanistan

The poverty, shortage of female health workers and low access among other factors contribute to maternal mortality in Afghanistan. The Afghan Ministry of Public Health has developed a comprehensive National Reproductive Health Strategy for lowering maternal mortality. This strategy aims to provide well-organized antenatal care for all by focusing on increasing the availability of skilled birth attendants (community-based midwives), enhancing quality, expanding coverage and use of emergency obstetric care, particularly in rural areas (Bartlett, Mawji, Whitehead, Crouse, Dalil, Ionete, & Salama, 2005).

To improve the quality of RHCS, the National Reproductive Health Strategy adopted the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) (Ministry of Public Health [MoPH], 2012a). Additionally, an estimated budgetary commitment of about 3.1 billion USD was made by the Afghanistan government and the international community to the health sector for 2016-2020. This commitment included ordinary and development budgets, as well as direct donor contributions for strengthening access to health services (Ministry of Public Health [MOPH], 2016).

Despite these efforts, Afghan women's access to reproductive health care services remains low (UNICEF, 2015). An assessment conducted by Doctors for Human Rights reported that at one point 53 % of women extremely suffered from illnesses but were unable to receive RH services (Condee Padunov, 2010).

The Afghanistan Mortality Survey 2010 conducted by the Ministry of Public Health reported that the life expectancy at birth is nearly the same for females at 64.2 years compared to 63.6 years for males (Afghanistan Ministry of Public Health, 2011). According to the World Bank (2005), women in Afghanistan are three times as likely as men to die between 15 to 49 years of age. The same report indicated that, due to pre-

disposed health and social factors, Afghan women have a high risk of dying during pregnancy (World Bank, 2005a).

During pregnancy, 74 % of maternal deaths could have been prevented if women had access to essential obstetric care such as safe delivery by skilled birth attendants (Wagstaff & Mariam, 2004, p. 6).

2. 5 Ethnical Diversity in Afghanistan

Afghanistan is culturally a diverse state with over fourteen ethnic groups[1]. This rich tapestry of tribal groups presents its challenges as national unity only seemed to awaken during the decades of war with foreign invaders. Rivalry across tribal groups translated into political tensions, maladministration of diversity, corruption, and low levels of education (Mujtaba, 2013).

Pashtun is the dominant ethnic group in Afghanistan and account for over half of the population and followed by Tajik 25%, Uzbek 6%, Hazara 12%, and other 5% respectively. The predominant religion in Afghanistan is Islam which 99% of the population follow. The Afghan Muslim population is divided into two groups Sunni and Shia, in which the Sunni Muslims are approximately 85% of the Afghan population and the Shi'a makes up 14% of the Afghan population.

The Pashtun ethnic group reside in the eastern and southern provinces of the country and most speak Pashtu and are mostly Sunni Muslims. They are divided into tribal and sub-tribal groups to which they remain loyal, and their family structure is mainly extended, families. These multigenerational units practice close economic cooperation and come together in all life-crisis situations because in most of the rural communities the extended family acts as an important social and economic unit (Merrill et al., 2006b). The headships and guardians of the family honour are related to the eldest male (usually the grandfather or father). The eldest male has high power, and he is the one

[1] Pashtun, Tajik, Hazara, Uzbek, Turkman, Baluch, Pachaie, Nuristani, Aymaq, Arab, Qirghiz, Qizilbash, Gujur, Brahwui and other tribes.

who oversees the household income activity and takes all decisions regarding the household tasks, welfare and needs (Coleridge, 1999; Morioka-Douglas et al., 2004). As described by Merrill et al. (2006):

> *The values and beliefs in extended family life emphasize a man as the head of the family to control over family decisions, as well as promote a patriarchal notion within the family. On the other hand, these values and beliefs subordinate women to men and pressurize them to play the role of caretaker for the household. In rural Afghan society, Tajik are also living in extended families and to some extent having the same values and norms as Pashtuns* (Merrill et al., 2006a, p. 7).

Whereas the Tajiks residing in urban areas of the country's, have access to education and are believed to be well-off. They are mainly Sunni Muslims, they speak and write Persian and settled in the western and northeastern areas of Afghanistan (Merrill et al., 2006a).

Other than the influence of ethnicity on gender roles, gender relations between women and men are shaped by socio-cultural norms and customs that create hierarchical relationships, in which males are dominant and females are subordinate. Although the degree of hierarchy and dynamics of these relationships vary by urban/rural area, ethnic group, and region. In general, Afghan society expects women to be wives and mothers, performing (unpaid) household responsibilities such as housework, and child-rearing. Men are expected to be primary decision-makers, earn income through formal employment or entrepreneurship, and take active roles in public life, whether as leaders, public officials, or first-hand citizens.

Ongoing gender issues which limit Afghan girls' and women's rights, dignity, and well-being include early marriage, discriminatory family code (forced marriage, exchange of women for resolving family disputes in rural areas), and many forms of gender-based violence limiting women's access to SRH and family planning services. Other than women's limited access to their SRH services, gender inequality affects women's

access to education, economic opportunities, and political participation within the country (Equality for Peace and Democracy [EPD], 2015).

2.6 Sustainable development and health equity

For more than two decades after ICPD, SRH rights remain ignored by some countries and females' RH issues continue to fuel disputes across different ideologies, with devastating effects on women's health, in particular in low-income countries (Zuccala & Horton, 2018).

The Lancet Commission on SRH (2018) argues that SRHR is essential for sustainable development because of their links to gender equity, its impact on maternal health, and its roles in contributing to economic development and environmental sustainability. Unfortunately, progress towards fulfilling SRHR for all has been hindered because of lack of political commitment, lack of resources, persistent discrimination against women (Guttmacher–Lancet Commission, 2018).

In the work of the UN, the health of women, and in particular reproductive health rights, have become politicized. Forums of the UN have become a platform for dispute between those who would frame reproductive rights as a morality policy versus those who frame these rights as a feminist policy. The framing of women's reproductive rights poses a unique challenge to implementing some of the goals of SDG3 and targets 3.1, 3.7, and 3.8. Strategies to overcome the challenge are twofold: (i) UN might return to the different frames, often found when addressing reproductive rights in media; and (ii) a medical frame, which is more effective both at the local and at the intergovernmental level. Therefore, UN organizations must more fully commit to seeing reproductive health as a public health issue (Sommer 2020).

The SDGs exemplify a potentially transformative advancement plan as it provides a strong focus on inclusion and reducing inequalities. Marmot and Bell (2018) argue that health equity provides a cross-cutting theme, based on evidence, that would help countries develop coherent action across the sectoral goals and target areas of the SDGs.

Health equity resonates with the SDGs' overarching principle of leaving no one behind and the implicit moral imperative of social justice. Health equity, as described by the WHO Commission on Social Determinants of Health (CSDH), is the absence of inequalities in health that are avoidable by reasonable means. Health is universally valued, and health for all is a societal goal justifiable on moral grounds. Achieve health equity requires action on the social determinants of health (CSDH, 2008).

The SDH discussion on the source of data that connects ill health to SDH reflecting contributory paths in broad abstract structures led to common consciousness that wellbeing and health differences are the outcome of interrelating SDH. A study by Krumeich and Meershoek (2014) explains how SDH contexts can be interpreted to successfully inform specific public health policies. The authors indicate important challenges affecting passable translation of SDH structure or outline into existing strategy and interference as follow: (i) overcoming the inclination to conceptualize SDH as mere barriers to health behaviour to be modified by lifestyle interventions by addressing them as structural factors instead; (ii) obtaining sufficient in-depth insight in and evidence for the exact nature of the relationship between SDs and health. (iii) to adequately translate general determinants and pathways into explanations for ill health and limited access to health care in local settings. (iv) to develop and implement policies and other interventions that are adjusted to those local circumstances. They conclude that to transform generic SDH models into useful policy tools, an in-depth understanding of the unique interplay between local, national, and global SDH in a local setting is needed to be able to address structural SD in the local setting and decrease health inequity (Krumeich & Meershoek, 2014).

2.7 Conceptualizing the literature

The diagram, presented in Figure 2.1, illustrates the interplay between sustainable development goals, structural determinants of health, health equity for women, contributing to promoting access to RHS for Afghan women ultimately supporting the achievement of global SDG 3.1 to reduce maternal mortality. All of this is within the context of global political systems & processes, global public goods (e.g. knowledge,

human security), development assistance and moral values (e.g. health as a human right, women rights, social justice, equity).

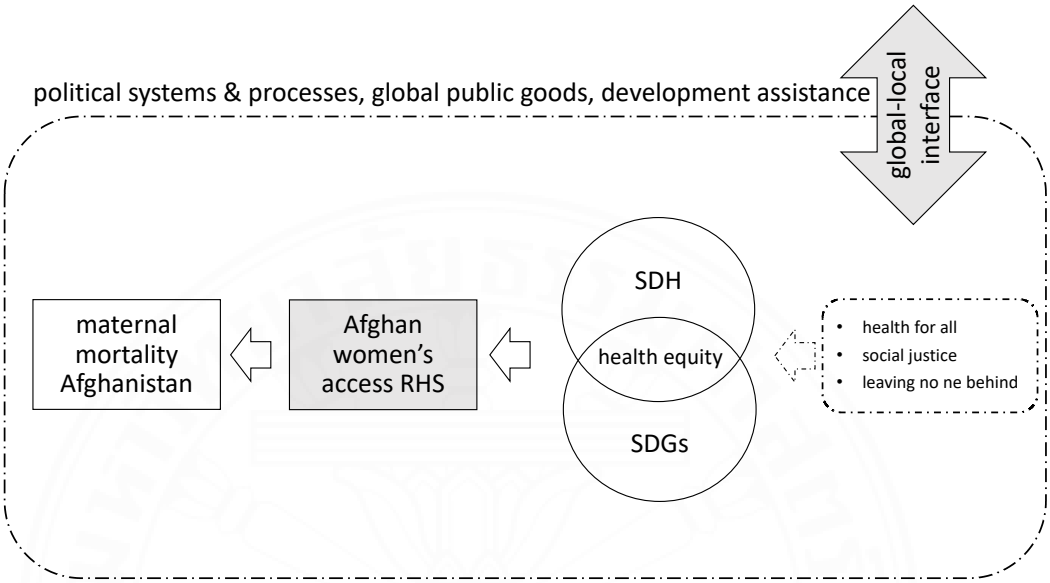


Figure 2.1: A Conceptualization of the Literature

2.8 Inquiry problem

Although globally, maternal death reduced by more than 40% between 1990 and 2015, inequalities exist both between and within states, with Afghanistan being among the highest-burden countries suffering high maternal mortality. SRH rights are vital for SDGs due to their relations to gender fairness and women's welfare, their influence on youth health, female health, new-born and children, and their roles in influencing upcoming financial progress and ecological sustainability within a country. SD of women's RH plays a key role in advancing their uptake of RH services and preventing maternal mortality. To date, it is unclear to what extent public policy and action plans in Afghanistan address the SD of women's RH. This requires recognizing the interaction between local, nationwide SDH in Afghanistan to be capable to address structural determinants (SDH) in Afghanistan and lessening health injustice.

Therefore, the question surfaces to what extend are key SD of women's reproductive health addressed by policies across relevant Afghan government sectors? In addition,

what joined cross-sector efforts are in place to bring about change in women's access to RHCS? Moreover, in the context of the global community's SDGs, it is unclear to what extent public policy addresses SDGs relevant to women and maternal mortality in Afghanistan. And finally, to what extend is public policy addressing local priorities grounded in Afghanistan's socio-cultural realities and/or serves global actor values and priorities?

2.9 Study scope

About the inquiry problem described above, SRH-rights of Afghan women are a complex issue involving besides local determinants also global-local interactions and impacts. While recognizing its complexity, within the scope of an independent study project, it is not feasible to address this holistically. Therefore, this study will be limited to a broad analysis of national policy concerning SRH rights of women in Afghanistan and its relevance to locally identified needs and socio-cultural realities expressed as social determinants.

2.10 Inquiry question and objectives

2.10.1 Inquiry question

To what extend does domestic public policy and action plans address relevant key social determinants of women rights to reproductive health in Afghanistan?

2.10.2 Inquiry objectives

- Describe social determinants relevant to women's RH rights and maternal mortality in Afghanistan.
- Explore the involvement of local policy actors in the development of public policy related to women's RH rights and maternal mortality.
- Explore Afghan public policy or lack thereof affecting women's RH rights and maternal mortality across relevant sectors.
- Determine deficiencies in Afghan public policy adversely affecting women's RH rights and maternal mortality.

2.11 Conceptual Framework

The conceptual framework of the study is presented in Figure 2 below. As described under study scope, section 2.7, the study limits its focus to (a) explore the literature to describe the social determinants of women's RH relevant to Afghanistan; (b) explore Afghan public policies to describe those relevant to promoting women's RH rights, and (c) explore the literature to describe the bottom-up policy-making process in Afghanistan. An analysis of these three foci could then allow: (i) identification of key social determinants of women's RH addressed by public policy; (ii) describe how local policy actors are involved in the development of policies relevant to RH rights of Afghan women; and (iii) identify areas for improvement in terms of RH rights policymaking and policy content.

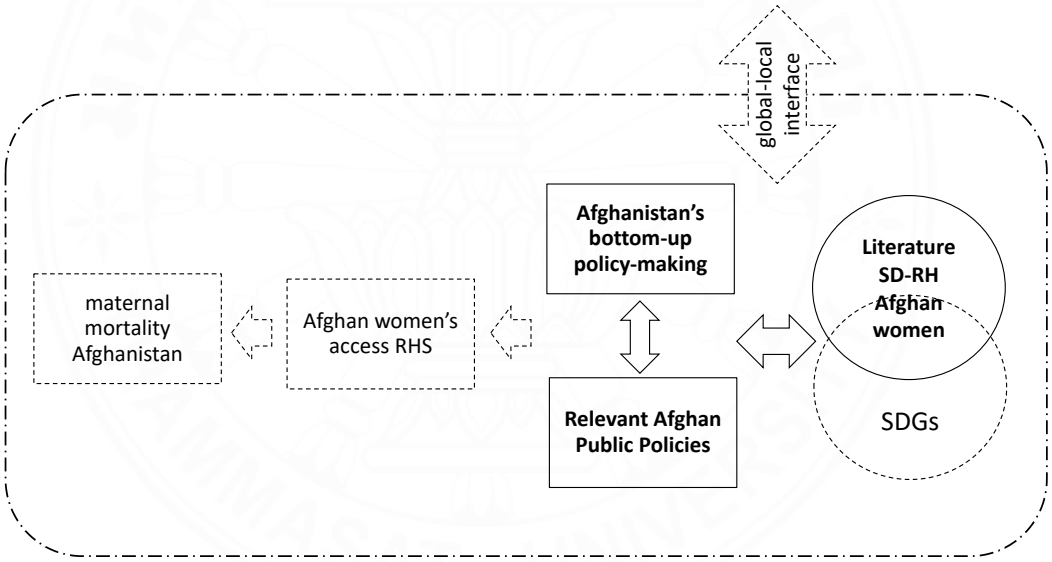


Figure 2.2: Conceptual Framework of the Study

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Study design

The study adopted a qualitative documentary review. It reviewed the SD of women's RH relevant to Afghanistan; the involvement of local actors in the process of the formulation of policy; and the national programs and strategies relevant to RH for women in Afghanistan, by analyzing policy content. This allowed us to identify RH policy and policy deficiencies in addressing women's rights to RH in Afghanistan.

