Changes Creep to Northern Afghanistan

Feature article and photos by Gazelle Gaignaire - August 2003

In the village of Tibir

If a light-bulb existed in Tibir and if, by some miracle, it was hanging from the ceiling of a room and glowing, a villager with the aim of putting out the light would find an object to stand on, take a deep breath, and blow.

"There is no electricity here, no water, no roads," says Aida, a midwife who moved a few months ago to Tibir, located in the poor, remote, north-western province of Sar-i-Pul. "No park, no kintergarden, no cinema, no museum". And she adds, laughing, "It's my luck that my husband is from here!"

Children in Tibir seek shade by a river on a hot summer day

Until June of this year, there was also no clinic in Tibir. Or at least not a *real* clinic. It was more like a small health post, but with no drugs or qualified personnel. When an MSF team first entered one of the consultation rooms, they stopped a staff member who was just about to inject a syringe into a baby's tender scalp. It turns out this acting "nurse" was in fact the security guard. In a country where many uncertified nurses call themselves doctors, why wouldn't a guard call himself a nurse?

In the backyard the team discovered a huge pile of junk and saw the staff rummaging through it to fish for expired ORS (Oral Rehydration Salts) which they were mixing with bacteria-infected water from a nearby river-pool.

Fired Bricks

The health care needs in the area were obvious and MSF decided to support the clinic. Reconstruction work was the first step, but buying raw materials on the local market proved harder than expected. Basir, an Afghan MSF logistician, drove to the village of Tucsar, six kilometers from Tibir - the closest location to obtain fired bricks. A salesman told him he needed to see the village commander who owned the bricks before he could purchase them. Basir found the commander in a bazaar shop and spoke to him, mentioning at some point in the conversation that the bricks were needed for the Tibir clinic. Then he went back to the salesman, negotiated the price, came to a final agreement, and said he would return the next day.

But the next day when Basir arrived with an empty truck and 300 US dollars, the original salesman was not there, and a new, unknown man at the shop told him: "We cannot sell you bricks for Tibir". He also delivered a strange warning: "You should leave Tucsar, or you might get into trouble".

Ethnic rivalry can turn "business as usual" into unusual business in Afghanistan. Tibir is

held by the Junbish, a political party composed mainly of ethnic Uzbeks, while Tucsar is in the hands of the Jamiat, comprised mainly of ethnic Tajiks. Once loosely allied against a common enemy - the Taliban - the two factions are now vying for power and control of land and smuggling routes in various parts of the country, and tensions between commanders regularly escalate into local clashes. Apparently money could not be accepted from an organization perceived as providing services to the "enemy". And maybe for the salesman a cut on the deal meant risking punishment from his superiors.

With fired bricks bought instead from Mazar-i-Sharif, rehabilitation of the Tibir clinic continued. Then fighting broke out in Gosfandi, less than 20 kilometers away. Sixteen persons were killed before the town fell to the Junbish. Due to the fighting, MSF was unable to travel to Tibir for 10 days, and the opening of the finished clinic was delayed.

History Books

The official inauguration finally took place on June 3rd, kicked off by the inspiring speeches of several local authorities. They spoke convincingly of the need to educate girls, train female medical staff, improve basic health care, and respect women's human rights. Sitting among a crowd of more than 90 Afghans, Maria Lindeberg, a Swedish, MSF doctor, was thrilled to hear such messages in this quiet, isolated backwater. "It made me think there is hope for this country," she said after the ceremony. And when the newly-hired, female vaccinator was called on stage, it gave Maria the chills - simply because a woman was being given a voice.

"These are the first three women to work in the clinic," the deputy governor proudly stated, referring to the new vaccinator, midwife and health educator. "Their names will be written in golden ink in the history books of Tibir!"

It sounded grand, but the reality today is that none of the children in Tibir have a history book. And if one were placed in their hands, few of the boys and none of the girls could decipher the letters on its pages. This too, however, is changing: for years there was only a primary school for boys in Tibir, but one for girls has recently opened. "There is also interest and a demand for fourth to sixth grade classes, but for the time being there are no teachers" explains Dr. Yonus Mutawasim, the head of Tibir clinic.

According to Dr. Yonus, among the 70,000 or so inhabitants of the district of Khulam Faza which covers Tibir and its surrounding villages, only about a dozen women can read and write. This is nothing out of the norm: illiteracy is appallingly high in Afghanistan, with a national average estimated at more than 85% for women and more than 50% for men. The numbers are of course higher in rural areas. Not surprisingly, none of the three, educated women who now work in the clinic (and were the only three who applied) are from Tibir. Aida, the midwife, is from Mazar-i-Sharif, while both Masoma and Rosia, the health educator and vaccinator, were born and raised in Iran.

