Reproductive Health of Afghan Women in Victoria

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Background

Link Health and Community is a community-based health service that provides an extensive range of health services within the City of Monash and surrounding areas. Link HC aims to be widely known as a vital, caring and sustainable organization that actively engages the community and provides a range of accessible and supportive services and programs that improve people's health and wellbeing (Strategic Plan, Link Health and Community, 2012-2017). Under Link HC's strategic priorities, the organization aims to expand the range of high priority services in the Eastern and South-Eastern areas of Melbourne and to position the organization as an important partner and contributor to the development of a robust primary health care system (Strategic Plan, Link Health and Community, 2012-2017).

Link HC's programs have been developed to meet the health needs of its local population and to provide accessible and affordable health and social services particularly to those most in need. The programs provided by Link HC are supported by funding from the Victorian and Commonwealth Governments (Link Health and Community, Annual Report, 2013).

Health Situation in Afghanistan

Afghanistan is a land-locked country located in the South Central Asia. In the aftermath of more than three decades of war and instability, the country has lost its main infrastructures, which has led to the worst socioeconomic indicators in the world.

The Ministry of Public Health Afghanistan with support from its national and international partners conducted a national Afghanistan Mortality Survey in 2010. Following are some of the main findings from the study:

- Life expectancy at birth in Afghanistan for girls and boys born during the five years prior to the survey, is approximately 64 years. It has improved significantly compared to the previous years (Afghanistan Mortality Survey-AMS, 2010).

- Maternal mortality ratio has dropped to 453 per 100,000 live birth. Pregnancy-related deaths are a leading cause of death for women in their childbearing years. 41 percent of deaths to women in their childbearing years in Afghanistan are due to pregnancy-related causes. It is estimated that under current conditions approximately 1 in every 50 women in Afghanistan will die from a pregnancy-related cause during her lifetime. The lifetime risk of pregnancy-related death is five times as high in rural areas as in

urban areas (AMS, 2010). By comparison the maternal mortality ratio (MMR) for the period 2008–2012 for Australia is 7.1 per 100,000 women who gave birth (Australian Institute of Health and Welfare and University of New South Wales, 2015).

- Maternal conditions are responsible for one in five deaths to women at ages 15-59 years in Afghanistan. Haemorrhage is by far the leading cause of maternal deaths (56 percent). Eclampsia is associated with one-fifth of maternal deaths and prolonged or obstructed labour with 11 percent of maternal deaths. The percentage of maternal deaths attributed to sepsis is relatively low (5 percent). Also, indirect causes of maternal death—pre-existing conditions and diseases aggravated by pregnancy and delivery—are relatively rare (5 percent), which may be due to underreporting of such causes (AMS, 2010).

- In Afghanistan it is evident that three in five mothers (60 percent) received ante natal care (ANC) from skilled birth attendants (SBAs), that is, a doctor or nurse/midwife, for their most recent birth, while thirty-seven percent of women received no ANC at all. Eighty-five percent of urban mothers receive ANC from an SBA, compared with only 54 percent of rural mothers, only 60% of mothers were protected against neonatal tetanus and only 28 percent of women received postnatal care for their last birth (AMS, 2010). By comparison, 89.6% of Australian mothers born in English speaking countries benefit from antenatal care before 20 weeks of gestation (Multicultural Centre for Women's Health, 2010). The proportion of women attending 5 or more antenatal visits varies only slightly by remoteness and socioeconomic disadvantage (Australian Institute of Health and Welfare 2013).

- More than one-fifth of currently married women in Afghanistan use some method of family planning (22 percent), with the vast majority (20 percent) using a modern method (AMS, 2010). By comparison, contraceptive prevalence rate of both some method and current methods in Australian general population is 71% (Multicultural Centre for Women's Health, 2010).

- The under-5 mortality rate for Afghanistan is in the range of 102-105 death per 1000 live birth and the infant mortality rate is 77 deaths per 1,000 births. The survival of infants and children also is strongly influenced by the mother's age at birth; mortality is higher among children born to mothers under age 20 and in the age range 40-49 years than children born to mothers in the middle age ranges. Short birth intervals reduce a child's chance of survival; children born within two years of a previous birth

are one and a half times as likely to die during the first year of life when compared to children born two years after an older sibling (AMS, 2010).

If comparisons are made among the data found by the Afghan Health Survey, 2006, the Maternal Mortality in Four Districts of Afghanistan, 1999-2002 and the Afghanistan Mortality Survey, 2010, luckily, there are tremendous improvements in various health indicators in a period of 5-8 years in Afghanistan, however still there is much room for improvement.

Current evidence suggests that migrant and refugee women in Australia have poorer health outcomes and are at greater risk of developing adverse health conditions than women born in Australia. The maternal death rate is disproportionately higher for women born in non-English speaking countries. In 2000-02, 16.5% of all the births in Australia were to women born in non-English speaking countries; yet women born in non-English speaking countries accounted for at least 22% of all maternal deaths (where country of birth was known) (Multicultural Centre for Women's Health, 2010). This suggests the probability of a link between maternal deaths in Australia and the reproductive history of women in their home countries.

Further research is needed to identify the reproductive health status of the Afghanistan-born women living in Australia.

Victoria's Afghanistan-born Population

In Victoria the number of arrivals of people born in Afghanistan increased from 2,308 in 1991-2000 to 6,019 in 2001-2010 (Victorian Community Profiles, 2011 Census). It should be noted that age and gender distribution of Afghanistan born refugees is different to the population structure of Victorians generally. The ratio of males per 100 females is 136. The Afghanistan-born population of Victoria is also younger than the population of Victorians generally, with 59% between the ages 19-44 years (Victorian Community Profiles, 2011). Considering the age pattern of Afghanistan-born population and large number of Afghan population in Victoria, and the poor health indicators among women of reproductive age in Afghanistan, a great proportion of Afghan refugees in Victoria might be predisposed to poor reproductive health consequences.