3.2 Sample frame & strategy

3.2.1 Sources

Academic publications, grey literature (i.e., international organizations' publications and reports), and Afghan government documents.

3.2.2 Sampling strategy

Internet-based: search engines such as Medline, PubMed, Google Scholar, and public access domains.

Hard copies: government documents such as MoUs, policy briefs, guidelines, allocated resources, and reports on action plans.

3.2.3 Search strategy

A Boolean search strategy facilitated retrieval of internet-based electronic data. The Boolean search query combined "key words" with operators "AND", "OR", "NOT". For example social determinants "AND" women's RH "OR" women's RH rights "AND" Afghanistan; bottom-up "OR" local involvement "AND" policymaking "AND" Afghanistan; policy "OR" strategy "AND" women's reproductive rights "OR" women's RH "AND" Afghanistan.

3.2.4 Selection criteria

- *Inclusion criteria:*
    - Documents and peer-reviewed journal publications in English[2]
    - Produced from 2004 to 2020
    - Related to SD of women's RH in Afghanistan and other Muslim societies; related to bottom-up policymaking in Afghanistan; and Afghan policy briefs, action plans and guidelines addressing key SDH relevant to women's RH and allocated resources.
- *Exclusion criteria:*
    - Abstracts only

3.3 Data collection

In addition to papers published in academic journals, documents such as MoUs, policy briefs, guidelines, action plans, and resource allocations were retrieved from Government agencies or line ministries.

3.4 Data management

- The PRISMA flow diagram was used to depict the flow of documents through the different phases of the documentary review. It assisted in mapping out the number of documents retrieved, documents included and excluded and the reasons for exclusion.
- Selected documents were stored in EndNote for data management and citation purposes.

3.5 Data analysis

3.5.1 Analysis framework

The review of the documents was undertaken on: (i) publications related to social determinants of women's reproductive health, either in Afghanistan, South Asian and

[2] Although the official language for the Afghan Government is Dari, most policy related documents were available in English.

Middle East Muslim LMICs; (ii) publications on the process of involving local actors in policy-making processes in Afghanistan; (iii) and on public policy briefs of selected sectors of the Afghan Government. This review was guided by an analysis framework presented in Table 3.1 below.

Table 3.1: Analysis Framework

<table>
<tr><th>Women's RH (MM)</th><th colspan="2">SDH (women's RH)</th><th>National Policy of the Sectorial Ministries</th><th>Bottom-up Policymaking</th></tr>
<tr><td rowspan="6">Equitable Health for Women</td><td rowspan="3">Structural determinants</td><td>Socio-economic-political context</td><td rowspan="6">Relevant public policies of:
Ministry of Education
Ministry of Higher Education
Ministry of Information & communication
Ministry of Justice
Ministry of Public Health
Ministry of Women Affairs
Ministry of Religious Affairs</td><td rowspan="6">Civic engagement in policy development

Civic engagement in policy implementation

Civic engagement in policy monitoring & evaluation</td></tr>
<tr><td>Culture and social values</td></tr>
<tr><td>Socio-economic position & socio-demographic status</td></tr>
<tr><td rowspan="3">Bridging determinants</td><td>Community-level factors</td></tr>
<tr><td>Social connectedness</td></tr>
<tr><td>Social mobility</td></tr>
<tr><td rowspan="2">Intermediate determinants</td><td>Personal factors</td></tr>
<tr><td>Health system factors</td></tr>
</table>

3.5.3 Qualitative data

The analysis applied a thematic content analysis and was aided by matrix displays to explore patterns. The data were manually coded to create categories. Next, the data were attributed to various categories. Whereas clusters of categories formed themes that were analyzed to gain insights and discover patterns.

3.5.4 Triangulation

Where appropriate, findings were compared from two or more different sources and or two or more different data collection methods. This facilitated the discovery of regularities, comprehension of meaning and reflection; and identified cross-validation and or discrepancies.

CHAPTER 4
Results and Discussion

4.1 Introduction

This section highlights the study findings on the documentary review organized by the study objectives as follows: (a) findings on the social determinants of women's RH; (b) findings on the involvement of community representatives in the policy-making process in Afghanistan; (c) findings on Afghan public and social policies relevant to women's RH rights; and finally (d) findings on deficiencies in the Afghan public and social policies that adversely affect women's RH rights.

4.2 Documentary Review Findings

The PRISMA flowchart presented in Figure 4.1 below reports on the number of documents retrieved from searches, and the systematic removal and selection of documents portraying the flow of data through the diverse stages of documentary assessment. It enabled mapping out the number of records recognized, incorporated, and omitted from the assessment/review.

In addition, based on their explicit or implicit effects on women's uptake of RH services, women's access to education, gender roles, social inclusion of women, women rights, and empowerment; the following Afghan ministries were selected for the documentary review on public and social policies:

- Ministry of Education
- Ministry of Higher Education
- Ministry of Information & Culture
- Ministry of Justice
- Ministry of Public Health
- Ministry of Religious Affairs
- Ministry of Women's Affairs

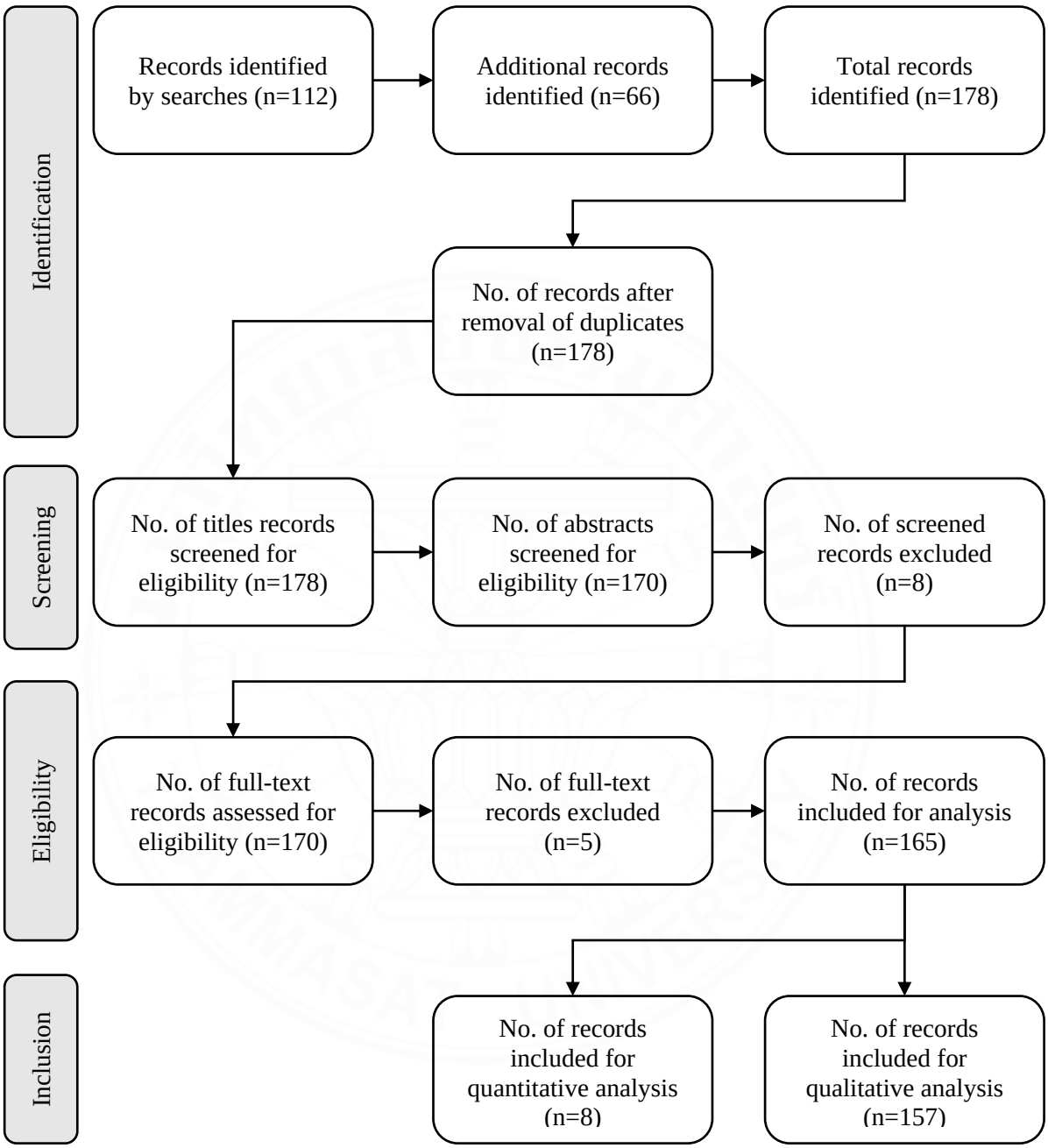


Figure 4.1 PRISMA Flow Chart

4.3 Findings on the SD of Women's RH

As described below, the social determinants relevant to women's RH rights fell into different levels such as structural determinants, bridging determinants, and intermediate determinants. Whereas the structural determinants were further divided into socio-

economic and policy context, and women's socio-economic and position and demographic status. Bridging determinants were divided into community-level factors, social connectedness, and social mobility. Finally, intermediate determinants were then divided into personal factors and health system factors.

4.3.1 Structural determinants

a. The socio-economic and political context

The four decades of unending civil war and militant rebellion placed Afghanistan economically and politically to rely on global financial assistance to establish a parliament, develop the Afghan Military, and boost primary schooling. During the Taliban regime (before 2001), Afghanistan faced overwhelming challenges in terms of gender equality that left very few or no girls in school and a deficit of women professionals. For instance, limited participation of women in the labour force, shortness of female teachers and doctors, women missing from political activities, and their involvement in decision-making at all levels of society were ongoing problems. This presented a near-complete removal of women from public life and the political scene in Afghanistan (Equality for Peace and Democracy [EPD], 2015). Since 2001 (after the fall of the Taliban regime) there has been progressing for women in terms of gender equality. For instance, Afghanistan's Constitution recognizes the equality of men and women. Today, women account for 28% of the members of Parliament, 21% of Provincial Council members, and 35% of Community Development Council (CDC) members. Also, in 2014 the Afghanistan gender equality report reported that 24% of Afghanistan's civil servants were women. The same report indicated that although 24% of civil servants were women, there were fifteen ministries with 10% or fewer female employees, while women represent less than 2% of Afghanistan's police forces (Equality for Peace and Democracy [EPD], 2015).

Concerning women's education, only 18% of Afghan women were literate, compared to 45% of men (UNESCO, 2014). In some provinces, the movement of girls and women's outside the house to acquire education remains prohibited due to insecurity and sociocultural norms (National Risk and Vulnerability Assessment [NRVA], 2007-8). Also, insecurity in many provinces of Afghanistan caused the closure of schools and

health facilities. In addition, cultural taboos and social stigma continued to pose limits for women's and girls' movements including access to education and health care services. Women's lower literacy levels were considered to be a dominant constraint to the improvement of the socioeconomic and health systems of the country (Amowitz and Lacopino, 2010).

Political instability and conflict had a profound influence on Afghanistan's social, health and education infrastructure. Insecurity exerts a huge influence on people's knowledge-seeking behaviour, particularly on girls' education. Moreover, according to the Afghanistan Mortality Survey (2010), there was a positive link between education and marriage. Those girls who continued to study at least up to secondary or tertiary levels delayed marriage by five years compared to those with no education. Evidence suggested that women's education is likely to increase their participation in the workforce, resulting in income and empowerment. Therefore, women's empowerment through education, income-earning and access to resources may increase their access to reproductive health care services and may also result in healthier reproductive and sexual lives. For instance, in many developing countries, gender, as a social construction, is an important indicator of vulnerability to limited access to health services because in these countries women are found in disproportionately large numbers compared to men among the most vulnerable population groups (Arber & Thomas, 2001; Doyal, 2000). On average women, when compared to men, were more likely to be poor; had less access to earning opportunities and less access to resources, including health services; and were more dependent on others for their social protection (Ensor & Cooper, 2004; Furuta & Salway, 2006; Parkhurst et al., 2006).

b. Culture and societal values affecting women

In the setting of Afghanistan, the low uptake of RH is likely to be driven by cultural and gender values (i.e. different roles and tasks allocated to women and men). Such socio-cultural practices and differences in gender roles and responsibilities influence women's access to RHC services. These roles were strongly linked to the traditional cultural practices and attitudes that exist in Afghan society. For instance, reproduction or RH remained the predominant role for women and men were having the role of

decision-makers/ or breadwinners. Moreover, men think that all RH aspects belong to women, and they should distance themselves from issues related to pregnancy or the RH of their women. Consequently, the societal view supports the opinion that men should not get involved or distance themselves from RH matters (Najafizada et al., 2017a; Van Egmond et al., 2004; World Bank, 2005c). Unfortunately, these views are often enforced by organizations working for RH by leaving men out of the equation in framing problems, deciding on a target population, and design and implement interventions.

In different Asian cultures, the power relation between women and men may reduce open conversation amongst partners to take decisions and access RH services (Aboufaddan & Abdel-Salam, 2013). Other studies also indicated that the cultural practices and attitudes, including norms surrounding sexuality and gender, carry profound meaning in every culture. This in turn affects an individual's reproductive health and their ability to access reproductive health care services (Doyal, 2000; Sinha, 2006).

This implies that 'being a woman' can be one of the most important predisposing factors diminishing access to reproductive health care services. Access to and utilization of reproductive health care services may be influenced by culture and ideological views, such as prohibition to consult male health practitioners, the lack of freedom to act without permission from husbands or senior kin, and lower value of the health needs of women and girls compared to that of men and boys. Evidence suggests that females are less likely to utilize health services; or limit access to those health services provided by a female health professional (Van Egmond et al., 2004). As illustrated by evidence from South Asian countries a woman's ability to leave home in general or to visit a reproductive health centre is subjected to permission from the husband or a senior family member and then the woman needs to be accompanied by a male member of the intimate family (Mumtaz et al., 2003). The same is true in the Afghan culture. These family relationships create a condition where a woman does not possess the power to act upon their reproductive health needs and depends on the final say by the husband or other senior family members (World Bank, 2005b).

Previous studies highlighted that due to cultural reasons and lack of men's involvement in RH issues, any discussion between husband and wife on the desired number of children and the use of FP are seen as sensitive and taboo (Ibn Sina & ICRH, 2002 Sahni, 2003). This was consistent with other studies that the attitudes and norms surrounding sexuality and gender carry profound meaning in every culture, affecting women's RH and their access to RHC services (Doyal, 2000; Sinha, 2006). However, even when health services are accessible service organizations may still be insensitive to socio-cultural norms. Therefore, culturally sensitive health care may improve access for women to RHCS. Furthermore, increasing the use of RHCS is not merely decentralizing health care services and technical interventions or making them affordable. Research indicates that people show reluctance to utilize health services that overlook local socio-cultural values and norms (Backman et al., 2008).