Rosia, 22, is from Tehran, and ended up here unwillingly. Her husband, an Afghan refugee, lived 7 years in Iran, then returned last winter to his original village, to cultivate wheat and fruits on his plot of land. Rosia didn't want to follow him, but as she explains, "I gave in to my father. He told me to go and join my husband". It was an arranged marriage. Apparently not a very good one. Rosia plans to go back to the capital of Iran in 6 months to a year, with or without him: unlike in Afghanistan, "it is not difficult to divorce in Iran".

Killing time - that's what Rosia seems to be doing in Tibir, and time goes faster when you keep busy. After her 8 am to noon job as a vaccinator, she gives free Persian and mathematics lessons to children, and buys books and stationery for them out of her pocket-money. She began the lessons at home for her young cousins, but the word spread fast around the village, and the number slowly mushroomed to 23 students - 14 girls and 9 boys. Though she admits feeling useful here, she says simply, "I cannot destroy my dreams for the people of Tibir".

Yet unintentionally, she might be creating dreams in the minds of others. On the day of her speech, Rosia was late, so she grabbed her cousin's bicycle and pedalled from her home to the clinic. Villagers who saw her passing by rubbed their eyes in disbelief: no

girl or woman in Tibir has the ability or would ever dare to even *try* riding a bicycle in Tibir. It simply is not done. Not even in Kabul. The last time an Afghan woman was spotted on a bike in Kabul was probably 20 years ago, during the Soviet occupation.

Compared to Rosia, Masoma is shy and modest, and is making an effort to "fit in". Outdoors she wears a *burqa* - a full-body veil with only a mesh opening for the eyes and nose. "At first it was difficult to breathe," she says. "Even now it's difficult, but we are obliged to do this".

Masoma knows that the other women in the village gossip behind her back, saying she is "showing her face to men in the clinic". "I think they are just jealous," she says with a coy smile. She has tried to explain to them in simple words that her job is about teaching other women how to eat well, keep clean, stay healthy. "But they don't care about what I tell them, and I don't care what they say about me".

Fortunately her husband doesn't care about the gossip mongers either. Then again, he works down the hall, as the clinic's registrar. And in the eyes of traditional villagers, that means he can "keep an eye" on his young wife, which makes her position a little more socially acceptable.

"Wind-women", Badakhshan province

In fact, there is another couple in the clinic: Aida is the wife of Dr. Yonus. In a year or two, they plan to move back to Mazar, so that their children can get a decent education. Which means that if Masoma stays, three clinic staff members will need to be replaced.

But that's a worry for the future. Today the search is on for a new history book character: a female doctor. Where on earth will she come from?

Female Doctors

Tibir is not alone. Eleven out of the 20 Ministry of Health clinics that MSF supports lack female doctors. "I thought we would be closer to solving the female medical staff problem by now," says Krist Teirlinck. He worked more than a year and a half in Northern Afghanistan between 1997 and 2001. When he returned to the country for a third mission with MSF as a medical coordinator, Krist was disappointed to see how little the situation had changed.

"Under the Taliban it was illegal for women to work," he says, "and they were beaten if they walked alone in the streets. The Taliban are gone, but does that make a huge difference? No. We can find female doctors in the main cities, as we could in the past. But in the remote areas, it's still extremely difficult, and there has only been a slight increase in the number of female staff. The universities are open again to women, but it's not because they are 'producing' female medical staff that we will see them working in the clinics. Often their husbands or parents don't allow them to work. And they still can't go out or stay overnight in the field unless they are accompanied by a *muharram* [a close male relative who acts as a chaperone]. This has nothing to do with the regime - it has everything to do with the culture".

In the words of Stijn Staes, an MSF field coordinator: "The most frustrating aspect about this work is that we are focusing on improving health care for women and children, but because of the status of women in this country, it is very difficult to make progress".

Access to Health Care

The reason that MSF's medical programs in the north focus mainly on women and children is that they are the most vulnerable population.

Afghanistan has one of the highest maternal mortality rates in the world. According to UNICEF, one out of every 9 women between the ages of 15 and 49 dies during pregnancy or delivery. Women also face diseases such as anemia, linked to numerous and closely-spaced pregnancies. Due to malnutrition they often give birth to tiny, low-weight babies (under 2.5 kilograms) who have little chance of surviving. Meanwhile many healthy infants and children become the fatal victims of basic, curable diseases. An MSF retrospective study conducted over three consecutive years in the north-western province of Faryab found that the daily mortality rate of children under five is as high as 3.5 per 10,000 (the emergency threshold is two).

