Gap analysis of sub-optimal uptake of family planning among married couples in Afghanistan

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Afghanistan

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A thesis submitted in partial fulfillment of the requirement of the degree of Master of Public Health

by

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Afghanistan

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Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with the departmental requirements.

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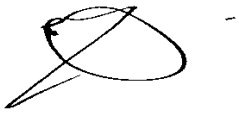

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ACKNOWLEDGMENT

Time passes by but it is more meaningful when one has valuable accomplishments that stay throughout one's academic life. During the last year I achieved one of my eternal dreams - obtaining my MPH. I praise Almighty Allah for giving me the precious opportunity and impetus to obtain my MPH and complete my thesis which has been a worthwhile endeavor. I owe special gratitude to my advisor for her tireless efforts, encouragement and hours of beneficial discussion for making my undertaking valuable, without her support and feedback the completion of this document would not have been easy and possible.

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Last but not least my sincere thanks go to my dear family, friends and loved ones; particularly my beloved mother who has been main supporter and well-wisher in my personal and academic life.

ABSTRACT

BACKGROUND: This study focuses on gap analysis of sub-optimal uptake of contraceptives among married couples in Afghanistan. The objective is to analyze the complex set of intertwined factors that impact utilization of contraceptives.

METHODOLOGY: In this descriptive study I have analyzed relevant documents, secondary data and some anecdotal evidence. The social ecological framework is used to organize findings. Analysis of factors contributing to poor uptake of contraceptives is performed at different ecological levels including intrapersonal, interpersonal, community, society and larger society (national level).

RESULTS: Ninety two percent of women have knowledge of contraceptives but only 21 percent adopt a method of contraception. This seems to indicate that women's capacity to act upon their knowledge and to have a healthy lifestyle is hampered. Women have 5.1 children on average, which is alarming compared to other Asian countries. Barriers at both supply and demand side contribute to poor adoption of contraceptives. The mere existence of policies is not the solution. Gap is not only in the policies but also in the actual implementation of policies. Comprehensive policy impact analysis should be executed to assure quality health service delivery. A set of multiple interlinked barriers affect relatively low demand for contraceptives. This includes women's poor education and low social position as well as the lack of open spousal communication and democratic decision making which is triggered by societal norms and cultures.

CONCLUSION: Despite improved knowledge on family planning the utilization rate for contraceptives in Afghanistan is very low, particularly among youth, rural dwellers and less educated women. Family planning interventions should address empirical barriers such as women's low education and lack of empowerment so that women initiate effective communication with their husbands on family planning issue. Poor security and weak political commitment further deteriorate the family planning service delivery.

Key words: Afghanistan, contraceptive prevalence, total fertility, birth spacing, family planning uptake.

Word count: 12.721

GLOSSARY OF TERMS

Adolescents: According to the Afghan National Youth Policy childhood is divided into three phases, one of which is the juvenile or adolescent period from 13-18 years of age (GIRoA 2013a).

Contraceptive Prevalence Rate: The percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49 (WHO 2014a).

Couple Year Protection (CYP): Is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period (USAID 2014).

Gender Inequality Index: Gender based inequalities reflected in three dimensions - reproductive health, empowerment and economic activity (UNDP 2013).

Mullah: A Muslim leader learned in Islamic theology and sacred law (Oxford dictionary 2014).

Parity: Number of times a women gives birth to a fetus with a gestational age of 24 weeks or more, regardless of whether the child was born alive or was stillborn (Patient.co.uk 2014).

Perinatal mortality rate: Death in the perinatal period, includes late pregnancy birth (stillbirth) and early neonatal mortality (the first week of life) per 1000 total births (live and stillbirths) (WHO 2005).

Stillbirth: The fetus of 28 weeks gestation that shows no sign of life at the time of birth. Stillbirth mortality rates are calculated per 1000 total births (live and stillbirths) (WHO 2014a).

Total Fertility Rate: The average number of children a woman has in her lifetime (WHO 2014a).

LIST OF ACRONYMS

AIHRC	Afghanistan Independent Human Rights Commission
ANYP	Afghan National Youth Policy
AMS	Afghanistan Mortality Survey
APHI	Afghan Public Health Institute
ASFR	Age Specific Fertility Rate
ASRHR	Adult Sexual Reproductive Health and Rights
BCC	Behavior Change Communication
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Center
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSO	Central Statistic Organization
CYP	Couple Year Protection
DH	District Hospital
FP	Family Planning
GII	Gender Inequality Index
GIRoA	Government of Islamic Republic of Afghanistan
HDI	Human Development Index
HP	Health Post
HSC	Health Sub Center
ICHD	International Course in Health Development
IEC	Information Education and Communication
KAP	Knowledge, Attitude ,Practice
MICS	Multiple Indicator Cluster Survey
MoPH	Ministry of Public Health
MHT	Mobile Health Team
MPI	Multiple dimension Poverty Index

NGO	Non-Governmental Organization
NH	National Hospital
PH	Provincial Hospital
RH	Reproductive Health
RgH	Regional Hospital
SAARC	South Asian Association for Regional Cooperation
SES	Socio Economic Status
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TFR	Total Fertility Rate
THE	Total Health Expenditure
USD	United States Dollar
VAW	Violence Against Women

INTRODUCTION

After graduation from Kabul Medical University (KMU) I joined a national maternity hospital in Kabul for my residency program in the field of obstetrics and gynecology. In four years of practice I noticed that the majority of maternal complications occur among women with high demographic risk factors, including births spaced closely (less than 24 months apart) women giving birth too young (18 years of age or below) or too old (35 years of age or above) and high parity births (parity four and higher). During my public health work with CARE International I learnt that the majority of women who don't intend to get pregnant and want to space their pregnancy can't do so for many different reasons. The Master in Public Health (MPH) program at the Royal Tropical Institute (KIT) bestowed me further knowledge on the principles of public health and motivated me to further study the factors that prevent contraceptive uptake among married couples in my country.

Family planning is a tool for empowerment and development. It is a high-impact, cost effective public health intervention that helps the decline of maternal mortality and morbidity especially in a world of quickly depleting resources and excess poverty. The health and non-health benefits of family planning have an essential link with accomplishment of all MDG goals. Despite remarkable improvements in the health indicators of Afghanistan during the past decade, most of the health indicators rank Afghanistan near the bottom in the Human Development Index. The total fertility rate of 5.1 live births per woman and the fact that only 21 percent of women are users of contraceptives is alarming compared to other countries in the Asia. Gender based violence is prevalent and multiple harmful practices (such as low contraceptive use) jeopardize the health and well-being of Afghan women, including their reproductive health. This implies that these women have little chance to enjoy their fundamental human rights.