This underscores the need for Afghanistan's health service delivery to pay attention to socio-cultural practices and be gender-sensitive with health staff respecting local social norms. This calls for female staff at health centres to examine women as they and their family members do not feel comfortable visiting a male health service provider. Furthermore, it is equally important that female clients receive culturally suitable care, and that clinic facilities and systems are organized in ways that respect local socio-cultural norms.

Further, socio-demographic factors, socio-economic status, including transport and affordability impact utilization of RHC services. The literature indicated that due to social norms and gender roles that open discussions on issues of RH or women's health needs between partners are uncommon in the Afghan society (Shawna, 2004; Singh et al., 2012). Moreover, community values and norms and gender roles make men decision-makers, whereas women are expected to be submissive within families. These factors affect relationships, family dynamics, women's dependency, community life, including women's mobility and access to education, and decision-making in general as well as in accessing health care, which may lead to unfavourable RH consequences (Jewkes et al., 2003; Agarwal, 1997). For example, women's isolation and limited

social mobility in rural Pakistan has been seen as a key factor adversely affecting their RH and their uptake of RH services (Douthwaite & Ward, 2005; Mumtaz & Salway, 2005; Mumtaz et al., 2003).

In more conservative Muslim societies, due to gender norms, it is often culturally unacceptable for women to express their reproductive health needs or to take the decision to access reproductive health services. Moreover, social pressure placed on men hinders them from providing support to their wives when they need to visit reproductive health care services. Those who show interest to support their wives during obstetric care may face embarrassing remarks from family members or neighbours, which may discourage them from using reproductive health services (Douthwaite & Ward, 2005; Horstman, 2004).

Various studies recognized how social norms and cultural practices influence women's ability to decide on using RH services. For instance, in rural south India, it is standard practice for pregnant women to seek advice and treatment from traditional healers over public reproductive health care services (Griffin, 2006; Matthews et al., 2005). While access to information and resources are necessary for decision-making concerning RH issues, gender roles may not value women's work, or offer them rights to a disposable income, or offer them the right to decide on using health services. These socio-cultural values keep women in a subordinate position and adversely affect their RH (Cottingham et al., 2002).

c. Socio-economic position and socio-demographic status of women

Literature from South Asian countries indicated that women's uptake of RH services is influenced by a variety of dimensions including individual, family, community, and health system factors. By tradition, Afghan cultural practices encourage male supremacy and power over women. Subsequently, this affects women's decisions taking capacity within the family. Men have the role of decision-maker and wage earner and a married woman adopts the role of a housewife who performs housework and raises children (Beath et al., 2012a; Shawna Wakefield, 2005). Apart from performing

household chores, most of the women are secondary income earners within the family. The main sources for women's secondary income include a variety of home-based work such as raising poultry, producing dairy products and tailoring. Earning a secondary income is a means of ensuring that the household runs smoothly, while the main income earner (head of the family) is occupied with agricultural work or travelling to nearby villages in search of work. Also earning a secondary income may help in times of financial crisis or unexpected family emergencies. An earlier study from South Asian countries, suggested that the family's socio-economic status has an important role in the uptake of RH services for women. And that women's age plays an influential role in their ability to take part in household decision-making. For instance, older women are more involved in taking decisions within the household, including decisions on RH services, as compared to those women who are young and newly married (Acharya et al., 2010).

According to Doyal (2000), age is a crucial factor in determining the health needs of partners and their access to available resources to satisfy these requirements throughout the life cycle. For instance, the needs of women for reproductive health care services may increase during the childbearing years when they are most dependent on men. In mid-life, levels of need may be reduced only to rise again in old age. Yet, in many South Asian societies, elderly women and men make decisions related to health care and other basic needs. Such influence by elderly women and men has a profound effect on the nature of gender relations at different ages and partners' access to reproductive health care services (Doyal, 2000).

About the family size and number of living children, Acharya et al (2010) mentioned that women with more living children have higher involvement in their own health decisions. Similarly, another study showed that women reporting more than one child were more likely to be involved in decision making towards reproductive health care use (Furuta & Salway, 2006b). Further, women who attained a secondary or higher level of schooling were reported to be more likely to use RH services (Furuta & Salway, 2006b). Acharya et al. (2010) reported that women who worked for cash (income earners) were more likely to access reproductive health care services. Another study in

rural Bangladesh found that women who worked for cash were likely to have greater access to reproductive health care services, compared to women who did not work outside the house (Chakraborty et al., 2003).

Earlier studies indicated that individuals with a high degree of power of control over earnings and resources have the sense that her or his actions will be effective in seeking reproductive health care services. An individual's power to control earnings and resources affects the process of decision-making at the family level, including decisions concerning accessing reproductive health care services (Cassidy, 1997).

- **Factors at the individual level affecting women's RH**

Hindin (2000) argues that occupation, level of schooling, and a woman's involvement in the workforce positively impacts their ability in decision-making in the household, including the uptake of RH services (Hindin, 2000).

Various studies reported that women's low level of education could adversely influence their uptake of RH services, in particular the use of contraception (Danforth et al., 2009; Saleem & Bobak, 2005). The opposite is true for those who are having a better level of schooling, are more likely to be employed and therefore boost their social status, which increased their ability to uptake RH services. The literature also reports on wives of educated husbands who earn well or work for pay are more likely to access RH services, as compared to spouses with no schooling or in which the wife may not participate in paid work (Becker et al., 2006). Occupations with high status offer increased income, better mobility opportunities, and greater health literacy (Krahn et al., 2010).

Namasivayam et al. (2012b) state that intra-household gender power relations and cultural norms are known to hinder women's ability to exercise control over earnings (Namasivayam et al., 2012b). Cassidy (1997) argues that individuals who have the power to control earnings and resources hold the key to access health services (Cassidy, 1997).

- **Factors at the family level affecting women's RH**

In a conservative Muslim society, the household is recognized as a unit of domination and male-controlled space over females (Mallett, 2004; Namasivayam et al., 2012a). Furthermore, the family is considered to be a private sphere where women are subjected to a life of reproduction and domestic labour (Mallett, 2004; Mason, 1987). For instance, they manage household consumption with no control over family resources. Women are integrated into the society through the private sphere of family where they remain socially isolated with few opportunities to achieve higher social, economic, and political status compared to their male partners who engage in paid work and hold political power in the public domain (Chakrabarti & Biswas, 2008; Mallett, 2004).

A study conducted in rural Pakistan stated that men are socially constructed as providers at the family level and women as dependents and homemakers, and such dependency of women may affect RH and reduce their access to health services when needed (Mumtaz et al., 2003). Sinha (2006) indicated that in rural India, women's lower status and experience of discrimination in the allocation of household resources are among the factors responsible for limited access to reproductive health care services and higher maternal mortality" (Sinha, 2006). "In India, a community-based study found that women's RH and the uptake of health services was influenced by 'bias' against women and their lack of control over household resources, in particular financial resources (Kutzin, 1993). A study in Bangladesh also suggested that husbands' lack of support was a significant factor in their wives' use of reproductive health care services and women's RH status. For instance, in a traditional society like Bangladesh there an imbalance of power between partners at the household level was common, which lead to husbands' dominating the decision-making process in accessing (reproductive) health care services. However, the decision-making process can also be influenced by older family members (Khan, 2003).

It is well recognized that men play a dominant role, as husbands in a marriage, over women's access to RH services. This is because social norms equip men with power in a marriage or consensual union to make decisions over women's health and wellbeing. Moreover, men's lack of health literacy especially concerning reproductive health is a

contributory adverse factor to women's RH. It's important to note that the same social norms and the lack of health literacy also adversely affects men's RH (Horstman, 2004).

4.3.2 Bridging determinants

a. Factors at the community level affecting women's RH

Many reports highlight the issue of young age marriage in Afghan communities. Referring to Islamic teachings, it is explicitly stated in the Holy Quran (Surah 'AL Baqarah') that men and women have equal rights towards each other. It is also mentioned that Islam emphasizes the rights of boys and girls to acquire an education and select his/her future partner or marry by mutual consent, and the avoidance of any kind of gender discrimination (Afghan Family Guidance Association [AFGA], 2012). However, in some Islamic contexts like Afghanistan, women and girls are not properly treated or given the authority of decision-making about their life (Women and Children Legal Research Foundation [WCLRF], 2009). The Afghan Family Guidance Association (AFGA,2012) report revealed that 57% of girls are being married before the age of 16 (Afghan Family Guidance Association [AFGA], 2012). One of the reasons for gender inequalities in rural areas of Afghanistan is the issue of maintaining "family honour". When Afghan girls are asked to get married at a young age instead of attending school. They need to respect their parent's decision and get married at a young age instead of completing their school or moving on to higher education (National Risk and Vulnerability Assessment [NRVA], 2007-8). The Afghan legislation and Islamic rules prohibit child marriage, early age arranged marriage is socially and traditionally accepted in many Afghan families, to such an extent that the average age of marriage amongst girls in rural areas is 15 and 16 in urban localities. Moreover, although Islamic rules give a girl the right to select her life partner, forced early age marriage is practiced in many Afghan families (Afghan Family Guidance Association [AFGA], 2012; UNIFEM, 2008). Moreover, evidence indicated that in 70-80% of the marriages one individual in the couples did not agree to the marriage, but was not in a position to either reject the unwanted partner or divorce[3] (Afghan Family Guidance Association [AFGA], 2012). Early age marriage and early pregnancy in Afghanistan contributes to

[3] Divorce is a taboo in the Afghan context, and many people, especially women, avoid appearing in judicial institutions in order not to go against family and community values.

maternal deaths and health issues. In addition, young women miss out on the chance of gaining an education, which also affects their health literacy (National Risk and Vulnerability Assessment [NRVA], 2011-12). The tradition of dowry[4] may also lead to early marriage of Afghan girls because the bride price (dowry) is the money, which is paid to a woman's parents, where it can constitute an important source of income for poor families. Therefore, families marrying off young daughters at an earlier time than they otherwise would have done. The tradition of paying bride price or dowry remains strong in rural communities of Afghanistan. However, the bride price varies according to the financial position of the families involved and will often be smaller if the parties are closely related.

Evidence suggested that families throughout the country viewed the high bride price they have to pay to marry their sons as a harmful traditional practice. Among the poor, it leads to forced and underage marriages, selling of girls, and increased risk of domestic violence. Because men are in fear and frustration at being in debt or having to work for years to pay off loans, that they took from others due to the dowry paid for their wives (Landinfo, 2011). There is general conformity that the practice of the size/or amount of the dowry (paying a wife/spouse price) breaches Islam saying. As, according to Afghan law, women who enter marriage shall have a dowry (mahr). The dowry shall remain the woman's separate property and is provided as security in case the husband dies or requests a divorce. The dowry concurs with Islamic law and tradition, but the Koran contains no instructions regarding the size of the dowry or when it should be paid. During the wedding ceremony, the mullah who performs the religious rites will ask the groom's father to state the size of the dowry (Hafizullah, 2005; Landinfo, 2011).

Moreover, it is "undeniable that a preference for sons is common in various Afghan communities. For instance, in many Afghan rural families, women who have given birth to sons are more valued in the household. Also, the son of a family usually receives more attention and is provided for his education and a future life because he carries on the family heritage and supports his parents during the economic crisis. In a study of

[4] A transfer of parental property, gifts, or money upon the marriage.

800 parents by WCLRF (2009), 69% of them preferred sons to girls. These parents gave many reasons for son preferences. For instance, 44% reasoned those girls are strangers and they will serve another family (they will go off to the husband's family after marriage). Around 80% of women indicated that their husband's value boys over girls and husbands threatened 7% of the women surveyed because they gave birth to a girl. Over 54.5% of women noticed that giving birth to a girl threatens them with a loss of value within both the marriage and the household, which increases their husband's desire to remarry or marry a second wife. Moreover, in some Afghan families, women who give birth to girls do not receive any support, respect, and proper feeding from their families. Some women with their baby girls are not welcomed and treated badly (Women and Children Legal Research Foundation [WCLRF], 2009).

b. Social connectedness of women:

The literature from South Asian countries indicated that some women were found to seek ways of negotiating access to RH care during pregnancy. Furthermore, a woman with a strong network of inter-personal relationships, both with her husband, marital family, and natal families, is in a stronger position to access RH care services. A well-connected woman can draw attention upon her natal family members and other relatives to press upon the mother-in-law to allow her to use the health services she desires (Mumtaz & Salway, 2007). Based on Afghan experts' opinion, in rural Afghanistan families, social networks are important, as formal social security systems are absent and trust in state institutions is weak. Women rely on their families and social support networks to access resources, including health services. Also, in this setting, the social roles and functions are maintained by a long tradition of cultural practices. One good example is that villagers and women often value their personal, family and community network as a means of obtaining social security, combined with financial support which comes mainly from the farm work. They often use such support for accessing health care services and other services such as transportation.

c. Social mobility of women

In South Asian countries, women's restricted social mobility has been viewed as a crucial barrier to their ability to access health care services. The issue, however, is not

straightforward for women's mobility in these countries. It is influenced by the complex notions of purdah (female's seclusion from male strangers) and izzat (honour). However, women's mobility is an important aspect of their gendered identity, and restriction of mobility will affect the uptake of RHC services (Mumtaz & Salway, 2007). The same is true for Afghanistan, where women are expected to practice 'purdah'; their unaccompanied mobility outside the home is viewed as culturally unacceptable, and they are dependent on their husbands or other male family members to get permission to go for health checkups (Beath et al., 2012b; World Bank, 2005c). Many of these roles and responsibilities have been socially prescribed and are rooted in the rural culture of Afghanistan, yet they greatly influence women's RH and their access to RHC services.

4.3.3 Intermediate determinants

a. Personal factors affecting women's RH

RH seeking behaviours are significantly challenged and affect women's access to services as health outcomes. In Afghan society, most reproductive health-seeking behaviour is based on traditional practices, beliefs, and perceived causes of specific illnesses. In rural Afghanistan, prayer is the initial way to deal with reproductive health problems because of people's strong faith in prayers. After that, traditional homemade remedies or practices will often be considered, and thereafter, an elderly woman and a traditional healer or religious leader might be called to provide some spiritual or traditional remedies. After having exhausted all these options, if a patient still does not feel better, then drugs can be bought from the nearby grocery shop (usually over the counter medicines are available in some of the grocery shops within a community). If this effort is unsuccessful, then based on the financial capacity of the household, a means of transport will be arranged for visiting a private pharmacy at the district municipality. If this is not successful, the last option is to seek care at a public reproductive health centre, because people believe that they can visit a public reproductive health centre only in the case of emergencies or in case of complications (Ahmed et al., 2004).

Socio-cultural obstacles include stigma and the absence of awareness about reproductive health, predominantly in the hard-to-reach communities. Furthermore, age, gender and socio-economic status extensively affect health care access and health-seeking behaviour. Because of the absence of information in low resource settings the likelihood of stigmatization is high among rural inhabitants affecting disadvantaged groups, including women. However, even when health-related services are within reach and accessible service delivery may still be insensitive to culture and gender norms. Culturally sensitive health care may affect women's RH and improve access to reproductive health services positively. Therefore, health services should take into account gender norms, and cultural values of local communities and their healthcare-seeking behaviour (Backman et al., 2008).