The fact that the morbidity and mortality rates remain so terribly high in Afghanistan despite the current absence of any major epidemic outbreaks or any other natural or man-made catastrophes is not a paradox: it only underscores how poor is the access to health care; how wide-spread is the ignorance; and how deep are the cultural, ethnic and religious constraints.

"It's not because you put up a health center in an area that you have given people access to health care," says Stijn. "There are many other issues".

Distance is the first. Where roads exist and have not been destroyed, there may be private buses, jeeps or taxis, but the poor cannot afford them. Travel is mainly by donkey or by foot - through snow in the winter and through dusty, 45^0 C winds in the summer. If the distance to cover is long, a woman and her children can only make the trip accompanied - but days can go by before a *muharram* is able to free himself from work.

Delays in coming to the clinic are also due to traditional beliefs and customs. In the villages, Afghans who fall sick first seek help from traditional healers - an elder widow, for example, or a *mullah* (religious leader). It is widely believed that these healers have the power to get rid of bad spirits called *jins*.

The *jins* are invisible, other-worldly creatures created by Allah who sometimes take revenge on humans and provoke diseases. A woman with fever and convulsions will be taken to a mullah who will receive payment for "curing" the patient by reading verses from the Quran, fabricating *taweez* (amulets) to be worn around the neck or waste, or prescribing pilgrimages to the tombs of saints and other holy sites.

A mullah in the village of Kurchi, Faryab province

Afghans will also visit local, quack doctors who administer infections first and ask questions later. Some of them leave children paralyzed because they don't know what a sciatic nerve is or where it is located.

Vaccination coverage surveys recently conducted by Stijn's team in the Balkh province have exposed a more subtle and sensitive problem: "Even within a five-kilometer radius around our clinics, there are different clusters of ethnic groups, and we suspect that some people are not going to our clinics simply because these structures are located on 'ememy' territory," says Stijn. "Some Pashtun villagers told us that they have to pay for their passage through lands occupied by Hazaras to access our clinic in Dawlatabad." But Stijn is cautious with any unverified information and says his team must take a closer look at ethnic issues to

better understand what is going on.

"We need to look closer, we need to dig *deeper*," stresses Krist, speaking broadly about MSF's approach. "We are examining people and treating them in our clinics, but we don't know what is happening inside their villages, inside their homes, behind the high mud walls".

The Curtain

Then there is *parda* - literally "the curtain" - but it can create a barrier as thick as a mud wall. The concept of *parda* is based on containing women's potentially destructive sexual powers, in order to avoid social chaos (*fitna*) and to prevent men from yielding to temptation. In practice *parda* involves the separation of the sexes, mainly by removing women from the public sphere and secluding them in the household. *Parda* also refers to women's modest behavior and to restrictions in their interactions with unrelated or unknown men.

The restrictions apply even between doctors and patients. Occasionally women will not remove their *burqas* in front of male doctors, or will cover their faces with their long head scarves. Hands-off examinations lead to improper diagnoses and treatments. Stethoscopes strain to listen to heart beats over layers of clothes. Recently, a woman with second and third degree burns caused by an accident with a hurricane lamp was taken to the Karte Amani clinic of Mazar-i-Sharif. The burns were on her chest. She refused to be seen by a male doctor.

Only in life-saving situations can a female doctor operate on a male patient, or a male doctor on a female patient - for example to perform a Caesarian section. As male doctors never carry out gynaecological examinations, preventable complications may arise if a midwife or female doctor is not around.

In the district of Chimtal it took longer to persuade a few men to allow MSF to vaccinate all the women in a village than to actually get the job done. Massoud, a calm and poised Afghan doctor who was part of the MSF outreach team, had met with the mullah and a dozen elders in Nawarad - a village about 50 kilometers from Mazar inhabited mainly by Pashtuns - to discuss the vaccination campaign. "They seemed happy and accepted the idea," says Dr. Massoud.

When the three, male, outreach team members returned on the agreed-upon day, they were surprised that none of the village women or children were gathered at the central mosque as planned. The elders had changed their minds. Why? Here was the shocking statement from one of the group members: "We would rather let them die than be vaccinated by a man".

The same elder then asked for female vaccinators. But it is against MSF's policy to pay for the transportation of outreach workers, and these had come to Nawarad... by bicycle. The elder responded spontaneously: "If you bring female vaccinators we will pay for the taxi". This sparked an internal discussion among the elders, who came to the conclusion that in fact, they were too poor to pay for a taxi. Someone in the group pointed out that in any case, that wasn't the solution, because the female vaccinators would have to be accompanied, and male chaperones would be next to them, watching.