This study sought to explore the complex of factors influencing effective utilization of contraceptives by married couples in Afghanistan. The majority of women have knowledge of contraceptives but only few apply it. It is likely that there is a range of different factors that prevent women to act upon their knowledge. To assure that women attain their human rights those challenges need to be addressed.

The promotion of contraceptive use by stakeholders would be a sustainable and effective approach for the accomplishment of the MDG goals. Internationally it is the best documented practice for the reduction of poverty, maternal and infant mortality, teenage pregnancy, prevalence and spread of Sexually Transmitted Infections (STI), including HIV. In addition, family planning enhances the environmental sustainability and advances women's empowerment and gender equality.

I am optimistic that findings of this study will help different stakeholders to effectively strengthen national policies and strategies, and to assure policies, strategies and interventions that have the potential to improve the family planning programs are effectively implemented.

CHAPTER ONE

AFGHANISTAN BACKGROUND INFORMATION

1.1 Geography

Afghanistan is a landlocked mountainous country, located in south- central Asia, bordering with Pakistan in the south and east, Iran in the west, Tajikistan, Uzbekistan, and Turkmenistan in the north and China in the Far East. Afghanistan has a land area of 652.290 square kilometers. It stretches 1.240 Kilometers from east to west and 565 kilometers from north to south. Topographically, the huge chain of the Hindu Kush Mountains divides the country into three distinct ecological zones; the central highlands, the southern plateau and the northern plains, each with a distinguished altitude and climate and distinct natural resources. For administrative purposes the country is divided into eight regions. It has 34 provinces, 15 large cities, 398 administrative districts and 32 towns. The capital is Kabul. The smaller units are called municipalities and villages (MoPH 2011a).

Figure 1 Afghanstan Map

Source: Afghanistan Atlas (infoplease 2001)

1.2 History

Excavation of prehistoric sites confirms that 50,000 years ago people were already living in Afghanistan. The strategically important location of the country caused a burden of challenges including political, social, and cultural ones. The 10 years of Soviet Union invasion (1978-1988) led to the death and migration of almost one and half million and six million civilians respectively. Despite the Soviet Union withdrawal in 1988 the country sunk into civil war and a turmoiled political condition which deteriorated the health system of the country. The Taliban took power in 1996 and ruled a very dark period in the history of Afghanistan. After their fall in 2001 a new era began. The first constitution in 30 years of history of the country was adopted in 2004. After the London conference in January 2010 Afghanistan joined a new partnership with international communities. The macroeconomic stability was significant, especially in the first five years following collapse of Taliban (GIRoA 2008).

1.3 Socio-cultural context

Afghanistan is made up of a wide variety of ethno-linguistic groups. There are more than 34 languages (30 minor and 4 major). The two most commonly spoken ones are Pashtu and Dari (Federal Research Division 2008).

No systematic and scientific censes has been carried out since 1979. The 1979 one reported a population of 15,551,358. The population growth rate is 2.6% per annum. Based on the 2012-2013 estimation, the general population is reported to be 27 million, of this 76.1% are rural and 23.9% live in urban residences. The sex segregated data shows 13.8 million men and 13.2 million women (GIRoA 2013b).

1.4 Gender

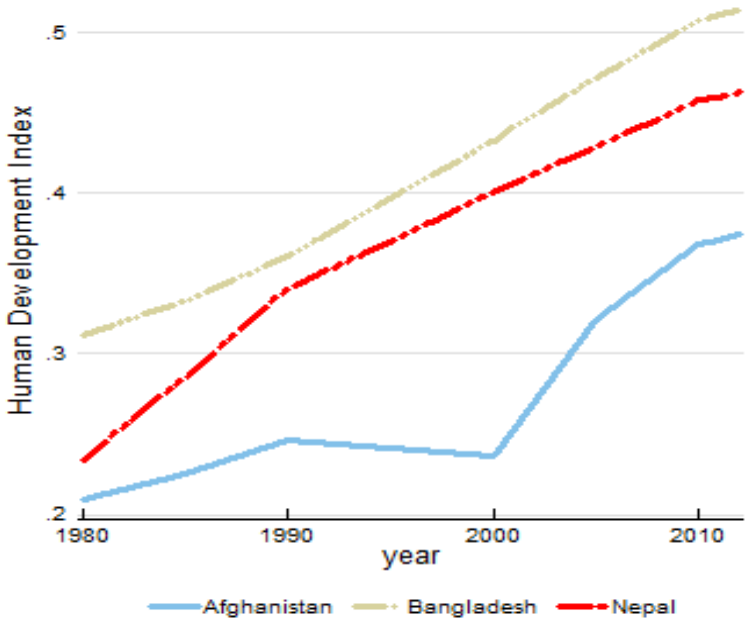
The Afghan constitution guarantees equal rights for all, yet due to the highly patriarchal society women are socially and economically dependent on men. This dependence is exacerbated by insecurity and war (UNFPA 2010). Prevalent gender norms lead to pain, suffering and humiliation of millions of Afghan women. Harmful practices such as forced marriages, girls exchanged to settle disputes, honor killings and many other forms of violence are major hurdles to women's empowerment (UN 2002). A large portion of Afghan women suffer from scarcity of policies and systems to support their human rights. For the majority of women the reality of human right is theories which are not even written, and less frequently practiced (UNAMA 2009).

1.5 **Economy**

Even though Afghanistan's economy has improved considerably since 2002, it remains among the least developed countries. The Gross Domestic Product (GDP) in 2009 was USD 10.8 billion. Economic growth had gradually improved by 2012; the GDP reached to USD 18.9 billion and the health expenditure per capita showed an increase of 13.86 from 41.73 in 2009 to 55.59 in 2012. Policy makers believe that economic growth would lead to improved national health system (MoPH 2013).

Despite promising progress in health service accessibility and a remarkable reduction in under-five and maternal mortality, some of the health indicators remain low and places Afghanistan near the bottom in international rankings. The latest human development report positions Afghanistan at 169 out of 187 countries (UNDP 2013c). About 36.5% of the population live below the poverty line (MoPH 2011a). The Multidimensional Poverty Index (MPI) analysis for the Multiple Indicator Cluster Survey-4 (MICS) shows that 39.1% of population lives in severe poverty . Dimensions measured in this index include poor living standards, deprivation from health services and education (University of Oxford 2014).

Figure 2 Trends in Afghanistan HDI 1980- 2012



Source: Adopted from Human Development Report Afghanistan 2013

(UNDP 2013a)

1.6 **Structure of the health care system**

In 2001, after the collapse of the Taliban regime, the government of Afghanistan and its partners developed the Basic Package of Health Services (BPHS) in response to poor health indicators and to deal with the main health priorities of the country. The BPHS provides a standardized classification of health facilities in the country (APHI/MoPH2011).