The customary practices in a community and opinions also influence women's RH and their uptake of RH services. For instance, a study in India revealed that many pregnant women preferred the services of a traditional birth attendant within their community to midwives from public reproductive health centres (Griffin, 2006). In many rural societies, cultural beliefs consider illness and discomfort to be a common part of women's lives and that, therefore, they are not worthy of treatment and care. This is affecting women's RH and well-being. In some South Asian countries, the decision to visit a health facility is not made by the women themselves, but the husband, village elders and/or other older family members, including the mother-in-law, are considered to decide for women to visit a health facility or seek medical care (Kutzin, 1993). This dependency on others' decision making may adversely affect their RH.

The above examples illustrate that women's RH is affected by traditional health beliefs, and cultural beliefs as well. This occurs irrespective of individuals having information on the availability of reproductive health care services; nonetheless, the combination of these factors acts as a powerful force on women's RH status.

b. Factors related to health system affecting women's RH

The factors related to the health system, which could hinder couples' access to RHCS, include unavailability of reproductive services within distances that are physically, financially, socially, and culturally acceptable for women; inadequate amenities, equipment and medicine at reproductive health centres; lack of privacy; inadequate provision of information and counselling; improper behaviour among services providers, in particular towards women and the poor; and failure of reproductive services by the needs of clients (Levine et al., 2007).

In Bangladesh, supply-side factors such as poor quality of provider interactions with clients, high travelling costs in rural areas due to distance, unavailability of vehicles, and poor road conditions were contributing factors to limited access to reproductive services (Khan, 2003). These issues indicated that the health system was ineffective and had low potential to provide quality services. An ineffective health system posed

the main hindrance for the disadvantaged and the underprivileged to access RH services.

Ravindran (2012) found that the location of a health centre may be an economic barrier in terms of needed pocket money for health care. Such economic barrier was further increased by transportation costs from the remote communities to the health centres in cities or towns where they were located. In some cases, because of the transportation costs and remoteness from public health facilities, people preferred to disregard visiting reproductive health care services and sought care from traditional healers who were available within the neighbourhood (Ravindran, 2012).

The Afghan government stated that it is committed to ensuring universal access to sexual and reproductive health care services for all in Afghanistan in its pursuit to achieve the Sustainable Development Goals and universal health coverage by 2030 (United Nations [UN], 2014). In line with ensuring universal access to SRHC services, family planning, information, and education, including the integration of reproductive health into national strategies and programs was stated in SDG 3, target eight. The Basic Package of Health Services (BPHS) and the Extended Package of Health Services (EPHS) in Afghanistan represent the approach taken by the Government of Afghanistan to promote free universal coverage at the primary-health-care level within the country (Trani et al., 2017).

4.3.4 Synthesis of social determinants relevant to Afghan women's reproductive health

Based on the above findings on social determinants of women's right to RH, Table 4.2 provides a synthesis of social determinates relevant to Afghan women's RH rights, providing a tool for screening sectoral policies in Afghanistan.

Table 4.1: Synthesis of Social Determinants of Afghan Women's Reproductive Health Rights

Main SDH	Sub-SDH	Description	Policy Checklist on SDH
Socio-econ-policy context & Socio-econ position	Governance	Participation of women in governance	• Promote women in the cabinet • Promote women in parliament • Promote female executives in ministries, provincial & district public sectors
	Macro-economics	Impact of poverty on women	• Micro-financing for women (income generation) • Women's education & jobs opportunities • Job opportunities for men
	Socio-cultural values	Early marriage Dowry practice Gender roles Importance of male offspring = multiple children	• Legal age of marriage • Women's right to divorce • Illegality dowry practice • Domestic violence • Access secondary & tertiary education (both girls & boys) • Public awareness on gender equity (mass media) • Family planning
Bridging determinants	Soc. cohesion & soc. capital	Social connectedness of women Social mobility of women Social capital & women	• Civic engagement • Rights of women • Inclusion of women in political positions
Personal determinants	Living & working conditions	Intra-household power relations Lack of husband support Fam. dynamics mother-in-law	• Job opportunities women

Main SDH	Sub-SDH	Description	Policy Checklist on SDH
	Biological & behavioural factors	Lack of knowledge	• RH promotion • RH education in schools
	Psychosocial factors	-	-
Health system	Quality	Number & competencies of human resources, staff attitudes, logistics, infrastructure/facilities	• HR (health) planning • HR (health) production • QA health professions' education • Essential drug list • HS logistics management • HS infrastructure planning
	Access	Affected by geographic, economic, cultural & functional factors	• Health service coverage • UHC • RH female health personnel • Service hours • Privacy arrangements for female visitors/patients
	Utilization	Affected by the need for care, sex, satisfaction with services, income, alternative care options	• Promote RH literacy • Address gender inequity • Poverty reduction/UHC • Inclusive health system (traditional healers, birth attendants, pharmacies etc.)

4.4 Findings on the involvement of community representatives in the policy-making process in Afghanistan

4.4.1 Policy development

The Government of Afghanistan is committed to facilitate women's participation in the formulation of government policy and the implementation thereof and to empower women to hold public office and perform all public functions at all levels of government. This commitment was made under the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). As, Afghanistan was a signatory to CEDAW, which requires state parties to take all appropriate measures to eliminate discrimination against women in the political and public life of the country, it also increases women's participation in government policy development. Moreover, the National Action Plan for Women of Afghanistan (NAPWA) outlined plans to develop and institutionalize a strategic framework and policies that foster women's leadership and participation in public life, especially in the areas of policy making and decision-making (Equality for Peace and Democracy [EPD], 2015).

To involve local communities in the policy development or the design of community-level interventions, the Afghan government and the international community focused on the Community-Driven Development (CDD) approach. It is a participatory initiative developed by the World Bank during the 1990s, and today it has been applied in different states, including in fragile and conflict-affected states. In Afghanistan, the community-driven development approach is focusing on the local communities to be involved in the process of decision making. It takes place through the Community Development Council (CDC). It is a decision-making body within the community, whose members are to be elected by a universal understanding of the right to vote in secret ballot elections. By doing so, decisions about project priorities are delegated to the local level, while program design uses standardized decision-making, which makes the communities accountable for the usage of funding (Vincent, 2020). Recent evaluations largely accepted that CDD has proven a relatively efficient and cost-effective instrument for designing large programs, including rural infrastructures (White et al., 2018). However, critics highlighted that there is no impact of CDD on

social cohesion[5]and that CDC was captured by local elites, where the inclusion of women in CDC was often undermined, and marginalized groups are also underrepresented (Vincent, 2020; White et al., 2018). A report by Plumb et al. (2017) suggested that the Afghan government's and the international community's failure to involve local communities or understand the local context may have contributed to ineffective or ill-informed policy making, which might intensify existing problems in policy making.

Therefore, the Afghan government and international community need to involve and gain the cooperation of Afghan communities for its most crucial policies to succeed. It also helps in reducing the assumptions of the "western" perspective in policymaking, which is largely subjective and probably mostly inapplicable in many settings (Plumb et al., 2017). The role of civil society in policy development needs to be defined clearly during the agenda-setting, and they should have in-depth knowledge of governance issues such as national priorities, legal and policy issues, and government roles and duties. Because in most cases, civil society actors are only engaged in government policy after policy is formulated and approved, or not at all. The same is true for subnational actors, including those from government and NGOs, who stated that due to the lack of prior consultations, they encounter challenges implementing these policies due to a lack of participation at the stage of designing and formulating policies (Nemat & Werner, 2016).

4.4.2 Policy implementation

The Afghanistan government is committed to offering practical and political assistance to women to assist them in participating and implementing policies. One good example was the participation of women in the community development council, which is likely to be a potentially fruitful means for engaging women in local community decision making and actual implementation of the policies. However, patriarchal norms in Afghanistan hurt the realization of women's right to get involved in policy

[5] Social cohesion has been defined as behaviours and attitudes within a community that reflect members' tendency to cooperate during the design or implementation of a development project.

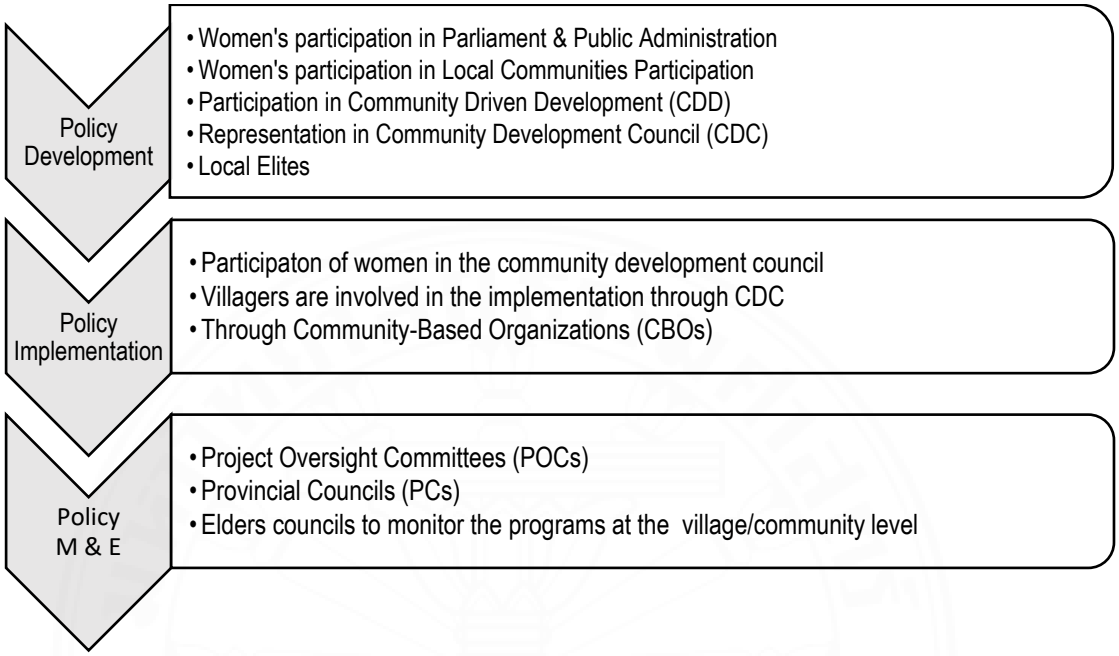
implementation. Also, patriarchal norms are restricting women's freedom outside the home and limiting their roles in public sphere activities (Afghanistan Research and Evaluation Unit [AREU], 2013). Though intended women's involvement in policy design and implementation may offer opportunities for them to realize their rights, these efforts have not taken place in practice and challenges remain. Evidence suggested that in health policy implementation more emphasis was given to close coordination with donors, and their ability in exploring funding mechanisms, rather than including women in policy implementation. Other than this, the focus was on the timely development of a routine data management information system and independent evaluations of Afghanistan health services implementation, while women's role in policy implementation was not clearly stated (Newbrander et al., 2014). Concerning community participation, an evaluation report stated that usually villagers are involved in the development of the project, but there is no significant impact of community involvement on health or health facility projects because the community development councils have insufficient capacity. Other than this, in the country, there are numerous socio-economic barriers to community participation. These include the lack of time, exclusionary or limiting norms (mainly for women), perceived benefit or capacity, poor engagement of the CDC, while the projects not serving community members' interests. It happened because the community-driven development program design may favour the elite or the prominent community members, rather than the community as a whole (White et al., 2018). Despite these problems, the Afghan government planned to progressively expand the role and involvement of community development councils in development projects. However, the sustainability of community-driven development and community development councils have been an ongoing source of concern (Vincent, 2020). In another study, emphasis is given to greater community participation through stronger ties between communities and local government bodies that are responsible for development interventions (Plumb et al., 2017). From a different angle, Nemat and Werner (2016) indicated that community-based organizations (CBOs), for example, CDCs, have become a major hub for the implementation of development and infrastructure projects in their communities. Among other CBOs, the CDCs especially played a dual role in governing the implementation of the project. For instance, they were involved in village decision-making in terms of the village needs, representing

their concerns and demands at the district, provincial, and national levels. By doing so, they tend to strengthen the perceived quality of state services in their community without competing with it. However, given the absence of a meaningful delegation of authority to subnational levels, it is difficult, to link community planning through districts and provinces, due to a lack of coordination and clear planning, including the resource allocation (Nemat & Werner, 2016).

4.4.3 Policy monitoring and evaluation

At the community level, the Afghan government emphasized the establishment of Project Oversight Committees (POCs), which monitor the transparency and quality of any intervention program occurring at the village level. However, evidence from rural communities suggested that interventions were implemented with low quality, due to the symbolic role of POCs, and they had no real power to control the quality of the projects or see whether needs are addressed (Plumb et al., 2017). At the district or provincial level, the Provincial Councils (PCs) are also monitoring government-run projects, but the PCs' role remains vague and consultative by law. To add to this, there is little or no clarity of roles, responsibilities, and obligations for PCs to monitor interventions at the community level. Moreover, there might be certain tensions over the oversight role of the PCs, either from the political level (governor or departments) or from the local level, where people often trust the local shura structure and informal governance mechanisms such as elders councils to monitor programs at the village/community level (Nemat & Werner, 2016). In another report, Katz (2017), argued that the Afghan government tried to involve community development councils in the development projects and to let them do monitoring of development activities. By doing so, they could hold the government accountable for the quality of the services provided to the communities. However, there was no proper mechanism in place. They could also enforce regulations and practices for themselves, including sanctions for their own irresponsible or improper actions concerning development projects (Katz, 2017).

The following diagram, presented in Figure 4.2 summarizes the involvement of individual and local stakeholders in policy development, policy implementation and policy monitoring and evaluation.



As various entities have a stake in policy-driven community development, with mandates often vaguely defined, and inequalities in power across them exist, it is not surprising that reports point to local politics and conflicts of interest. Figure 4.2 below illustrates who is involved in the development, implementation, monitoring and evaluation of policy-driven community-based projects and the potential areas of conflict of interest across key stakeholders.

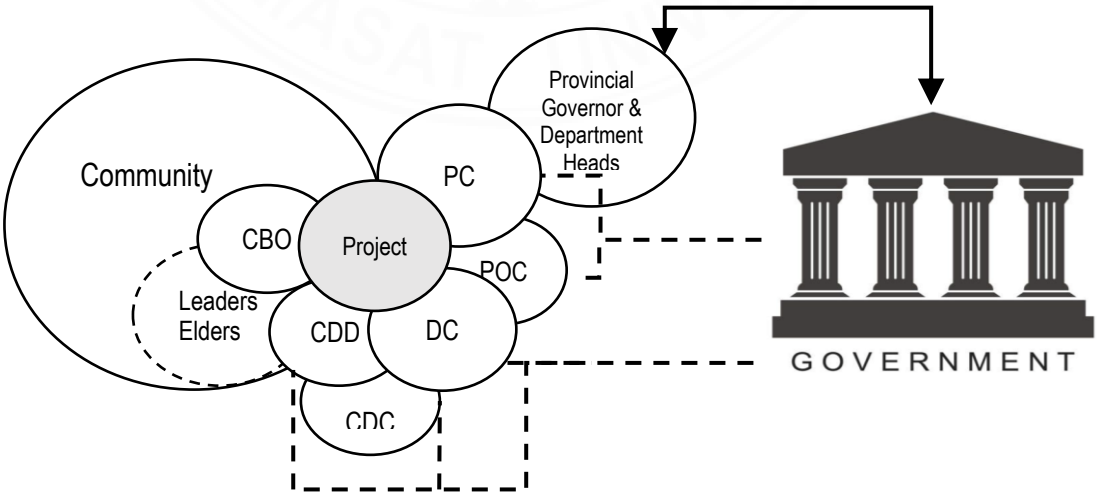


Figure 4.3: Stakeholders in policy-driven community-based development projects and potential conflicts of interest.