Dr. Massoud, who is patient and persuasive, spoke in a soft voice: "You know the Persian saying: 'If you refuse a good opportunity and let it go by, you are cutting your own leg with an axe'. This is a 'golden' opportunity for all the women in your village and all the children under two years of age to be vaccinated against six killer diseases: polio, measles, tuberculosis, tetanus, diphtheria and pertussis. You cannot refuse this."

The elders were convinced. At least they were at that moment. But amazingly, the next time the outreach team arrived in Nawarad, they were again prevented from working. Only on their third trip did they succeed.

"Sometimes I am disappointed and sad when men prevent women from coming to the clinics or getting vaccinated," says Dr. Massoud. "Just two or three elders can block the whole process and decide for everyone else. Often they are commanders or they are rich - in any case they are influential people. But you can discuss matters with them and change their minds. In the end we solved the problem in Nawarad and in other villages."

Dr. Kazim, the MSF vaccination supervisor, has his own style and "tricks". When the elders of a Pashtun village in the district of Imam Sahib (Kunduz province) asked for female vaccinators, he told them: "You do not let your women out of their homes to come to the mosque for vaccinations, and you do not bring your girls to school to be educated. How can you expect us to provide you with female vaccinators?"

He began by vaccinating the children only, but casually mentioned to the elders that the day before, he had immunized the chief's daughter in the nearest Pashtun village. Her familiar name was enough to shake their resistance, and the women were soon queuing to receive their shots.

Personal, Hidden Battles

MSF is constantly searching for new ways to adapt to the Afghan context. In other countries where the organization sets up "Therapeutic Feeding Centers," severely malnourished children receive special, high-protein milk and "plumpy nut" four times a day and are kept in the centers as long as needed to restore their health. But for many reasons - both practical and cultural - this is not feasible in Afghanistan. The beneficiaries come to the center only once a week, and can never stay the whole day.

Manzarsha, daya, during a post-partum visit

In January 2003 MSF launched a small pilot project in the nutrition center of "Camp 65", on the outskirts of Mazar. To try to encourage mothers to stay longer in the center so that their children could be fed more and gain more weight, MSF decided to also provide one meal per day to the mothers, and to spend time to show them how to prepare meals for their children. The MSF staff told the mothers to inform their families ahead of time that they would come home later than usual.

After this new approach was put to practice, Reila, the center's supervisor, remembers that "every day we were feeding 5 severely malnourished children. And every day one or two mothers said they had 'family problems'. Their husbands or mothers in law would ask them 'What do you do there? Why do you stay so long?' But they explained the situation to them and continued to come. After a while the complaints ended and everything was OK".

One woman, however, told Reila and a few other female staff members at the center that she had been beaten and electrocuted by her husband "for coming home late". "I thought it was unbelievable" says Reila, "but I believed her". And so did the others - even though they did not see signs or marks on the face or body of Wahida *[fictive name].* And the absence of any skepticism in their minds was as disturbing as what might have occurred in Wahida's home.

Reila was asked why, in her opinion, had Wahila shared this - could it be that she was she seeking attention? Or help of some kind? Reila's answer: "She wanted to explain why she had to leave earlier to go home".

Despite the reported incident, Wahila continued to come to the nutrition center for several weeks. Her two-year old son recovered from acute malnutrition and regained his normal weight-for-height. He was one of the last children to be dismissed before MSF closed the nutrition center in late March of 2003.

The "Dayas" of Faryab

A majority of the women living in rural areas deliver at home with the help of a "Traditional Birth Attendant" (TBA) - called a *daya* in Afghanistan. Dayas typically work part-time in their village of origin, assisting mainly members of their enlarged families. As age confers status and respect, they are usually 40 or older, and they are often widows - which has the advantage of giving

them the freedom to move around without a *muharram*.

Uneducated and illiterate, they have learned what they know from female relatives and from other, experienced dayas. Useful knowledge and skills are thus been passed on from generation to generation, but the problem is that harmful tips, traditional beliefs and cultural taboos are also part of the package.

Dr. Karima is well acquainted with the dayas' practices - good and bad. A single, dynamic, 35-year old doctor who graduated from the Balkh Medical University in Mazar, Karima joined MSF five years ago and is the supervisor of the mother-and-child health care program in Faryab province.