- Health Post (HP): Community outreach activities offered by Community Health Workers (CHWs) from their own house mostly known as Health Posts. Ideally one male and one female CHW are responsible for limited curative and wider preventive health care services to 1,000-1,500 people.
- Health Sub Center (HSC): An outpatient health service center located at maximum of two hours walking distance. HSCs function as an intermediate facility to link HP with other BPHS levels and cover the gap to access health care. 3,000-7,000 people benefit from HSC services which include; respiratory infections and diarrhea treatment, family planning, immunization, antenatal services, referral and follow up. HSC is composed of three staff including one male nurse, one community midwife and one worker.
- Basic Health Care (BHC): Provides primary outpatient care services to 15,000-30,000 people. Services include maternal and newborn health care including antenatal and postnatal care, delivery, newborn care, nonpermanent contraceptive methods, tuberculosis, and malaria treatment. Identification, referral and follow up of mental health patients and disabled people are also done by BHC services. Each BHC service is staffed with one nurse, one community midwife, two vaccinators, one CHW supervisor and two health care workers.
- Mobile Health Team (MHT): An extension of BHC services in order to assure essential and basic health care services are delivered once every two months to people living in hard to reach and remote villages. Each MHT consists of one male and one female health provider, one vaccinator, and a driver.
- Comprehensive Health Center (CHC): Covers a population of 30,000-100,000 with management of complicated cases of childhood illnesses and malaria and performs assisted delivery and outpatient care for mental health patients. Each CHC consists of two doctors and two nurses; (one male and one female), a lab technician, a pharmacist, a midwife, and a psychosocial counselor.
- District Hospital (DH): Staffed with an obstetrician, anesthetist, surgeon, pediatrician, lab and X-ray technician, and a pharmacist. It manages the most complicated patients and targets a population of 100,000-300,000.
- Provincial Hospital (PH): Offers specialty services and is a referral point for DH and also can refer the unmanageable cases to regional and national hospitals.

- Regional Hospital (RgH): Provides a higher level of professional emergency and inpatient diagnostic and curative services than that of a DH or PH.
- National Hospital (NH): Are specialty centers located in the capital that provid tertiary medical care. A NH is responsible to manage the residency training program for health care workers and acts as referral hospital for PH and RgH.

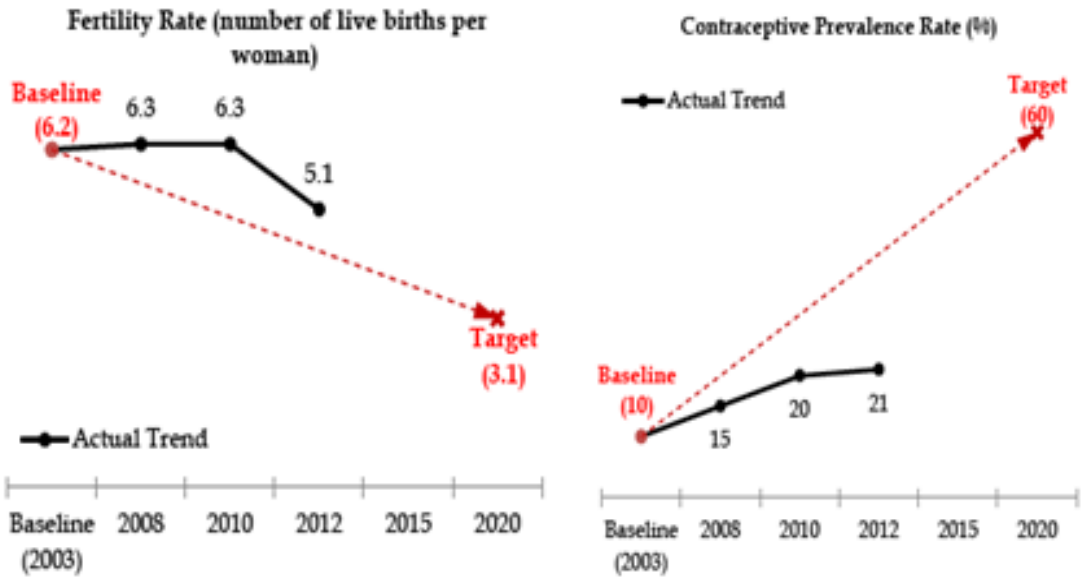
  As of 2013, there were 14.130 Health Posts, 526 Health Sub Centers, 823 Basic Health Centers, 103 Mobile Health Teams, 392 Comprehensive Health Centers, 75 District Hospitals, 28 Provincial Hospitals, 6 Regional Hospitals and 26 National Hospitals (MoPH 2013b).

1.7 **Current family planning situation in Afghanistan**

Women in Afghanistan have 5.1 children on average (4.7 in urban and 5.2 in rural areas), which is the highest fertility rate in Asia (WHO 2012). The Contraceptive Prevalence Rate (CPR) increased from 10.0% in 2003 to 21.0% in 2012, but still there is room for more improvement to assure the government reaches its commitment made at the UN summit; Total Fertility Rate (TFR) of 3.1 and CPR of 60.0% by 2020 (Safi 2012). Traditionally the term family planning is not always acceptable among people, In order to promote family planning acceptance the birth spacing term is used very commonly. Only a few family planning methods are common in Afghanistan. However, the government is committed to generate demand for other contraceptives (MoPH 2012a). Women are two times more likely to know a modern method than a traditional one; 92.0% know a modern method versus 45.0% a traditional method. Oral pills followed by injectables are widely known, while male sterilization and emergency contraceptives are less known methods (APHI/MoPH2011). Family Planning (FP) is an integral part of the reproductive health services such as ANC, PNC and delivery care. Virtually based on the Afghanistan constitution the provision of primary health care services, including Family Planning (FP) services are free of cost. However, most of the time national funding does not sufficiently support the growing demand for contraceptives and women have to bear the cost by themselves. The majority of women due to their poor socioeconomic status cannot afford the cost, which prevents them from effective utilization of contraceptives (IPPF 2011).

UNFPA provides contraceptive commodity to the Ministry of Health (UNFPA 2013). Few other non-governmental organizations and CHWs freely distribute contraceptives to the communities (APHI/MoPH2011).

Figure 3 Fertility Rate and Contraceptive Prevalence Rate in Afghanistan



Source: Adopted from Najibullah Safi's presentation on " Progress towards achieving the MDGs" (Safi 2012)

CHAPTER TWO

2 PROBLEM STATEMENT AND STUDY RATIONALE

2.1 Problem analysis

Family planning saves lives, time and money. It averts huge numbers of deaths, particularly in least developed countries, but only when the knowledge is put into practice (Smith et al. 2009).