Legend:

⟷ Two directional communications within the governance structure with bottom-up accountability.

- - - - Appointed by the government.

Leaders and Elders: Malik (from Arabic) status title meaning 'lord', 'ruler', 'chief' or 'leader' and elders are often religious leaders.

CBO: Community Based Organizations are public or private nonprofit organizations of demonstrated effectiveness that: (i) is representative of a community or significant segments of a community; and (ii) provides services to individuals in the community.

CDD: Community Driven Development also called "Shura": which is an Arabic word for "consultation". Originated from the Quran (Holly book for humanity) and the Prophet Muhammad (Peace and blessing of Allah be upon last Prophet Muhammad [Peace Be Upon Him]) encourage Muslims to decide their affairs in consultation with those who will be affected by that decision. CDD or Shura members are elders and local leaders nominated by communities but selected by the government for consultation, advice and support. A CDD or Shura enforces regulations and can determine sanctions for violating regulations but cannot be held accountable.

DC: is the government-appointed district council with a rather vague role but consultative by law.

PC: is the government-appointed provincial council with a rather vague role but consultative by law.

POC: Is the Government endorsed Project Oversight Council for project monitoring but its role is unclear and the committee has no power.

4.5 Findings on Afghan public and social policies relevant to women's RH rights

4.5.1 Ministry of Public Health

Based on the review of the national strategic plan on RH of the MoPH, there are several socioeconomic determinates of health stipulated in the document as a cover value of the strategy. These are gender, culture, ethnicity, and human rights. Concerning gender, emphasis has been given to issues related to gender and reproductive health rights of women. This means that the RH strategy aims at promoting gender equality as the basis of the RH program, especially maternal and newborn health programs, by addressing the lower status of women and discrimination against women. Further, it mentioned that the RH services should be provided on a rights-based approach, and with the involvement of Male. Health response to Gender-Based Violence (GBV) should be reflected in the development of treatment protocols and guidelines for the health facilities.

Moreover, the document stipulated that the RH services should be made more user-friendly to reflect not only the clinical needs but also the gender-specific needs of users. Privacy, dignity, and respect should be maintained, at all levels and times, along with the increased male involvement in maternal and newborn health services. By the national reproductive health strategy, the Ministry of Public Health of Afghanistan is committed to improving the accessibility of mothers and women of childbearing age to quality RH care services. The reproductive health strategy is intended to demonstrate how the policy can be successfully implemented and improve women's RH in the country. Thus, the strategy goes into detail on what needs to be done, to facilitate the implementation and how the strategy implementation should take place, for which the strategy focuses on the goal of the reproductive health policy, which is to improve the reproductive health status of families in Afghanistan through the provision of integrated reproductive health services in partnership with communities, development partners and the private sector. However, apart from emphasizing the main goal of improving the reproductive health status of Afghan families, four elements of the strategy were considered to have the highest priority, including maternal and neonatal health; family planning/birth spacing; STI, and breast and cervical cancer. In addition, infertility and obstetric fistula were also considered as priority strategic areas. Additionally, a separate section was created to address the role of several issues such as gender, culture, ethnicity, nutrition, and mental health as contributory factors to the poor health of mother and child, low use of contraception, and the increase in STIs among women, along with breast and cervical cancers cases. As described below, the social determinants relevant to women's RH rights and maternal mortality in Afghanistan fall into different levels such as policy context, socio-economic and individual level. Some of these social determinants of women's health are mentioned in the national RH policy and strategy.

a. Accessibility of RH services

To improve women's access to RH services, the policy specified that RH services should be combined into other services such as child and adolescent health services to be seen as accessible to women who are visiting the facility for other health services. The engagement in health promotion activities is encouraged by all RH implementing

partners to increase demand for RH services by focusing on the role of male, family, and community elders. According to the strategy document, the service accessibility is mentioned to be improved, through maternal and neonatal health, STI, including breast and cervical cancers.

The following sections describe the services mentioned in the RH strategy document that is prioritized by the ministry of health, through which the ministry is aiming to improve women's access to RH care services:

b. Maternal and Neonatal Health

Enhancing the provision and value of mother and neonatal wellbeing is stated as a priority goal within the national reproductive health strategic plans. This will be done through increasing women's access to and use of essential RHCS such as antenatal care, safe delivery by skilled health workforce, emergency obstetric care and neonatal care, including postnatal care. Furthermore, the Ministry of Public Health and implementing agencies are emphasizing increasing and strengthening community-based maternal and neonatal health services through CHWs in combination with family health action groups. Other than this, the Ministry of Public Health emphasized strengthening the community-level health care delivery by deploying community-based midwives. Also, to support the delivery of health services in their communities the religious leaders could be trained and involved in issues related to reproductive health. All the above-mentioned efforts are put in place by the Ministry of Public Health to improve access and utilization of services related to maternal and neonatal health combined with the provision of basic and comprehensive emergency obstetric and newborn care at the health facility level (Ministry of Public Health [MoPH], 2012b, p. 8).

c. Sexually Transmitted Infections and HIV/AIDS

Based on the RH strategy of the Afghanistan Ministry of Public Health is emphasizing interventions related to STIs and HIV/AIDS due to the close link between reproductive health and STIs, including HIV/AIDS. Besides, the Ministry of Public Health is emphasizing coordinating the activities of other partners involved in the control of HIV/AIDS within the country. To enhance the quality of STI interventions within the

health services several activities were mentioned in strategic plans that needed to be put in place: to integrate STI management and HIV screening, as well as prevention into primary health care service; to generate resources for additional STIs and HIV/AIDS prevalence studies; and to collaborate with implementing NGOs to provide resources for the training of health care workforce to build their capacity in STI management, prevention, identification, and treatment (Ministry of Public Health [MoPH], 2012a, p. 12).

d. Breast and Cervical Cancer

As stated in the RH policy document, a preliminary plan will be designed to address breast and cervical cancer's morbidity and mortality. The Ministry of Public Health emphasizes strengthening collaboration with implementing NGOs/partners for improving health staff's knowledge and abilities in the examination, detection at early stages and treatment of breast and cervical cancers. Besides, a specific focus was given to improve knowledge among the public, particularly among women regarding breast and cervical cancers. For example, an awareness-raising campaign among women about the importance of on-time detection and medication of breast cancers was created (Ministry of Public Health [MoPH], 2012a, p. 12).

The said 3 crucial elements of mother and child health care were added into BPHS and offered at 4 levels of the health system. These four levels of the RH services comprised of DH, CHC, BHC, and HP:

The District Hospital level:

District hospitals provide the essential health care or all elements of RH services stated in the BPHS. In addition, it handles complicated cases related to reproductive health. In contrast to BHC and CHC, the DH is the first health centre, which includes a wider reproductive health department, staffed by health providers such as doctors (female obstetricians/gynaecologists; a surgeon, an anaesthetist, and a paediatrician) a doctor as a focal point for mental health, and psychosocial counsellors/supervisors; midwives; laboratory and x-ray technicians; a pharmacist; a dentist and dental technician; and two physiotherapists (male and female). Apart from serving routine reproductive health

cases, the clients referred to DH encompass those in need of comprehensive obstetric care, emergency care, surgery under general anaesthesia including male and female sterilization. The number of beds available at district hospitals range from 30 to 75 and can serve up to four districts with a recommended coverage of 100,000 people at a minimum and 300,000 people at a maximum (BPHS, 2010, p. 7).

The Comprehensive Health Care Center level:

> "Staffed by male and female doctors, two midwives, and nurses, as well as technicians and pharmacists with a recommended coverage of 30,000 people at a minimum and 60,000 people at a maximum. The CHC offers a wider range of services than the BHC. Apart from attaining normal deliveries, a CHC can assist in some complicated health situations, for example, assisting certain complications related to childbirth" (BPHS, 2010, p. 7).

The Basic Health Care Centre level:

> "Staffed by a midwife, a nurse or an auxiliary midwife, and vaccinators with a recommended coverage of 15,000 people at a minimum. A basic health centre provides Ante Natal Care (ANC), safe delivery, Post Natal Care (PNC), family planning services, newborn care, immunization, and Integrated Management of Childhood Illness (IMCI)" (BPHS, 2010, p. 6).

The Health Post level:

> "Volunteer female and male community health workers (CHWs) are trained and given basic supplies by the respective NGOs. A health post provides family planning methods such as condoms, oral contraceptives, and injections with a recommended coverage of a minimum of 1,000 people, equivalent to 100 families. In addition, health post raises community awareness about institutional delivery through the assistance of skilled birth attendance, identifying danger signs of pregnancy, and referring pregnant women at the time of delivery to a basic or a comprehensive health centre" (BPHS, 2010, p. 5).

The national reproductive health strategic approach seeks to extend the reach of basic RHCS at the community level and is being implemented at different levels of the health system. Consequently, reproductive health care services become an integral part of primary health care services under the domain of BPHS and are regularly provided through district hospitals, basic health centres, and health posts, which offer mainly basic services at the community level. However, the overarching dilemma is the lack of strategic approaches and operational services to address men's reproductive health needs. The policy objectives included men for enhancing women's access to RHCS, but no particular consideration is being given to their reproductive health needs/services. Another challenge is a weak emphasis on privacy and confidentiality of examination that undermines women's and men's ability to decide whether they should access public reproductive health care services (BPHS, 2010; Ministry of Public Health [MoPH], 2012b).

Available policy briefs indicated that little consideration was in place for socially suitable care. Therefore, clients' privacy, comfort, and confidentiality may not be properly respected in the delivery of reproductive health care services. Several access barriers are also not appropriately addressed in the strategic approach such as discrimination and violence against women or those that are disadvantaged. For example, no specific measures were put in place to ensure that no preferential treatment will be given based on sex, and socio-economic status. Also, less emphasis has been given to couple counselling, especially for family planning/birth spacing. This implies that health care workers, especially midwives are less capable of counselling clients of the opposite sex or counselling couples together. Providing couples' counselling could also advance the couples' communication skills over RH decisions such as the uptake of services, including family planning.

f. Quality of RH services

The Afghan government is committed to obtaining universal access to RH for all its citizens in its pursuit of the Sustainable Development Goals (SDGs) and priority has been placed on improving the quality and increasing the uptake of RH services (United Nations[UN], 2014). Furthermore, the National Reproductive Health Strategy has been crafted (under the umbrella of BPHS & EPHS) to ensure that all Afghan citizens have access to standard RHCS by putting into implementation the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The Strategy intends to advance women's well-being and decrease morbidity and mortality, and accomplish universal access to RHCS (Ministry of Public Health [MoPH], 2012a). The Basic Package of Health Services contracting approach also poses challenges for ensuring the quality of sexual and reproductive health services. Evidence suggested that general health NGOs who may be contracted to provide the Basic Package of Health Services may not have the experience, knowledge or commitment to deliver sexual and reproductive health services according to internationally agreed standards (Roberts et al., 2008).

The other challenges are that there may be very limited space and funding available for NGOs working in specific health sub-sectors, such as reproductive health, to provide services, give training and technical assistance, and monitor and evaluate the quality of services. Another study suggested that "not only poor quality or absence of reproductive-health services explains women's low health status in Afghanistan. The important impact that social and cultural factors have on reproductive health, underlines the need to see reproductive health in Afghanistan in a broader perspective than from a quality of health care and healthcare provider point of view alone (Van Egmond et al., 2004). Though the quality of reproductive-health services remains critical at improving women's access to RH services, the literature suggests that actions to improve reproductive health in Afghanistan should include efforts to empower women, including educating girls and providing economic opportunities to women, and educating men about women's reproductive needs through community-based programs (Roberts et al., 2008; Van Egmond et al., 2004).

g. Unitization of RH Services

The ongoing conflict in many regions of Afghanistan has hindered progress towards the realization of many basic rights for Afghan citizens, including those related to the use of sexual and reproductive health services. From 1996-2001, severe restrictions imposed by the Taliban on women's mobility, access to employment, and education negatively impacted the availability and utilization of reproductive health care services (Bartlett et al., 2017). In recent decades, significant efforts by the government, donor communities, non-governmental organizations, and international organizations have produced important results in some areas of reproductive health, though reliable statistics are unavailable and difficult to obtain, particularly in the context of insecurity and conflict. For instance, the number of health facilities went up from 1,075 in 2004 to more than 1,829 in 2011 and further expanded over the past decade. Afghanistan has also made progress in setting up a comprehensive framework to eliminate gender inequality and social exclusion by ratifying the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, in 2003). A Gender Unit within the MoPH Reproductive Health Directorate was established in 2006 and promoted to the Gender and Human Rights Directorate in 2013 (Newbrander et al., 2014; WHO, 2021). Even with this progress across the country, women are still unable to utilize reproductive health services for different reasons, one of which is the lack of trained health professionals. A significant proportion of women still give birth at home without a skilled birth attendant, and the number of women who use contraceptives is still low i.e. the use of any contraceptive method and the use of a skilled birth attendant is as low as 21% and 43% respectively (UNICEF 2015). In rural areas many women, and indeed their husbands, are suspicious of the utilization of RH services. For example, people believe that FP or immunization could create the problem of infertility or causing lasting infertility. In contrast, the utilization of the traditional health practices continues to play an influential role in rural Afghan communities where traditional healers or older members of the community may be the only people to whom patients can turn when suffering from a reproductive health problem. Though, the Afghan Ministry of Public Health's strategy of deploying female health workers to remote areas to help increase acceptance and utilization of reproductive health care services among women appears to be effective in secure areas. This initiative could be more effective through

the involvement of men in promoting women's rights and utilization of RH services (Ameli & Newbrander, 2008). Although RHCS should be available to any adult, regardless of sex, age and gender or marital status, in Afghanistan, in contrast with other health services, differentials in the utilization of reproductive health care services exist. Traditionally RHCS too often focuses on women with men being left out. Including men's reproductive health needs in health, programs may not only help them but will also support their wives. For instance, family planning decreases the burden for men in providing for a large family, at the same time it benefits women physically by spacing pregnancies and decreases the burden of childcare. Therefore, the engagement of men in RHCS could improve women's reproductive health, resulting in shared responsibility in family planning (Pearson, 2003).