While conducting a survey last winter, Dr. Karima spoke to a daya in a remote village in the south of Faryab and found out what her reaction had been to a newborn baby that was not breathing: "The placenta was still attached to the baby and the daya placed the placenta in a pot and on a stove to burn it. It is a traditional belief that this will save the baby". Other dayas told Dr. Karima they had "dealt" with the problem of placenta retention by "making smoke in the room" - perhaps to ward off *jins.*

Placenta retention leading to hemorrhage is the number one cause of maternal mortality in Afghanistan, yet it can often be easily prevented. Simply allowing the baby to breast-feed immediately after birth will cause contractions of the uterus that help expulse the placenta. But here comes another taboo: in Afghanistan, colustrum, rich in antibodies, is considered to be "dirty" and "bad" milk because of its watery consistency, and the mothers are told (by dayas as well as mullahs) to discard it.

The first two or three days of their lives, babies are usually given tea with sugar. Then they receive breast-milk until they are about two years old, but no other food. In addition, mothers often stop breast-feeding overnight when they get pregnant again, as they believe their milk becomes "poisonous". Such brutal weaning can trigger malnutrition in children.

MSF's TBA program aims to lower the incidence of diseases and deaths among mothers and infants by teaching dayas about breast-feeding and weaning, nutrition, vaccinations, basic hygiene and safe deliveries. Above all, they are taught to recognize danger signs - such as fever, anemia and ante-natal bleeding - and to refer cases to clinics when necessary. One of the measurable impacts of the program is that the 250 dayas trained by MSF have significantly increased the number of referrals to clinics for ante- and post-natal consultations.

But one of the achievements in Faryab province that Dr. Karima most eagerly shares is the spread of awareness about oxytocin. In Western countries this potent drug is only administered intravenously in very small, diluted doses and under close supervision. In Faryab bazaar pharmacists were selling oxytocin like candy and dayas were giving it to women in labor via intra-muscular injections to provoke uterus contractions and accelerate deliveries. Women were dying from the high dosages, which cause internal bleeding by rupturing the uterus.

Dr. Karima helped rally local medical authorities and push for regulations on the drug. "Today, compared to three years ago," she says, "the sale of oxytocin without a prescription from a certified doctor has decreased by more than 60% in Faryab province".

However small or slow, each step towards some improvement motivates Dr. Karima and other MSF staff to continue their work. Occasionally they get an extra boost when their expectations are surpassed. That is what happened on July 9th when Dr. Karima and Zarintoj, a TBA trainer, went to see Manzarsha in the village of Bilchiragh.

Manzarsha

The MSF team was on a follow-up visit, to check how the 17 newly-trained dayas in Bilchiragh were faring and to supervise their work, one week after the end of the course. They began with Manzarsha, an 80-year old widow and the eldest of the 17.

"Although the dayas we train should be older than 20 or 25," says Dr. Karima, "we don't care about their age". But Zarintoj admits that she prefers the younger dayas: "they learn faster and catch things more easily". Unfortunately, because they are younger and therefore less respected by other village

Manzarsha's mood and expressions changed swiftly from deep sorry to joy

women, they are slower to pass on their knowledge. And that is why the best-case scenario is an old, traditional and well-respected daya who is open-minded and able to change her habits.

The meeting was somber at first. Manzarsha shed tears while she shared the story of how the lives of 9 of her 11 children had been taken away - six died at a young age from chicken pox, diphtheria, tetanus and other diseases, and three of her adult sons were war victims.

When Manzarsha fell silent, Dr. Karima cited a verse from the Quran and gave a few words of encouragement, then smoothly transitioned to another topic: the recent training Manzarsha had followed.

The transformation in Manzarsha was sudden and striking: she sat upright, her face lit up, her eyes became sharper, and she began to speak about what she had learned with great enthusiasm, energetic hand gestures, a louder, higher voice, and visible joy tinged with pride.

Dr. Karima asked her questions to test her new knowledge. Yes, she remembered the correct proportions for the preparation of ORS; she had even recently given it to a child with diarrhea and
seen that "it works!". Yes, she would tell mothers about vaccinations at the clinic - "if only there had been a clinic when I was young," she said, "and vaccinations for my children".

No, she no longer advised pregnant women to avoid eating meat or certain sweet foods - as she had probably done often during her 30 years as a daya. "I tell them to eat anything they can get their hands on!" she said laughing.

Had she helped with a delivery since the training course? Yes, two in fact. She had used that "trick" that is an extra protection against bleeding: she had tied three knots on the umbilical cord instead of two. And she was now telling other dayas in the village to do the same.

Zarintoj, Manzarsha's trainer, sat quietly throughout the meeting. She did not say a word, but she listened intently. And though it showed only a little, inside she was beaming.

Zarintoj, TBA trainer