Despite years of continuous conflict Afghanistan has made substantial progress in rebuilding its health system. Maternal and child health indicators have improved, yet the burden of some health problems has remained high (Todd et al. 2009). Globally between 1990 and 2010 CPR increased from 54.8% to 63.3% and likewise the unmet need for family planning declined from 15.4% to 12.3% (Alkema et al. 2013). The unmet need has improved in Sub-Saharan Africa but is still high with the current level of around 10.0%-12.0% in south and south east Asia (Sedgh et al. 2007). Globally family planning averts 30-40% of maternal deaths, prevents 20 million unsafe abortions, 80 million unintended pregnancies and 10.0% of childhood deaths. In less developed countries 17.0% of all married women in a certain period of time prefer birth spacing and one-fourth of pregnancies are unintended or mistimed; this results in unsafe abortion and maternal morbidity and death (Ashford 2003).

Multiple factors influence effective uptake of contraceptives, ranging from personal issues like illiteracy and lack of knowledge to policy issues and poor policy implementation. People usually only consider contraceptives a birth spacing tool; whereas the health and non-health benefits of family planning are rife. Family planning reduces poverty, controls population growth, helps with universal coverage of education, contributes to women's empowerment and long term environmental sustainability (Cleland et al. 2006). Given that contraceptive uptake at least indirectly helps to achieve several MDGs (Ali 2014).

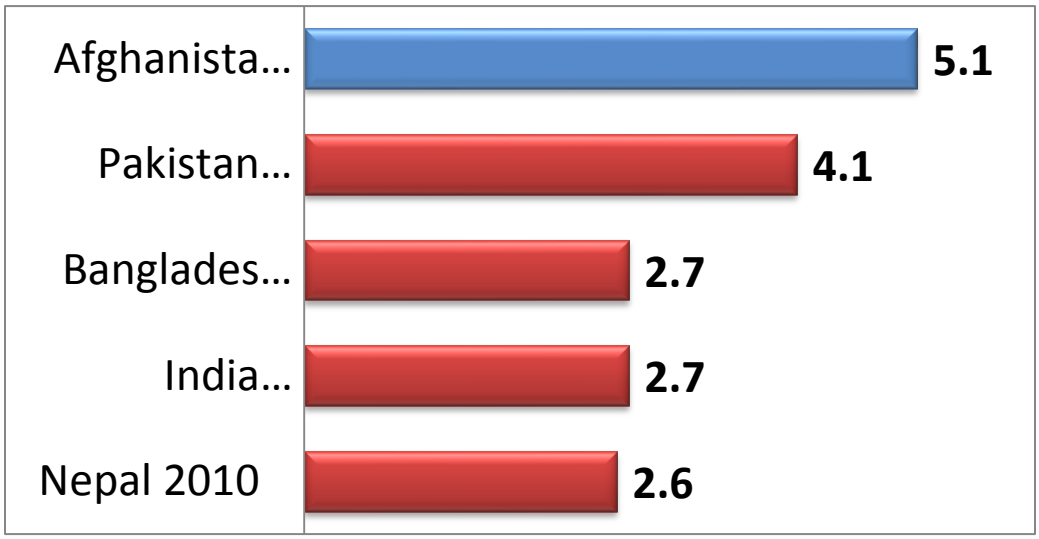
Demographic changes have been extremely rapid and widespread in the last five decades. According to the UN population projection, the population of Afghanistan will increase to 47 and then to 76 million by 2025 and 2050 respectively. This remarkable population growth will impact the availability of resources including quality health care services and education (MoPH 2012b). It also deteriorates the already poor economic status of Afghanistan, creates food security issues and pushes people into poverty. This contributes to a poor security condition in the country since the majority

of the disfranchised youth are likely to be recruited by insurgents and to be influenced by antigovernment elements (GIRoA 2008a).

According to the Afghanistan Mortality Survey (AMS) more than nine in ten Afghan women know of at least one method of contraception but surprisingly only almost one-fifth of currently married women use any of the available modern methods (MoPH 2011a). This raises the question of which factors are responsible for this huge gap between knowledge and practice. Though family planning continues to be a priority for health interventions in Afghanistan, the FP indicators are very low compared with other similar countries like Iran and Bangladesh (Safi 2012).

Unfortunately identification of the unmet need for contraceptives and the consequences of unintended pregnancy and the question of how to overcome those needs are entirely ignored by current national health policies and strategies. A successful family planning program can not only be achieved with a focus on CPR and TFR. A public health approach to promote access to family planning information and services as a universal human right can lead to a strong family planning program.

Figure 4 Comparison of Afghanistan's TFR with other Asian countries



Source: Adopted from Surya Dalil's presentation on " Key findings, Afghanistan Mortality Survey 2010" (Dalil 2010)

2.2 **Justification**

According to the above problem statement, the utilization of contraceptives in Afghanistan is low compared to other countries in the region. This challenge is known by the government, as the Afghan minister of health in the regional family planning conference in 2012 stated "I see family planning as an important tool to improve the living conditions of many women and men in Afghanistan." However, only a few studies have been carried out to explore the underlying factors to poor adoption of contraceptives.

I believe that the dimensions of family planning benefit transgress the boundaries of overpopulation control; it impacts the health of women and children. Access to FP services saves women's time and boosts women's labor-force participation. Likewise it is more cost effective compared to the cost paid for other maternal morbidities that happen as a result of unwanted pregnancies; hence FP saves money and improves the economic status of women. Family planning is mostly considered a women's matter; however it is an issue of human rights, empowerment and attaining one's highest potential. All of these facts are burning issues in the current situation of Afghanistan and need to be addressed through a cost effective and sustainable intervention like family planning as an integral part of a more comprehensive public health program.

The public health importance of FP is proven and the government of Afghanistan is also committed in taking actions to improve contraceptive uptake. Considering these justifications I personally feel motivated about this topic, as some of the challenges that currently Afghan women face, can be solved with appropriate family planning programs. Therefore I have tried to review the diverse factors at the micro and macro level to explore the reasons for the huge gap between knowledge and adoption of family planning in order to make evidence informed recommendations to overcome the identified problem.

2.3 **Objectives**

2.3.1 **General objective**

To identify the complex set of factors contributing to sub-optimal uptake of family planning methods among married couples in Afghanistan, and to make evidence informed and feasible recommendations for improved national family planning interventions.