h. Human Resources for Health Strategy

RH's strategic plans did not highlight the human resources for health strategy. However, the National Health Strategy (2016-2020) human resources for health aims towards ensuring that the health workforce is fit for purpose. Also, to have the *right* and *ready* human resources for health to effectively support and facilitate the overall quality and coverage of priority health services essential to a healthy and productive population in Afghanistan. Therefore, the Ministry of Public Health should effectively, efficiently, and with quality produce the appropriate quantity and skill mix of personnel sympathetic to the health and disease needs of individuals and communities throughout the country. Also, it makes health personnel feel valued, motivated and it retains them working for the public sector. In line with this, the Ministry of Public Health intends to ensure that all Afghan citizens can access a health worker who can provide quality health interventions at need. However, it is struggling to mitigate a nationwide shortage of health workers caused by out-migration, poor retention and low morale, and unequal distribution of the existing human resources. The country's current human resources for health ratio of 0.7 is still far below the WHO benchmark of 2.5 (combined doctors, nurses, and midwives per 1,000 population). Due to population growth, the ratio of professional health workers to population is expected to increase only marginally over the next five years, despite the nation's large number of pre-service educational institutions, focusing on the educational career and training of health staff, particularly

female health staff (Ministry of Public Health [MoPH], 2016). Recognizing the challenge posed by Afghanistan's alarming maternal and neonatal mortality along with shortage of female health workers, the Ministry of Public Health and the Ministry of Higher Education and its national and international partners decided to focus on strengthening midwives as a cadre of female health providers who were distinct from nurses and dealt exclusively with maternal and neonatal health. In 2003, the Ministry of Public Health identified the need for both conventional midwives based in hospitals, and community midwives deployed to basic health facilities offering the BPHS with a strong emphasis on outreach. Supported by USAID, the World Bank and the European Commission, the Ministry established two streams of pre-service education programs to accommodate two sets of needs, for hospital and community-based midwives (United Nations Population Fund [UNFPA], 2014). Moreover, the Ministry of Higher Education carries out equitable development of education facilities and provision of fair and competitive access to quality higher education. The adoption of measures in this regard was in line with the needs of the labour market of the country. In addition, higher education is well equipped to produce graduates that are professional, capable and committed to providing services to society. By doing so, the ministry contributes to solving economic, social, and cultural problems through conducting and delivering scientific, educational, and purposeful research (MoHE, 2015). However, Afghanistan has been involved in the conflict for the past four decades, therefore, the infrastructure including the educational infrastructure has been devastated by this long-lasting war. At present, because of war, the low quality of education is a matter of concern to all educators and pedagogues in the country. The main reasons for this problem are being described as the lack of professional teachers, lack of quality teaching-learning materials, inappropriate infrastructure, and security threats in some areas. Moreover, the quality of education is low and remains extensively teacher-centred and physical punishment is common in some of the Afghan schools (Mansory, 2007). Despite some progress in the training of teachers, as reported by the Ministry of Education (2021) more than half of the teachers do not have the required qualifications and effective teaching skills which are considered a big challenge for quality education in Afghanistan. Especially, the lack of qualified female teachers in the majority of schools located in districts is believed to be a substantial barrier to the quality of education

(National Education Strategic Plan [NESP], 2021). Education is a pre-condition for men and women to take part in the workforce and build a career. However, the disparity between men and women participating in the labour force exists. For instance, based on the report of the Afghan Government's Central Statistics Organization (2021), the total number of government employees in 2020 were reported 414,902 persons of which 74 per cent were males and 26 per cent were females. The difference between men and women in Afghan culture is that men have the priority to get an education in the family, but not females. Families have more confidence in males more than in females to earn money, as men are the breadwinners of their families (NSIA, 2021). Other than employment opportunities for women, the Afghan Civic Engagement Program (ACEP) also promotes women's rights by ensuring that Afghan citizens are well informed about the actions of government officials and that citizens have the means to influence public policy and advocate for political reform. The program aims to achieve this goal through five action areas: (1) regular civil society organization (CSO) engagement with government; (2) increased CSO and media thematic expertise in democracy and governance; (3) expanded civic engagement; (4) improved access to independent news and public affairs information; and (5) increased CSO organizational capacity (USAID, 2019). However, Afghanistan National Development Strategy stipulates that the representation of women in public office should reach 30% by 2020. Also increasing women's leadership, developing participation opportunities and mechanisms are to be considered as priorities in the five-year National Action Plan for Women in Afghanistan (Akhmetova & Kim, 2014; Kogut, 2014).

4.5.2 Ministry of Women's Affairs (MoWA)

The importance of women's role in the development of the Afghan nation cannot be overemphasized because women constitute an enormous reservoir of human resources that could significantly strengthen the government's effort to rebuild the nation. The current situation of women in the country presents a serious challenge to human development. The women of Afghanistan are among the worst off in the world, both in comparison to Afghan men and with women of most countries. Their situation is particularly poor in the areas of health, deprivation of rights, protection against violence, economic productivity, education and literacy, and public participation as

compared to Afghan men (ANCUI, 2018). The MoWA with the support of Marie Stopes International Afghanistan, have jointly drafted a national Reproductive Health Rights Strategy 2020-2025 to support the sexual and reproductive health of Afghan families. Moreover, to respond to the global initiatives such as the International Conference on Population and Development (ICPD, 1994) and the Beijing Conference on Women, 1995. Such conventions set out the vision for those providing SRH services at national and international levels, as well as describes the fundamental principles underpinning SRH provision for all. The specific objectives of the National Reproductive Health Strategy 2020-2025 are as follows:

- Increase couples' access to SRH services and secure their rights of access to all necessary and quality reproductive health services.

- Decease unmet needs to family planning by providing contraceptive services and counselling within the context of comprehensive sexual and reproductive health services for couples.

- Establish awareness-raising activities and provide comprehensive sexuality and reproductive health education for couples particularly, for vulnerable and disadvantaged groups(Ministry of Public Health[MoPH], 2016).

Aside from the above objectives, the strategy provides a comprehensive overview of international instruments that address women's sexual and reproductive health needs. It also suggested, adapting these documents at the national level in relevant ministries, in line with the international commitments that the Afghan government has already made, including to the SDGs, and with international and regional human rights treaties. The strategy further focused on ensuring that women can benefit from SRH services and their reproductive health rights are protected by access to reproductive health information and services. The strategy is also instructed by the principles of human rights or reproductive rights as human rights and gender equality and expecting that the outcomes of this strategy will strongly support the reproductive health rights of all individuals in Afghanistan.

According to the National Action Plan for the Women of Afghanistan being implemented by the Ministry of Women's Affairs (National Action Plan for the Women of Afghanistan [NAPWA], 2017), health is an essential requirement for any human being to carry out social and other activities of life. Hence, for women as being part of this society and responsible for carrying out these activities it is very important and needed to provide them with access to health services especially when it comes to sexual and reproductive health. The national action plan for women mentioned that women's health involves their emotional, social, physical, and biological wellbeing and is determined by the social, political, and economic context of their lives. Afghan women 's health and wellbeing, as measured by several interrelated indicators, deviates strongly from global standards. Afghan women are among the worst-off women in the world as measured by high fertility, low relative and absolute life expectancy, extremely high Maternal Mortality Rates (MMR), malnutrition, and other indicators. The national action plan also mentioned that Article 54 of the Afghan Constitution provides that the State will adopt necessary measures to ensure the physical and psychological well-being of the family, especially of child and mother. The Government of Afghanistan believes there is a need to take dramatic measures to make good on this obligation in light of the disastrous state of women 's health. The high fertility rate affects women 's life and health in a variety of ways. In many instances, frequent pregnancy impairs women 's ability to pursue an education or engage in economic opportunities. Early and frequent pregnancies increase the risks of maternal and infant deaths. The high fertility rate and youthful population not only place an outsized burden on women and women 's health. It also strains the capacity of the government to provide education and health services to its young population. This leaves women with inadequate public resources available for health care and other needs. This high rate of fertility and frequent pregnancies cause a huge number of maternal deaths. And to make a dropdown in this increasing number of deaths it requires a huge number of female health workers in the community to prevent these deaths and ascend this concern in reproductive health.

The national plan for women further mentioned that a lack of access to quality reproductive health services adds to an increasing in these preventable maternal deaths. Moreover, traditionally women are not allowed to approach to health centre unless it is subjected to male approval or an elder family member. Women are restricted to visit health care centres by their own choice or when they feel the need for it. Overall Afghan women are mostly not independent to decide for their health-related issues when it comes to sexual and reproductive health. On the other hand, gender discrimination at each stage of the female life cycle contributes to health disparities, taking forms that include sex-selective abortions, especially in India and Pakistan; the neglect of girl children; reproductive mortality and morbidity; poor access to health care for girls and women (UNDP, 2016a).

As per National Women Action Plan Goal and Objective, the improvement of women ‘s health is a priority for the Afghan government and holds top priority in an agenda that is committed to promoting the status of women and building their human capital. And one of the core indicators of the policy is to increase reproductive health services in country health facilities. Achieving targets of this policy in the health sector could yield measurable results towards the goal of reducing poverty and improving the wellbeing of all Afghans. This in turn could improve the wellbeing and productive capacity of families. The following objectives were mentioned to be pursued within the overall framework of the government ‘s work:

- Strengthening the quality and improving women ‘s access to the Basic Package of Health Services.
    - Increased investment in training women health workers including doctors, nurses, and midwives.
    - Increased resources for and effective implementation of the National Reproductive Health Strategy, placing particular emphasis on reduction of fertility rates and.
    - Enforced policy of mandatory capacity on reproductive health services, family planning and handling of violence against women cases in all health

facilities (National Action Plan for the Women of Afghanistan [NAPWA], 2017).

While setting goals and objectives and practising measures to achieve set targets, some challenges and constraints may impede implementation and achievement of targets which are listed as below:

- Inadequate medical services and infrastructure are available.
- Lack of human resources and low representation of women in the health sector.
- Cultural constraints in accessing health care.
- High Maternal Mortality Rate due to lack of quality health services.
- Need to focus on women's health beyond maternal health.
- The limited practice of and access to family planning (National Action Plan for the Women of Afghanistan [NAPWA], 2017).

To overcome mentioned challenges and constraints regarding the RH, the nationwide implementation plan stated that there are certain strategies and policies to practice which has been identified as follow:

- Improving and expanding health services and infrastructures, particularly for rural women.
- Promoting women's representation in the health sector.
- Promotion of a culture of health care and an understanding of basic health.
- Reducing maternal mortality by providing quality services and enhance the service delivery system.
- Promoting access to family planning(National Action Plan for the Women of Afghanistan [NAPWA], 2017).

As per the National Women plan, a national wide advocacy and public information campaign will be undertaken to generate massive support for the women 's agenda. Islamic scholars and religious leaders, media, academe, NGOs and other sectors will be

engaged in promoting people ‘s understanding of women‘s rights, reproductive health, the importance of girls‘ education, social and economic impacts of violence against women, gender issues in poverty and the adverse consequences of underage marriages (National Action Plan for the Women of Afghanistan [NAPWA], 2017).

4.5.3 Ministry of Education

According to the National Education Strategic Plan ([NESP]2017-2021) and as per research conducted and paper published by the Ministry of Education, the Islamic Republic of Afghanistan has made significant achievements with the support of partner development agencies in the educational sector in term of developing new classroom strategies, school renovations, building new schools conducting awareness for enrollment of young girls and boys to educational institutes and schools which caused into a very significant rise in several enrolled students by nine times. Furthermore, the Ministry of Education not only struggles to enhance the education system in terms of classroom and books being in educational places but also it has been struggling to enter the health sector into the system for a healthier and reliable future generation (National Education Strategic Plan [NESP], 2021).

As stated in policy objectives and outcomes of the research:

> *“Learners at all levels acquire the knowledge, skills, attitudes, and values needed to be productive, healthy, and responsible citizens prepared to contribute to the welfare of society and equipped for viable employment in the national and international labour market”* (National Education Strategic Plan [NESP], 2021, p. 32)”.

Moreover, health education and youth girl’s engagement into educational policy is not only bound to schooling and science institutions but also educational policy has entered health education into a pre-schooling stage where children from the very beginning of their journey to society must know the value of being healthy and its contribution into having a very well organized and sustained economy. As stated by the Ministry:

> *"A new Early Childhood Development/Primary Education speciality diploma is planned for teaching the first three primary grades. Teachers with specialist instructional and developmental skills and understanding can have a positive impact on the dropout rate and ensure solid learning by lower primary children. Pre-school and early grade specialists will study early grade reading techniques and cross-cutting issues such as health, environment, and gender equality*" (National Education Strategic Plan [NESP], 2021, p. 58).

As part of supporting discourse with stakeholders, the MoE will conduct regular information sessions and consultations with direct and indirect stakeholders in the reform, whose understanding, support, and participation are required for effective implementation. In addition, MoE will work with MoPH to develop a comprehensive school health strategy including health screening and support services (vaccination, health education, etc.) for children and communities making use of school facilities. A small allocation has been included in the national education strategic plan budget for the development and implementation of this program, which will be monitored and reported. School facilities will be constructed (classrooms, labs, boundary wall, water, and sanitation) in close collaboration with communities and the private sector. School design and safety measures will consider functional requirements, gender, use of locally available material and maintenance (National Education Strategic Plan [NESP], 2021). However, according to Afghanistan Research and Evaluation Unit (AREU), the acceptance of birth control and access to RH services and resources are low. The promotion of women's sexual and reproductive health rights has been met with scepticism and resistance in many rural conservative communities and made it difficult for women to access information, or to enhance women's ability to negotiate use RHC services. The report further suggested that education for adolescent girls and boys on their reproductive health has met with even more resistance. To the extent that they exist, such activities are mainly run by international NGOs, often under the guise of other activities(Afghanistan Research and Evaluation Unit [AREU], 2013).

4.5.4 Ministry of Higher Education

The Ministry of Higher Education's (MoHE) long-term aim is to ensure full access to education, including higher education for Afghan women and girls. Also, the MoHE is committed to providing a safe and convenient educational environment for girls and women along with focusing on the inclusion of a reproductive health curriculum in the universities teaching system. This is a joint MoPH and MoHE effort in advancing women and girls' awareness about reproductive health issues. Such effort is taking place through coordination in Information, Education and Communication (IEC), Behavioral Change Communication (BCC), and pre-service training to the public and private university students across the country (MoHE, 2015).

> "*With the short-term goals, the ministry is leading and managing a diversified and coordinated system of higher education comprised of public and private universities, institutes, and colleges. To meet the learning needs and aspirations of individuals through the development of their intellectual abilities throughout their lives. Addressing the development needs of the society and provide the labour market in a knowledge-driven and knowledge-dependent society, with the changing high-level competencies and expertise necessary for the growth and prosperity of a modem economy. Improving the quality of higher education institutions with international standards as a long-term benchmark in close cooperation with the Ministry of Higher Education is planned. Establishing an accreditation and quality assurance system to ensure institutional and program quality, national and regional relevance, as well as international mobility and recognition. Providing and enhancing research capacity for the advancement of knowledge and the application of research activities to technological improvement and social development and providing funds sustainably and equitably to ensure quality higher education through the principle of shared costs"* (MoHE, 2015, p. 8).