The Cities of Greater Dandenong (2nd), Monash (5th) and Kingston (19th) are among the top twenty Local Government Areas (LGA) in Victoria for the number of Afghanistan-born residents in 2011. The Greater Dandenong LGA constitutes 25.3% (2,520) of the Afghanistan-born population Victoria, while the City of Monash LGA is the residence for 2.3% (232) and

the City of Kingston is for 0.5% (53). Neighbouring Casey LGA has the largest number of Afghanistan-born residents in Victoria (44.6%, 4,437 people). Almost 35% of all the Afghanistan-born population of Australia live in Victoria (9,944 people), the primary destination state ahead of New South Wales (Victorian Community Profiles, 2011 Census).

These statistics do not include arrivals since the last Census. The Afghanistan-born population has increased with resettlement of refugees (including family reunion) and arrivals of asylum seekers now living in the community on bridging visas in the suburbs of Greater Dandenong and Casey. Refugees and arrivals from Pakistan will also include displaced people who are ethnically Afghan.

Health Needs and Issues

According to the Southern Academic Primary Care Research Unit (SAPCRU, 2011), local refugee residents (in Greater Dandenong LGA and Casey LGA) are 23% more likely to present to a public hospital emergency department and 47% more likely to be admitted to hospital than other residents in the region. Preliminary analysis shows that refugees are more likely than non-refugees to be discharged from regional public hospitals with diagnoses related to: mental health (psychosis, anxiety/somatisation and depression), obstetric complications (female genital mutilation or circumcision, foetal death in utero and stillbirths) and infectious diseases (tuberculosis). Across the region, the bulk of refugee specific primary care is delivered by general practice and refugee health nurses, although it is clear that the Refugee Health Clinic at the Dandenong Hospital and, by default, hospital emergency services also deliver primary care services.

A recent study of Afghan community health needs conducted by Link Health and Community found that family violence, forced marriages, gender inequality, low knowledge about family planning, and poor knowledge about sexual health are common among Afghan in Greater Dandenong, Monash and Kingston (Link Health and Community, 2015-2016). This study involved extensive consultation with Afghan community organisations and with agencies providing services and support to the Afghan community.

Low level of contraceptive prevalence rate and poor nutrition among Afghan women in their home country have led to multiple pregnancies, miscarriages, low birth weight, stillbirth and poor birth spacing that would contribute to poor health consequences specially in older age. For example there is probability of developing faecal incontinence, urine incontinence, rectal prolapse, anal fissure, haemorrhoid, and endometrial and cervical cancer. Poor monitoring

systems for Pap smear screenings, no vaccinations for human papilloma virus and poor gynaecological check-ups among women in Afghanistan might also contribute to the high incidence and prevalence of both cervical and endometrial cancers among Afghan women of older age in Australia.

Considering the fact that most of the deliveries in rural areas in Afghanistan and in the refugee camps in Pakistan and Iran, are assisted by non-skilled traditional birth attendants and even in remote areas by illiterate grandmothers, this might contribute to the poor health outcomes in older age among Afghan women in Australia. For instance there might be increased chances of menorrhagia, dysmenorrhea, anaemia, early onset of menopause, and anxiety and depression pertaining to that. Moreover, early age of marriage that result in increased fertility rate, could be considered another contributory factor to the poor health outcomes among Afghan women.

It should be noted that there are no routine breast cancer screening programs in Afghanistan. A large number of breast cancer cases in Afghanistan have remained hidden or diagnosed at very late stage because of lack of screening programs at the health system level and stigma pertaining to that at the individual and family levels. Hence, breast cancer might be one of the main health problems among Afghan women in Australia at the later stage of life.

Keeping in mind that eclampsia is associated with one-fifth of maternal deaths and that the prevalence of diabetes in Afghanistan is around 6.6% (International Diabetes Federation 2015), there might be the possibility of high incidence and prevalence of gestational diabetes, post gestational diabetes and high blood pressure among Afghan women in Australia.

Rationale for Further Research

Given the high maternal mortality ratio and heavy burden of reproductive health diseases among Afghans in their home country as well as in Australia, and the health consequences for Afghan women in the later age of reproductive life, the Afghan women who fall under the above mentioned category might deserve priority for more targeted preventative and early health interventions. This report aims to increase awareness and understanding of the reproductive health needs and awareness of Afghans' women on the current reproductive health and counselling services in the aforementioned areas. Further research is needed.

Objectives:

- Identify barriers to accessing reproductive health services, including preventative and early intervention services among Afghan women of reproductive age.

- Determine the prevalence of health problems as consequences of poor reproductive health problems in their home country
- Determine Afghan women's perception and experience of reproductive health and counselling services
- Identify interventions that might better respond to the current health and reproductive problems among the target group

Method:

Focus group discussion and interview could be conducted among Afghans women of reproductive age. Around 20 women from different location, ethnicity and date of arrival in Australia could be included in the study. A female facilitator would conduct the focus group discussion and interview. The focus group discussion and interview would be audio recorded throughout the sessions after getting consent from each participant. All the study participants would be assured of the information privacy and confidentiality. Data would be stored securely in the Microsoft word software and analyzed thematically.

Ethics approval:

Ethics approval may be needed for this project.

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