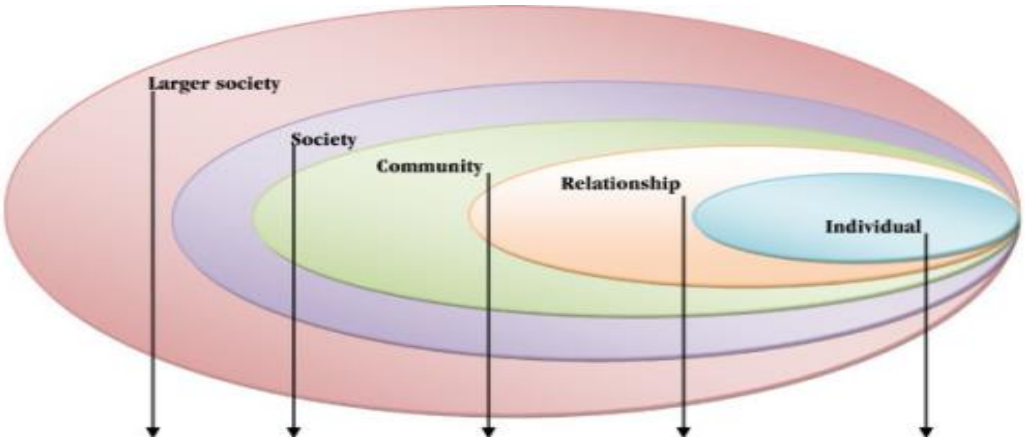
2.3.2 **Specific objectives**

1- Analyze relevant national health policies, strategies, and laws in order to identify gaps in policies and their implementation that create a barrier for contraceptives uptake.
2- Identify demand side barriers that impact effective uptake of contraceptives at personal, interpersonal, community and society level.
3- Identify evidences and best practices of effective and successful family planning interventions in a few other Asian countries.
4- Formulate feasible, context appropriate and evidence informed recommendations based on the identified gaps to relevant stakeholders, including the MoPH.

2.4 **Methodology**

I selected the social ecological theoretical framework to inform the search strategy of this descriptive study. This framework also helped to organize and analyze the findings of this document. Social ecological model originated in the field of psychology and human development in the mid-20th century and has since then been widely used in the fields of epidemiology and maternal child health (Lemyre 2002). The framework emphasizes the linkages between multiple factors (determinants) affecting health. I applied it to the sub-optimal uptake of family planning methods. The multiple determinants ranging from micro to macro level I have selected as relevant for my topic encompass:

Figure 5 Social Ecological Framework



National health policies, strategies and political commitment	Health care service delivery	Place of residence	Spousal communication	Age of woman
	Health care providers and infrastructure	Norms, cultures and perceived beliefs	Peer influence	Knowledge and Practice
	Patriarchal society	Poverty and socio economic status	Religious leaders influence	Education
	Religion	Adolescent pregnancy	Violence against women	Social network and Acculturation
	Infant and Child mortality	Son preference		Number of living children

Source: Social ecological model Heise,L.L. (1998) (Cited in Antai 2011)

2.5 **Search strategy**

A review of literature on factors influencing the optimal uptake of family planning among couples in Afghanistan was conducted. I made extensive use of sexual and reproductive health teaching materials of the ICHD course in my review. In addition, academic and scientific electronic search engines including PubMed, Google scholar, MEDLINE were used. Relevant journal articles, researches, published reports were retrieved from UNFPA, WHO, UNICEF, UN, and Afghanistan Ministry of Health webpages. Also, secondary data and findings of the latest Afghanistan Mortality Survey 2010 (AMS) and Multiple Indicators Cluster Survey 2010 (MICS) were used widely. For this study KIT and VU facilities were used for internet search.

2.6 **Limitations of the study**

Dearth of data on different factors influencing optimal uptake of contraceptives in Afghanistan was one of the major limitations of the study. In particular, data on unmet need, unintended pregnancy, and policy impact analysis was scarce. Most importantly men's knowledge, perceptions and beliefs regarding family planning uptake were not available. Due to the limited number of articles, the few studies exclusively performed on family planning situation of Afghanistan were used extensively. Scarcity of time prevented primary data collection.

2.7 **Structure and organization of the document**

The following chapter; chapter three, assesses the factors influencing the sub-optimal uptake of contraceptives in the Afghan context, making use of the social ecological framework. It starts with an analysis of national health policies, strategies, and laws with the aim of identifying gaps in policies and their implementation. Then factors at society, community, relationship and individual level contributing to sub-optimal uptake of family planning are identified and analyzed. The first part of chapter four looks at evidences and successful FP programs from Iran and Bangladesh. The second part opens a discussion making use of evidences and best practices for successful family planning programs in Iran and Bangladesh, and findings from the literature review of chapter three. Its aim is to explore the feasibility for replication or adaptation of successful family planning models elsewhere in the Afghan context. Chapter five starts with a conclusion and subsequently presents evidence informed, feasible and context appropriate recommendations to further improve interventions that promote family planning uptake in Afghanistan.

CHAPTER THREE

3 FINDINGS OF LITERATURE REVIEW

This literature review focuses on the identification and analysis of significant factors affecting the optimal uptake of contraceptives. These factors are respectively situated on the larger society (national level), society, community, interpersonal and individual level of the social ecological framework. This chapter starts with evaluation of factors at national level which influence the supply of family planning information and services as well as demand for contraception. Subsequently the lower levels of the social ecological model which includes factors affecting demand for contraception are explained and argued. For some factors scarcity of relevant data and information from Afghanistan context, led to elaboration of literature findings from other Asian countries.

3.1 NATIONAL HEALTH POLICIES, STRATEGIES AND POLITICAL COMMITMENT

3.1.1 Evolution of health policies and strategies

Health policies impact the ability of health systems to function effectively. Not only policy formulation but also the means to sustain policy momentum are critical. Health sector reform thrived in 1980 in response to ineffective health care service delivery. Three major donors – the European Commission, USAID and the World Bank - under leadership of MoPH invested huge sums of money to renovate Afghanistan's disrupted health system (Strong 2003). In response to the abysmal health situation multiple health policies, strategies and assessments to influence the policy process and inform resource allocation was developed. Examples are the first ever national maternal mortality study of 2003, the National Health Policy (NHP) and the National Health Strategy (NHS), Reproductive Health strategy of 2003; Afghanistan Mortality Survey of 2010, Multiple Indicator Cluster Survey for 2010 and the first Strategic Plan for the MoPH. Considering the tough situation Afghan women have been through, the policies and strategies are mostly gender sensitive. The government is committed to promotion of gender equity in order to improve health outcomes for women and their children (MoPH 2016). Yet it is not clear who makes the policies and strategies, the donor or the government (Michael et al. 2011).