Given the high importance of education, the MoHE is increasing the number of female students and teachers in higher education institutions and at universities. Therefore, the MoHE is trying to encourage families to recognize the value of equally educating their

girls and boys, as the Afghanistan constitution guarantees all citizens' equal rights to education without discrimination. In line with this, the strategy document stated that Afghanistan has made some progress over the past decade in establishing its legislative and policy framework to ensure girls' education. Important gains have been made to narrow the gender differences in education, and women's participation in public life and their political representation have increased in some areas. However, discrimination against girls' education still exists in rural communities, notwithstanding parents' wish that their daughters and sons should have equal rights and opportunities within a secure environment for education (MoHE, 2015).

4.5.5 Ministry of Information and Culture

The Afghanistan Ministry of Information and Culture (MoIC) strategic plan aims to protect cultural and historical assets and promote cultural activities along with awareness-raising through mass media to advocate for youth rights in the political, economic, and social sphere of life. The strategic plan stipulates that the national heritage can become a rallying point for Afghans, enabling them to rebuild ties and dialogue and redesign a common identity and future together. As culture and media can contribute to this endeavour in many ways. Afghanistan's recent history provides a wide range of examples of how a lack of public investment, lawlessness, and repression within this sector have: (i) fueled prejudice and intolerance; (ii) led to a notable impoverishment of culture capital; (iii) spoiled many of Afghanistan "s major cultural assets; and (iv) strengthened the network in the illicit traffic of antiquities, as there is clear evidence that networks dealing with drugs and illicit traffic of the country's cultural property are closely intertwined (MoIC, 2015).

Additionally, the strategic plan encouraged the Afghan authorities to continue inter-ministerial coordination as well as discussion and information-sharing between provincial and national authorities for the benefit of all tangible and intangible heritage in Afghanistan. Moreover, the cross-cutting issues of the strategic plan are gender, environment, drug addiction, health, and well-being, which are mentioned to be addressed in close coordination with the ministry of health and other inter-sectorial initiatives (MoIC, 2015). Other than this, the ministry is working together with

international organizations such as UNFPA on sexual and reproductive health information and services, including counselling on issues related to safe sex, sexually transmitted infections, family planning, and contraception. The ministry also focuses on issues related to gender-based violence and available services for survivors, along with addressing the effects of harmful practices such as forced, early and child marriages, and how to get help in these situations through youth helpline and referrals to nearby public health facilities and other support services. UNFPA is supporting the MoIC because access to information and services on sexual and reproductive health and rights are crucial to the well-being and productivity of individuals and society as they have a significant influence on a country's development and prosperity (MoIC, 2015; UNFPA, 2015).

4.5.6 Ministry of Religious Affairs

The Ministry of Religious Affairs (MoRA) is responsible for the provision of an excellent religious institution in the country and providing services for pilgrims at a low cost for Afghan citizens. Moreover, the ministry is implementing a capacity-building training program for religious schools and students. Also, the ministry is keeping active coordination with the MoE, MoHE, and MoPH to deliver the health education sessions through prayer rooms and Friday prayer ceremonies. In the meantime, the ministry is coordinating with the MoE and MoPH in the delivery of awareness-raising on environmental health throughout the country. Recently, the MoRA endorsed a social and behaviour change communication activity promoting family planning and maternal health through mosques.

This activity is taking place through Afghanistan's social marketing organization with support from SHOPS Plus a USAID-funded project. This activity aims to increase male/husband engagement in maternal health and address normative barriers and misconceptions about family planning methods. Given the respect in the community and regular interactions of religious leaders in their communities could help change the attitudes of the worshippers/villagers in addressing some of the deep-rooted social and cultural beliefs about male engagement in family planning and maternal health (USAID, 2020).

4.5.7 Ministry of Justice

The Ministry of Justice operates with the strategic goal of strengthening Afghanistan's judicial system, deliver quality legal as well as judicial services. The main responsibilities of the Ministry of Justice of the Islamic Republic of Afghanistan include preparing or reviewing law drafts and decrees of the President of the Islamic Republic of Afghanistan. Advice on legal compliance of international contracts, conventions, foreign commercial agreement letters with Afghanistan Islamic Republic (MoJ, 2018). As part of its mandate, the Ministry is also focusing on the delivery of lawful and legal consultation to state ministries and departments. Taking measures for the implementation of the decisions issued by courts on legal and civil disputes. This is in line with the attempts for raising public legal awareness and reviewing political parties and social organizations' charters, registration, and issuance of a license for their official activities. This is combined with regulating affairs related to offending juveniles from the law in juvenile correction centres.

4.5.8 Divorce law

According to Canadian Women for Women of Afghanistan (CWWA) divorce is linked to family law, broadly speaking it is the law or regulation of familial relationships such as relations within the immediate family (husband and wife) and/ or extended family. Family law matters can be linked with the law of property (ownership) and criminal law (issues relating to abuse including violence). When family rights have not been legislated in law it can be difficult for women's rights within the family to be protected, or for women to access justice. Afghanistan has codified family law; however, it is poorly enforced. Family laws in Muslim societies are based on diverse sources of law, ranging from various interpretations of the Quran and Sunnah originated from teachings of the Prophet Muhammad (Peace and blessing of Allah be upon last Prophet Muhammad [Peace Be Upon Him]) to colonial common law. Family law reform is also influenced by the diverse cultural, legal, judicial, and political systems that can influence the interpretation and application of laws. Family law reform is often linked to constitutional law and criminal law, which at times can create tensions between the pursuit of gender equality and the right to religious freedom. The spread of international law seeking the protection and promotion of human rights has also provided a

framework and motivation for reforming family law in Muslim societies to better protect women's rights to divorce. However, as many of these sources overlap or produce conflicting rules, Muslim women need access to the law that is the most just to them. The Afghan Family Law is generally considered to be progressive from a gender perspective in that it provides some important protections to women and child custody, inheritance and divorce rights (CWWA, 2021). The right to divorce is also closely linked to the Nikah (marriage contract). In Islam, the nikah is a formal binding contract that is considered integral to the validity of a marriage. It outlines the specific rights and responsibilities of the bride and groom that both agree and signs to. It requires that two adult witnesses sign the contract as well. Once the terms are agreed upon and signed, the marriage is declared publicly. Islam does not consider the nikah a ritual, which is subjected to being revoked or cancelled, which means divorce is permitted and can be initiated by either party. Therefore, the nikah can serve as an important tool for women to protect their rights and enforce what they are entitled to within the marriage, or in the event of the marriage's dissolution. However, in practice there are insufficient provisions for the requirement of consent to marriage, there is the language around the need for wives to be "obedient" to husbands and to request permission from husbands for various acts, and unequal rights to divorce and inheritance between men and women. Given the Afghan Constitution's guarantee of gender equality, the current family law contravenes the new constitution, in addition to international law that Afghanistan has ratified CEDAW and other relevant conventions that supports women's rights (CWWA, 2021; Swenson & Sugerman, 2011).

In the case of women's rights to divorce in other Muslim countries, for instance, in Bangladesh, the interpretation of Sharia Law is aligned with the country's constitutional law. These laws are both conjointly used to regulate and monitor the issues of divorce among Muslims in the country. However, Islamic law provides husbands with the authority of divorcing (in Arabic "talaq") their wives known as Talaq-e-Tawfiz or ending the marriage through the written document of the contract of marriage (Patwari & Ali, 2020). Whereas women's power to exercise the Talaq-e- Tawfiz solely depends on the will of their husband. Although Muslim women can deny their marriage through

the process of "khula[6]" or "mubarat[7]", however, these are only executable with the free consent of their husbands. In the case of "Khula", a woman can pursue "khula divorce" from her husband by leaving any legal rights she is entitled to such as dowry, money, property and so forth. Nevertheless, the breakage of marital union in "khula" is only possible with the consent of the husband. In Bangladesh, a Muslim women's right to the dissolution of her marriage is handled by the court (Patwari & Ali, 2020).

4.5.9 Legal Status of Women

Whilst the 1964 Constitution contains an equality-before-the-law provision that does not differentiate between men and women, the legal system however does. Many aspects of Islamic family law as applied in Afghanistan accord differential rights to men and women. A Civil Code declared in 1977, introduced some significant reforms. The new Civil Code repealed the law of marriage of 1960 and reformed several aspects of Hanafi family law. Under the 1977 Civil Law women are permitted to choose a husband without needing the prior consent of their guardian, a divorce pronounced by a husband while intoxicated is no longer recognized as valid, and it establishes a minimum age of 15 years for a female to enter a valid marriage. The legal capacity to marry is 18 years for boys and 16 years for girls (Lau, 2002). A formal recording is required for all marriages and unlike the provisions of the 1960 Marriage Law non-registration does not affect the marriage's validity. The practise of polygamy has not been outlawed but has been regulated by the 1977 Civil Code. For a husband to enter a second marriage he must prove that there is no fear of injustice to any wife, he must be able to provide the necessities for all the wives, such as food, clothing, housing and health care, and a lawful reason must exist for the second marriage, such as the first wife is barren or sick with an illness requiring difficult treatment. According to the Afghanistan Constitution (2004), all citizens are equal before the law. No discrimination shall prevail because of bind, race, sex, opinion or any other personal or social condition or circumstance (Kakakhel, 2004; Lau, 2002).

Though not enacted yet, Afghanistan has ratified several key treaties relating to individual rights and liberties. These treaties include the Convention on the Political

[6] Khula: the wife desires the divorce and initiates it

[7] Mubarat: both spouses desire the separation

Rights of Women of 1953, which provides that women shall have all the political rights that are afforded to men, including the right to vote in all elections as well the right to run for and to hold public office. Afghanistan was one of the first nations to ratify this treaty. Afghanistan is also a party to the International Covenant on Economic, Social, and Cultural Rights and the International Covenant on Civil and Political Rights. Both covenants provide that the enumerated rights shall be granted equally without regard to sex, religion, or race. These two treaties provide rights in broad areas and because Afghanistan has ratified these agreements, they will provide Afghan women equal rights as to men in those areas (Kakakhel, 2004; Lau, 2002). Though these conventions are ratified, the Afghan Government did not enact the necessary legislation to give domestic effect to these treaties. In addition, Afghanistan also signed the Convention on the Elimination of All Forms of Discrimination against Women, but this convention needs to be ratified yet. Moreover, the country is a member of the International Labor Organization and ratified the Convention Concerning the Equal Remuneration for Men and Women Workers for Work of Equal Value of 1951, which provides that men and women must earn equal pay for equal work. Moreover, Afghanistan ratified the Convention Concerning Discrimination in Respect of Employment and Occupation of 1958, which provides that parties agree to undertake programs to stem all discrimination (both race and sex-based) concerning employment. These treaties are promoting women's rights in different aspects of their life such as health, education, and employment (Kakakhel, 2004).

4.5.8 Summary

As presented in Table 4.2 below, policies were screened by using the factors identified through a review of concerned literature and marked as "+" if directly addressed by a policy or law; marked as "(+)" if indirectly supported by a policy; marked as "-"if not addressed by a policy or law; and marked as '(c)' if policies or laws were contradictory. Not a single factor of the SD of health applied to women's reproductive health was addressed jointly by all selected ministries. Whereas one-factor microfinancing for women' was not addressed at all by any of the selected ministries. There were two factors namely 'women's rights to divorce' and 'women rights' that were subject to

contradictory policies or laws. Finally, it is important not to confuse factor coverage by policies of selected ministries of law with actual intervention.

Table 4.2: Summary of SDH Addressed in Public Policy by Selected Ministries in Afghanistan

Main SDH	Sub-SDH	Factors addressed in policies	Selected Ministries in Afghanistan						
			Public Health	Education	Higher Education	Women's Affairs	Information & Culture	Religious Affairs	Justice
Socio-econ-policy context & socio-econ position	Governance	Int'l agreements addressing gender inequity	-	-	-	+	-	-	+
		Promote women in the cabinet	-	-	(+)	-	(+)	-	+
		Promote women in parliament	-	-	(+)	-	(+)	-	+
		Promote female executives	+	-	(+)	+	(+)	-	-
	Macro-economics	Micro-financing for women	-	-	-	-	-	-	-
		Women's education & jobs opportunities	-	+	+	(+)	-	-	+
		Job opportunities for men	-	(+)	(+)	-	-	-	-
	Socio-cultural values	Legal age of marriage	-	-	-	+	+	-	+
		Women's right to divorce	-	-	-	-	-	-	(c)
		The illegality of dowry practice	-	-	-	(+)	-	-	+

Main SDH	Sub-SDH	Factors addressed in policies	Selected Ministries in Afghanistan						
			Public Health	Education	Higher Education	Women's Affairs	Information & Culture	Religious Affairs	Justice
		Domestic violence	(+)	-	-	(+)	+	-	+
		Access secondary & tertiary education (girls & boys)	-	-	+	(+)	-	-	-
		Public awareness on gender equity (mass media)	(+)	-	(+)	+	+	-	-
		Family planning	+	-	+	(+)	+	+	-
Bridging determinants	Social cohesion & social capital	Civic engagement	+	+	-	+	+	-	+
		Rights of women	(+)	(+)	(+)	+	(+)	(+)	(c)
		Inclusion of women in political positions	-	-	(+)	-	-	-	+
Personal determinants	Living & working conditions	Job opportunities women	-	(+)	+	(+)	-	-	+
	Biological & behavioral factors	RH promotion	+	-	+	+	+	+	-
		RH education in schools	+	+	+	(+)	-	(+)	-
	Psychosocial factors	Mental health	+	-	-	-	+	-	-

Main SDH	Sub-SDH	Factors addressed in policies	Selected Ministries in Afghanistan						
			Public Health	Education	Higher Education	Women's Affairs	Information & Culture	Religious Affairs	Justice
Health system	Quality	HR (health) planning	+	-	-	(+)	-	-	-
		HR (health) production	+	-	+	(+)	-	-	-
		QA health professions' education	-	+	+	-	-	-	-
		BPHC-EPHS & Essential drug list	+	-	-	(+)	-	-	-
		HS logistics management	+	-	-	-	-	-	-
		HS infrastructure planning	+	-	-	(+)	-	-	-
	Access	Health service coverage	+	-	-	(+)	-	-	-
		UHC	+	-	-	(+)	-	-	-
		RH female health personnel	+	-	-	(+)	-	-	-
		Service hours	+	-	-	-	-	-	-
		Privacy arrangements for female visitors/patients	+	-	-	-	-	-	-

Main SDH	Sub-SDH	Factors addressed in policies	Selected Ministries in Afghanistan						
			Public Health	Education	Higher Education	Women's Affairs	Information & Culture	Religious Affairs	Justice
	Utilization	Promote RH literacy	+	-	+	(+)	+	(+)	-
		Address gender inequity	(+)	-	+	(+)	+	-	-
		Poverty reduction/UHC	(+)	-	-	-	-	-	-
		Inclusive health system	(+)	-	-	-	-	-	-

Legend:

[a] In public sectors (national, provincial & district); [b] Traditional healers, birth attendants, pharmacies etc.; + Social determinant of women's RH directly addressed by sector policy;

(+) Social determinant of women's RH indirectly addressed by sector policy; - Social determinant of women's RH not addressed by sector policy; (c) Conflicting law sources

4.6 Discussion on deficiencies in the Afghan public and social policies in addressing social determinants of women's reproductive health rights

4.6.1 Policies concerning socio-economic and political contextual determinants

4.6.1.1. Women's participation in governance

Though Afghanistan's Constitution recognizes the equality of men and women, there is limited participation of women in the labour force, women are missing from political activities and decision-making at all levels of public life. For example, the MoWA reports that women's participation in the national parliament is low compared to men. Evidence shows women account for 28% of the National Parliament, 21% of Provincial Council seats, and 35% of Community Development Council (CDC) seats. Notwithstanding the progress, Afghan women still have a long way to go be proportionally represented in the political sphere and participate in political decision making.