3.1.2 **Health financing mechanism**

The main financing source for health is the government through the Ministry of Finance, external donors, and households. The government in public service delivery has remained donor dependent. According to a national health resource assessment in 2003, NGOs deliver 80.0% of the health services (Strong 2003). The cumbersome bureaucratic procedure in the government causes substantial under spending of MoPH annual funds. The high amount of 73.3% out-of-pocket expenditure by households can be a factor to push people into poverty (Newbrander et al. 2014). The parliament decided "free health care for all" without mentioning of alternate options for health care financing (Michael et al. 2011). Despite abolishment of formal fees according to a study by Loma Linda in 2008, 80.0% of patients pay informally (Belay 2010). According to National Health Accounts (NHA), Afghanistan in 2011-2012 allocated 8.0% of its GDP to health expenditures. 16.4 percent of the Total Health Expenditure (THE) is spent on reproductive health including family planning (MoPH 2013). The second largest portion of THE for RH is spent on medical goods such as medicines and contraceptives. Nonetheless contraceptives are categorized as preventive services which account only for 3.0% of THE for RH. A cost analysis of national hospitals showed that on average USD 1.85-2.02 is spent per family planning outpatient client. This contradicting data creates an information gap on fund allotment for contraceptives (MoPH 2012f). After 9/11 international communities pledged approximately USD 25 billion for the rebuilding of Afghanistan. If this had been allocated and spent appropriately, fundamental changes would have appeared in the lives of Afghans and in the national health system. Failure of donors to harmonize their priorities with the government and with people's genuine demand and to create a mutually accountable and transparent system caused the aid ineffectiveness (Sultani et all 2009).

3.1.3 **Public private partnership regulation**

Pubic Private Partnership (PPP) is considered a successful approach for the realization of the BPHS. The Ministry of Health emphasizes on its continuation for at least the coming five years. Funding for implementation of PPP increased from USD 100 million in 2003 to USD 277 million in 2008. This allowed the MoPH to contract out different projects with NGOs which deliver health care services to remote and hard to reach provinces of the country (Belay 2010). Most of achievements in women and child health indicators including the decline in fertility is attributed to BPHS and the contracting out mechanism which makes sustainability promising (Newbrander et al. 2014).

3.1.4 **Afghanistan Constitution & Civil law**

The government is committed to attaining a quality and prosperous life for all Afghan citizens through a set of fundamental principles. The Constitution ratified in 2004 by the president supports equity among Afghan civilians. Article 52 states "The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions in the law,". Article 54 states "The state will adopt necessary measures to ensure physical and psychological well-being of the family, especially of the child and mother, and the elimination of traditions contrary to the principles of the sacred religion of Islam" (GIRoA 2004). Yet there seems to be shortfalls, the government only pays 6.0% of THE and 73.3% is paid by the households. Likewise the civil law article 70 states the marriage age 16 and 18 for girls and boys respectively (GIRoA 2006a), still 57.0% of girls marry before age of 16 and 70-80% undergo forced marriage (Medica Mondiale 2008).

3.1.5 **The Afghanistan National Development Strategy (ANDS 2008-2013)**

The ANDS serves as the country's Poverty Reduction Strategy Paper (PRSP) and reflects the government's political commitment toward realization of the MDG goals and Afghanistan compact benchmarks. The Compact developed in 2006 is a political commitment; the overarching goal of ANDS is that by end of 2010, 90% of population will have access to basic health care services and maternal death will be reduced by 15%. It also targets 100% immunization coverage for children and 20% reduction in their morality rate (GIRoA 2006b). Substantial poverty reduction and improvement in the quality of Afghans lives and promotion of a healthy life style is the principal objective of the ANDS. Regarding health the ANDS promotes reproductive health including family planning, a referral system between communities and health facilities, adolescent health through school health programs, disease control and pharmacy management. Lack of health care providers and gender inequalities are the pivotal programs supported by ANDS. The National Priority Program (NPP) is the implementation plan for ANDS. Through a holistic public health approach it helps with achieving the aim of health for all. One of its components is about improved health and nutrition practices, which is expanded in a separate document called the Health and Nutrition Sector Strategy (HNSS) (MoPH 2012g). Maternal and child health, Information Education Communication (IEC) and Behavior Change Communication (BCC) for reproductive health including family planning and increased contraceptive utilization are the main parts of the HNSS, which helps government achieve the set goals for MDG 5 (GIRoA 2008).

3.1.6 **MoPH Strategic plan 2011-2015**

This document builds on the HNSS, and lays the foundation for movement toward a Sector Wide Approach (SWAp) and intervention prioritization. Equitable access to quality health services, community empowerment and health promotion are among the 10 strategic directions of this document (GIRoA 2011b). The MoPH progress in the development of sub-sectoral policies and strategies has been remarkable. However, their performance in formulating concrete action plans and analyzing impact of the policies has been less considerable (Michael et al. 2011).

3.1.7 **Basic Package of Health Services (BPHS2010)**

In 2001 after the Taliban collapse the interim government showed commitment toward renovation of the country's shattered health system. The Basic Package of Health Services (BPHS) was ratified in 2003 as a national health program and is viewed as key for recent MoPH successes (Newbrander et al. 2014). The BPHS lays the foundation for basic health service delivery, especially for those living in remote and hard to reach communities of Afghanistan. It also helped with underlining the stewardship role of the government, so that donors focus on national priorities and strategic directions instead of imposing their own agendas (Belay 2010). The BPHS is comprised of seven primary elements with high impact interventions. Mother and child health including family planning is at the top of these elements. The BPHS focuses on community based health care services in which the role of the CHW as the first line health care provider is impressive and vital (MoPH 2010). With the BPHS not only access but also utilization of health care services has increased from 2.0 million to 44.8 million consultations per year (Newbrander et al. 2014). The aim is to increase the rate of access to health care services from 85% to 95% by 2015 (MoPH 2012e). Despite improvement in national health indicators still Afghanistan compares poorly with other Asian counties. Managerial autonomy, stewardship imbalance, and mechanisms for expansion of the BPHS have remained unaddressed in this document. Dependency on external donors, high out of pocket expenditure, insecurity in some remote areas, non-paid CHWs and inadequate female health care providers in rural communities are challenges for the realization of the BPHS (Akbari 2012).

3.1.8 **Family planning as an integral part of reproductive health policy and reproductive health strategy**

The Reproductive Health policy and Reproductive Health strategy lay the foundation for delivery of high quality uniform services for women of reproductive age. The core values of these documents include human rights, equity, gender and culture. The RH strategy consists of six main components, one of which is Family Planning. The strategy promotes integration of family planning into reproductive health services (MoPH

2012c). Multiple strategic approaches for improved family planning interventions are presented in the RH strategy. This includes training of different health cadres, a community based family planning approach, and the strengthening of monitoring and reporting systems (MoPH 2012a). Male involvement including the religious and community leaders regarding RH and FP, promotion of an enabling environment to make contraceptives available inside and beyond health sector, and IEC/BCC is promoted in order to uplift the demand for and use of contraceptives by couples. The national family planning program promotes community based family planning services via CHWs, women's action groups, and religious leaders. The FP guideline and contraceptive logistic guideline also provides guidance for health care workers (MoPH 2012a). Unfortunately health strategies are not formulated in a way to address the major shortfalls in health service delivery to insecure areas. Almost half of rural areas are considered no-go for the government, including the MoPH, due to insecurity (Michael et al. 2011). Moreover, the RH strategy does not target the unmet need and unintended pregnancies which implies that the approach of public health is lacking in this policy. Despite the promotion of male participation in the issue of reproductive health, still male involvement in democratic decision making is not salient. Men remain the ones making the decision regarding timing and spacing of children in the absence of open spousal communication (Sato 2007).

3.1.9 **National child and adolescent strategy (2013), national youth policy (2013)**

The national child and adolescent strategy and national youth policy show commitment toward promotion of birth spacing in order to improve the survival of women and children. Their aim is to delay the age of girls at first marriage and pregnancy (MoPH 2013a). The national youth policy is the only document in which promotion of Adult Sexual Reproductive Health and Right (ASRHR) is discussed (MoPH 2013b).

3.1.10 **Afghanistan and MDG**

Afghanistan was isolated and cut-off from international communities during the repulsive Taliban regime but subsequently joined the millennium declaration by 2004 and set development goals to be achieved by 2020. In addition to the eight MDG goals Afghanistan is also committed to the ninth goal- to enhance security (Rassoul 2010). Afghanistan's MICS 2010 shows tremendous improvement in the health sector. The achievements are remarkable for a post-conflict country with poor governance and a poor accountability system (GIRoA 2012). Afghanistan's public health system has shown outstanding resilience to different contextual adversities. However currently it appears as a standoff, because the state is unable to provide more long-term funding and the donors seem unwilling to step in (Michael et

al. 2011). This means that the country has a long way to go to realize the MDG pledges.

3.1.11 **Gender strategy 2012-2016**

The national gender strategy supports MoPH's mission and other international treaties that Afghanistan is a signatory of. This strategy addressed the gender aspect of health issues such as reproductive health, family planning, and child and adolescent health (MoPH 2012d). The discrepancies between what official documents promote and on ground realities are potentially notable especially when it comes to gender.
An assessment of the country's health system showed that women lack access to health services mainly due to limited freedom in movement and unwillingness of families to spend on women and to allow them to consult a male health care provider. Unfortunately none of these issues are addressed in the gender policy (Michael et al. 2011).

3.2 **SOCIETY FACTORS**

3.2.1 **Health care service delivery**

Years of civil war (1989-1996) and the Taliban government (1996-2001) deteriorated Afghanistan's public health system (Rassoul 2010). During the Taliban government the administration of the already centralized health system became more disconnected. Vertical health service delivery was dominant and public health care delivery was inattentive to rural communities. Between 1952 and 1972 only 1-4% of the national budget was allocated for health, which caused poorly equipped health facilities to remain underutilized. Despite peace during 1960-1970, Afghanistan's health indicators lagged behind other countries in the region (Strong 2003). After the establishment of a family planning department; in 1970 the birth spacing service delivery started in the capital and during one year extended to 20 other provinces of the country. According to UNFPA the CPR in 1972/73 was 2.0%. Less attention was given to family planning during the 1980s and with the arrival of the Mujahidin in 1992 the family planning department was closed down (World Bank 2005). Despite years of war Afghanistan's health indicators showed noticeable improvement from 2003 onwards. The concept of Non-Government Organizations (NGOs) arose in 1980 with their initial focus on Afghan refugees and cross border interventions. This focus gradually shifted to Afghanistan to enhance efficiency in delivery of health services under a government regulated structure (Strong 2003).

Currently the family planning department at the Ministry of Health is understaffed. This department lacks close relations and networks with related ministries, NGOs and the private sector. Additionally the link

between the Ministry of Health and community is not strong. All these factor influence the supply of quality services (Rahmani et al. 2013). Countries like Iran, Egypt, Thailand and Colombia made remarkable progress with FP programs between the mid-1980s and 2000, while the progress in south Asian countries and Sub-Saharan Africa has been sluggish due to poor access to health care services and inadequate political commitment (Tsui et al. 2010). The Afghan Government reports that almost 85.0% of Afghans have access to health services, but still major barriers to access quality health care services exist. Barriers include a deteriorating security situation, increased poverty, low literacy, lack of women's empowerment, poor road maintenance and transportation systems (Sultani et al. 2009).

According to the RH national strategy (2012-2016), 81% of health facilities provide at least three methods of contraception and the aim is to increase this coverage to 100% by 2016 (MoPH 2012a). However, a study of the RH situation of Afghanistan in 2009 showed that only 29.0% of primary care centers provide three or more than three types of contraceptives and some contraceptives without quality approval are supplied (Aitken 2009).

3.2.2 **Health care providers and infrastructure**

The Human Resources (HR) for health were demolished during the war. With the Taliban emergence in 1996 female education was banned, which impacted the already poor HR for health (MoPH 2011b). Culturally women should be visited by female health care providers especially for reproductive health care services (Newbrander et al. 2014) .Only 28.0% of the overall public health care providers are female workers. The number of health workers including private and public doctors, nurses and midwives is 7.26 per 10.000 population, which is three times lower than the WHO target of 23 per 10.000 population. This indicates a shortage of qualified health care workers (MoPH 2011b). The sex segregation among health care providers caused a radical decline in availability and quality of health services for women (Ward 2002). The absolute number of female health care providers, including community midwives, increased from 467 in 2003 to 3,001 in 2012 (MoPH 2012a). Yet the near-total female staff deficit creates a hurdle for access to health care services by women (Michael et al. 2011). Excess staff turnover and brain drain due to weak capacity building, poor payment in public services, insecurity and fear of retaliations remain unaddressed gaps in the health strategies of the country. Poor infrastructure, lack of buildings and if available are mostly rented ones, unstable hospital conditions, lack of safe water and intermittent electricity deteriorates the health care service delivery further (Acerra et al. 2009).

The launch of BPHS and the deployment of CHWs at the current number of 22,000 has overcome the access barrier to health care services to some extent (Newbrander et al. 2014). CHWs receive training on interpersonal

communication skills so that each woman of reproductive age living in rural communities receives information and counseling on contraceptives from them. CHWs administer second dose of injectable contraceptives and refer interested women to health facilities to seek permanent contraception methods (MoPH 2010). According to a USAID project, 71.0% of family planning visits at the community level is performed by non-paid CHWs (Sato 2007). More than 50% of CHWs are illiterate. Their remuneration has been an issue of constant debate at national level, in which controversial statements about the quality of their service are made (Michael et al. 2011).