4.6.1.2 Women's participation in development

Different policies and plans are focusing on creating job opportunities for Afghan women and men. The Ministries of Education and Higher Education focus on access to and quality of education, thereby indirectly supporting job opportunities for women. This is mainly done through donor assistance of donors. Unfortunately, commitment often remains limited to policy statements, the implementation of these women-centred policies remains weak and leaves women to fight alone against the daily challenges. Evidence shows that only 26% of females were government employees in 2020 (NSIA, 2021). Inequalities that comes from gender is a challenge for women participation in the workforce, despite that jobs can bring advantages for women, their families, businesses, and communities. Also, women's participation in the labour force boosts self-esteem and can pull families out of poverty. Yet gender disparities persist in the world of work. Closing these gaps, while working to stimulate job creation more broadly, is a prerequisite for ending extreme poverty and boosting shared prosperity. Concerning job creation, in Bangladesh, for example, the expansion of the garment sector has created millions of jobs for women. These jobs have increased women's earnings, reduced poverty, and increased girls' education levels. Furthermore, garment sector jobs have enabled many women particularly, young and unmarried women to

break from traditional norms by migrating from villages to cities for work, and they have enjoyed increased social status through greater economic significance in the household and society (World Bank, 2010). In contrast, the same report indicates that women in Afghanistan's police force report rampant levels of exposure to sexual harassment and assault by male colleagues. Policies and programs to increase women's entry into male-dominated fields should be accompanied by planning for robust monitoring, oversight, training, and redress mechanisms to ensure women's freedom from violence on the job (World Bank, 2010).

4.6.1.3 Women and Afghan socio-cultural norms and values

Women's rights to divorce and the legal age of marriage is described in the policy documents of the Ministry of Justice, which emphasize women's rights to divorce. However, there are conflicting sources when it comes to women's right to divorce. In addition to Afghan cultural values, Sharia Law (Islam's legal system) creates inequality between men and women and promotes men's supremacy over women in diverse aspects of family and public life.

In contrast to South Asian traditions, dowry in Afghanistan is property, commodities and or money given by the groom to the bride on their marriage. According to Afghan law, women who enter marriage shall have a dowry (called mahr in the Arabic language). The dowry shall remain the woman's separate property and is provided as security in case the husband dies or requests a divorce. The dowry concurs with Islamic law and tradition, but the Quran contains no instructions regarding the size of the dowry or when it should be paid. During the wedding ceremony, the religious leader who performs the religious rites will ask the groom's father to state the size of the dowry. If the marriage is documented in writing, the size of the dowry must be recorded. The Afghan dowry system can be a source of financial security for women, however, at the same time, it might also lead to early marriage driven by financial opportunity. Although domestic violence is addressed by Afghan criminal law, it did not bring justice to victims. Within the public sector, only the MoPH and the MoWA adopted a focus on domestic and gender-based violence through the national action plan for women, which states that RH services should be provided to target domestic violence

and provide health sector responses to Gender-Based Violence (GBV). GBV responses should be reflected in the treatment protocols and guidelines of the health facilities.

4.6.2 Policies concerning social cohesion and social capital

The issue of social cohesion and civic engagement from the community to the national level is directly addressed by the MoPH, the MoWA, the MoHE, and the MoIC. Other ministries encouraged women's participation within the community or the workplace indirectly. Additionally, the Afghan Civic Engagement Program (ACEP) also promotes women's rights by ensuring their rights to influence public policies and that Afghan citizens are well informed about the actions of government officials about their rights. In line with this, the Afghanistan National Development Strategy stipulates that the representation of women in public office should reach 30% by 2020. On the other hand, the National Action Plan for Women in Afghanistan emphasized increasing women's leadership, enhancing participation opportunities and mechanisms for women. However, evidence suggests that women's participation in government remains low, indicating that most of the policy documents are not translated into action yet.

4.6.3 Policies concerning Afghanistan's health system

Afghanistan's reproductive health strategy includes maternal and newborn health, family planning (including access to contraception), prevention and treatment of HIV and STIs, and sexual and gender-based violence. However specific populations such as adolescents, ageing persons and people with disabilities are not explicitly targeted. Ensuring that no one is left behind in sexual and reproductive health calls for including these potentially vulnerable groups. Moreover, the involvement of men, particularly husbands, whose decisions in the household could have a direct impact on women's access to RH services, which is overlooked in the RH policy and other sectoral policies. There are no specific family planning advocacy and counselling programs at the community and health facility levels for men. Other than male involvement, the maternal mental health of women is also missing in the MoPH's RH policy. However maternal mental health is only one element amongst many cross-cutting health issues mentioned in the RH policy. The relevance of attention for mental health becomes clear

in cases of gender-based violence or to those who may encounter sexual harassment such as rape.

The current policy also neglects to raise awareness about risks associated with opium and other substance uses, especially during pregnancy and childbirth. Since substance abuse is forbidden in Islam and socially unacceptable, addicted people especially women have to remain underground and are socially excluded as a result of social stigma and discrimination. Neglecting these realities however increases the risk of violence, STIs, and unintended pregnancies amongst addicted women (Carrieri et al., 2006; Heil et al., 2011).

The Afghan government is committed to ensuring universal access to sexual and reproductive health care services for all in Afghanistan in its pursuit of the Sustainable Development Goals and the achievement of universal health coverage by 2030 (United Nations [UN], 2014). In line with ensuring universal access to SRHC services, family planning, information, and education, including the integration of reproductive health into national strategies and programs have been mentioned in SDG 3, target eight. The Basic Package of Health Services (BPHS) and Expanded Package of Health Services (EPHS) are Afghanistan's strategies to promote free universal coverage at the primary-health-care level within the country (Trani et al., 2017). In line with this, the MoPH and its partners are committed to enabling all Afghan families to have access to quality reproductive health care services. However, evidence is missing as to what extend progress has been made in universal access to reproductive health care services for all Afghan women.

The RH policy of the MoPH and the National Health Strategy (2016-2020), mentioned gender as a cross-cutting issue by addressing barriers to gender equity that exist externally in the form of high illiteracy and cultural norms. Moreover, it mentioned that gender barriers exist internally in the way public health services are structured and delivered, with limited career opportunities for women across the country. Concerning barriers to gender equality, the National Health Strategy identified three existing barriers in the health sector: (i) physical or geographic barriers posed by distance, harsh

terrain, road blockage or poor road network, and transportation challenges; (ii) psychosocial barriers, due to lack of women's decision-making power; and (iii) service barriers, created by a shortage of female staff, insensitive health providers, and lack of infrastructure that facilitates socio-cultural norms and privacy for women (Ministry of Public Health[MoPH], 2016).

The country's current human resources for health ratio of 0.7 is still far below the WHO benchmark of 2.5 (combined doctors, nurses, and midwives per 1,000 population). Due to population growth, the ratio of professional health workers to population is expected to increase only marginally over the next five years, despite the nation's large number of pre-service educational institutions, focusing on the educational career and training of health staff particularly, female health staff (Ministry of Public Health[MoPH], 2016).

Recognizing the challenge posed by Afghanistan's alarming maternal and neonatal mortality along with shortage of female health workers, the MoPH and MoHE and their national and international partners decided to focus on strengthening midwives as a cadre of female health providers who were distinct from nurses and dealt exclusively with maternal and neonatal health. In 2003, the MoPH identified the need for both conventional midwives based in hospitals, and community midwives deployed to basic health facilities offering the BPHS with a strong emphasis on outreach. Supported by USAID, the World Bank and the European Commission, the MoPH established two streams of pre-service education programs to accommodate two sets of needs, for hospital and community-based midwives (United Nations Population Fund [UNFPA], 2014).

CHAPTER 5
Reflections and Conclusion

5.1 Study limitations

- *Search challenges*

Due to time constraints and in absence of personal contacts within few ministries, not all potentially relevant ministries have been included. However, all key sectors were represented.

As Afghanistan's public administration presents a mixture of printed and/or electronic materials, issued in Dari and/or English, not all relevant policies may have been included.

- *Confirmation bias*

The scope of the study both in terms of available time and credits did not permit the incorporation of key informant interviews to guide searches for relevant policy documents and to further clarify selected policy documents. The absence of key informant guidance may have posed a potential risk of interpretive bias.

- *Selection bias*

As only English publications on social determinants of women's reproductive health were included in the study, some factors relevant to South Asian political-economic and socio-cultural settings might have been overlooked if these were only published in local languages.

- *Planned vs actual policy*

Policy documentation presented often broad statements of goals, without specific objectives. There was often no specific implementation plan that named actors, actions, and desired outcomes. As a result, policies were often expressions of intent. The current study was unable to capture the translation of policies into action. It is therefore important not to assume that all documented policy addresses the very issues that triggered their development.

- *Holism*

Social determinants of reproductive health and the public policies addressing them are parts of the societal context and are interconnected, therefore they cannot be understood without reference to the context. In other words, the whole is greater than the sum of its parts. Where possible findings were placed into context and interactions pointed out. It was however outside the scope of this study to address in-depth the interconnectedness and interactions across social determinants and the policies addressing them.

5.2 Women rights in tomorrow's Afghanistan

For almost twenty years, women enjoyed advances in their rights being respected. Starting from women in the country's cities it gradually extended to the less-privileged rural communities. There is still a long way to go in fulfilling women's reproductive health rights, but at least Afghanistan was on the right path.

However, today Afghan women fear a return to a marginalized existence as the Islamist militant Taliban not only consolidated their political power under a peace deal with the USA but also militarily the Taliban recaptured the country, within a very short time. Today Afghanistan is ruled by the Taliban once again. There are real concerns about how the social landscape in Afghanistan will shift under Taliban influence, and what conditions will be forced upon women. As stated by Amnesty International's Asia-Pacific Director: alongside the withdrawal of international troops, Afghanistan is drifting towards an outcome that threatens to undo more than twenty years of progress for women and girls (Amnesty International, 2021).

5.3 Conclusion

In Afghan society, many women suffer from a lack of access to RH services which not only infringes on their right to health but also affects morbidity and mortality. The health system, although essential, is a rather narrow basis to address women's reproductive health as determinants manifest and influence across a range of societal domains.

The Commission on Social Determinants of Health stated that to make real change in the health and wellbeing of people, especially women, there is a need to address the SDH. This study identified social determinants of women's RH as described in the literature to facilitate a description of the policy context of women's RH rights in Afghanistan.

The study findings showed governance policy favouring women's empowerment through ensuring their voice in governance as well as by Afghanistan being a signatory to a variety of conventions and treaties that address women rights. Unfortunately, many of these were not enacted yet.

In terms of macro-economic determinants, female jobs were promoted across sectors and supported by education strategies for girls and young women which are likely to benefit urban women. However, policy supporting rural women in income generation was lacking.

Although policies were in place across public sectors directly addressing social-cultural determinants of women's reproductive health rights or indirectly supporting these, making progress was challenged because of defective policy, inaction due to the lack of action plans, social norms posing barriers, and conflicting laws.

The policy that addressed social cohesion and social capital were in place by ensuring the civic engagement of women through their participation in local, provincial, and national decision-making forums, however realizing its full potential is a work in progress. Generally, representation remained low and socio-cultural norms continue to pose barriers in voicing their views.

Finally, health system policy concerning women's reproductive health and beyond was in place but major challenges remained in terms of access, quality, and utilization of reproductive services and this due to defective policy, absence of action plans, including resources, and socio-cultural gender norms.

In summary, in broad terms, current Afghan public policies do address key social determinants of women's reproductive health. However, what was often not available across public sectors was the translation of policy into tangible action plans. In absence of action plans, including resources, and the presence of persistent social-cultural norms posing barriers in promoting women's rights in Afghanistan's patriarchal society, policies are at risk of being unable to achieve their full potential.

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APPENDICES

Appendix-A: Data collection tools

Table A1: Document Check List

Document type	Available	Not Available
Office of the President		
• National development plan		√
• Signatory & enactment to relevant conventions, covenants, treaties & declarations		√
		√
Ministry of Public Health		
• Sector development plan		√
• Policy briefs SDH concerning SRH	√	
Ministry of Education		
• Sector development plan		√
• Policy briefs SDH relevant to women's rights	√	
Ministry of Women Affairs		
• Sector development plan		√
• Policy briefs SDH relevant to women's rights	√	
	√	
Ministry of Communications & IT		
• Sector development plan		√
• Policy briefs SDH relevant to women's rights		√
Ministry of Higher Education		
• Sector development plan		√
• Policy briefs SDH relevant to women's rights	√	
Ministry of Justice		
• Sector development plan		√
• Policy briefs SDH relevant to women's rights	√	

BIOGRAPHY

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B. Education Background

2021 MPH (Global Health), Thammasat University Thailand
2010 Diploma in Public Health (DPH), Pakistan Institute of Modern Studies (PIMS), Pakistan
2005 Medical Doctor, Balkh Medical Faculty (MD) Mazar-e-Sharif, Afghanistan
1996 Baccalaureate Experimental Science, Al-Taqwa Experimental Science High School Peshawar Pakistan

C. Summary of Employment Background (2006- 2021)

1. Jan. 2021 to date **Country Director,** MSIA Reproductive Choice, Afghanistan
2. Jul. 2018 to Dec. 2020 Acting Country Director and **Deputy Country Director** Marie Stopes International, Afghanistan.
3. Dec. 2016 to Jun. 2018 **Operation Manager**, Marie Stopes International, Afghanistan.
4. Apr. 2012 to Dec. 2016 **Health Support & Research Team Leader,** Marie Stopes International, Afghanistan.
5. Feb. 2009 to Apr. 2012 **Project HMIS Senior Officer,** Partnership Contract for Health Services (PCH) Project, Kabul, Afghanistan
6. Nov. 2008 to Jan. 2009 **Acting Project Manager,** Performance-based Partnership Agreement (PPA), Nimroz Province, Afghanistan.
7. Jun. 2008 to Nov. 2008 **HMIS Officer,** Performance-based Partnership Agreement (PPA), Nimroz Province, Afghanistan.
8. Sep. 2007 to Jun 2008 **Hospital Supervisor,** Performance-based Partnership Agreement (PPA), Nimroz Province, Afghanistan.
9. Sep 2006 to Sep. 2007 **Clinical Supervisor,** Performance-based Partnership Agreement (PPA), Nimroz Province, Afghanistan.
10. Feb. 2005 to Sep. 2006 **Master Trainer & Assistant Faculty Member** in BRAC Training Resource Center (BTRC), Mazar-i-Sharif Balkh Province, Afghanistan.