3.2.3 **Patriarchal society**

In the male dominated society of Afghanistan generally men have power over women. A Knowledge Attitude Practice (KAP) study among women in reproductive age showed that 93.0% of women need approval from their husband or another male family member to seek health care services and to use family planning methods. This approval is very often denied (Egmond et al. 2004). Generally, in a patriarchal society discrimination against girls starts from the time of birth or even before. This appears in the form of sex differences in feeding, dressing and schooling (United Nations 2002). A study in Pakistan showed that contraceptive uptake increases by roughly 38% if husbands approve it (Khan et al. 2010). A study in Nepal showed that in the absence of concurrent agreement between couples, the husband dominance contributes to the unmet need for family planning (Yue et al. 2010). Also in India the patriarchal society leads to power imbalance and makes men the major decision makers regarding contraceptives use (Malhi 1997).

3.2.4 **Religion**

In Afghanistan Islam is the cornerstone of daily life. 99.0% of people are Muslims. Neither Islam nor any text in the Quran prohibits pregnancy prevention. People believe that children are Allah's gift and perceive family planning as a tool for the spacing of pregnancies not for planning the number of pregnancies (Egmond 2002). A case control study in India showed that Muslim women are more prone to a higher risk of unwanted pregnancy than Hindu women. Muslims have more children and want to sustain fertility and in case they don't want more children they are not likely to use contraception (Dixit et al. 2012).

3.2.5 **Infant and child mortality**

Since 2003, a 60% reduction in the under-five mortality rate has occurred. However, according to a UNDP report "The under-five and infant mortality of Afghanistan rates are still among the highest in the world; only Angola, Liberia and Sierra Leone have higher rates" (UNDP 2013b). The mortality rates of 77 infants and 97 under-five children per 1,000 live births are among the highest (MoPH 2011a). These alarming facts about poor survival

of children contribute to low contraceptive uptake and high fertility. It is estimated that annually 50,000 child deaths could be averted if the contraceptive prevalence rate would reach 40.0% (MoPH 2009b). Afghanistan is a signatory of the MDGs and is committed to two-third reduction in under-five mortality by 2020. In order to achieve this goal, the government has developed several strategies which support birth spacing, breastfeeding, neonatal care, complementary feeding, and immunization (MoPH 2011a). Likewise, the immunization coverage is low compared to international standards. Diarrhea and respiratory infections are still main killers of children. The overall perinatal mortality rate is 42 per 1,000 pregnancies (Belay 2010). Children's survival is directly linked with that of their mothers. Family planning enables women to make informed choice on family size, and delay, space or limit their pregnancies, in order to have well-nourished babies and to contribute to a more productive nation (Singh et al. 2012).

3.3 **COMMUNITY FACTORS**

3.3.1 **Place of residence**

Contraceptive uptake differs widely between urban and rural communities. The likelihood of contraceptive use is two times higher among urban women; 36.0% urban and 18.0% rural women use contraceptives (MoPH 2011a). The government has had success with building health centers based on two logical criteria: population estimates and distance. However, still the main reason for 50.0% of poor utilization of health care services, including family planning services, is physical inaccessibility. Moreover, securities as well as economic and geographical challenges cause shortfalls in the number of health care providers working in rural districts, which creates problems in availability of health care workers. Poor infrastructure, including road maintenance, creates access problem in rural areas (Sultani et al. 2009). It is known that urban women have better access to contraceptives, health care providers and media information versus rural women (Khan et al. 2010). However, a survey by a nongovernmental organization showed that women despite living in urban communities of Afghanistan have an unmet need for contraception. Ninety eight percent of women in this survey who could not access contraceptives pronounced their interest in receiving contraception (World Bank 2005).

3.3.2 **Norms, cultures and perceived beliefs**

In Afghanistan misconceptions about contraception is rife. People believe that oral pills cause mental diseases and injectables lead to severe bleeding and death (Sato 2007). Even health care providers believe that injectables reduce breast milk, modern family planning leads to infertility and the uterus

of a mother who works hard or is multiparous is unable to keep the Intraa Uterine Contraceptive Device (IUCD) in (Huber et al. 2010).

Intimate adherence to traditional and sociocultural practices creates barriers to access family planning services and information. This also exacerbates the already low social position of women in the household and community (Alvi 2011). A predominant example can be husbands reluctance to allow their wives be visited by a male health care provider due to culture and norm (Haider et al. 2009).

3.3.3 **Poverty & Socio Economic Status (SES)**

Since 2008 the level of poverty has not improved. According to the National Risk and Vulnerability Assessment (NRVA) of 2011-2012, 36.5% of Afghans live under the poverty line. High fertility is positively associated with poverty (GIRoA 2011a). Poverty influences the financial access to health care services including family planning. Principally rural households have to pay a big sum of money for transportation and for other marginal costs, which hinder women's access to family planning services (Sultani et al. 2009). Women in the highest wealth quintile have the maximum uptake of any contraceptive method. It doubles twice from 17.1% among women with the lowest socioeconomic status to 34.0% among women with the highest socioeconomic status (MoPH 2011a). A study in Pakistan showed that there is a positive correlation between the husband's income and use of contraceptives (Khan et al. 2010).

3.3.4 **Adolescent pregnancy**

The majority of Afghanistan's population, 68%, is under the age of 25 (GIRoA 2013a). Forced and child marriage is outlawed by civil codes. However, there is no evidence for interrogation of parents who commit this act for girls under the age of 16. Adolescent motherhood is a foremost health and social problem that causes life threatening risks, not only to the mother but also to her child. 57.0% of girls marry before age of 16 and 47.0% of deaths among women aged 20-24 are due to pregnancy related complications. Child marriage and childbearing becomes socially and legally acceptable after marriage in Afghan society. Twelve percent of 15-19 year old women have started child bearing, before they are physically and mentally ready for it. The earlier the sexual debut, the longer the reproductive life, is the motto. Adolescents in the age category 15-19 have the least knowledge of contraceptives and only 9.0% of them use any method of contraception (MoPH 2011a). In general, child marriage occurs when families sell out their daughters due to poverty or tend to settle down family and tribal disputes (Medica Mondiale 2008). Many girls commit suicide or resort to self-immolation to escape forced marriages and unwanted pregnancies (Alvi 2011). Results of a RH study in Afghanistan showed that

67.0% of married adolescents were pregnant, none of them used contraceptives and all of them wanted more children (Egmond et al. 2004).

3.3.5 **Son preference**

Son preference in many South Asian countries is another barrier to family planning utilization. This custom is also deeply rooted in Afghan society. Women with no son are less likely to use contraception. Afghan families believe that a son will stay with the family and will keep the family name after marriage, while girls go to their in-laws. If the husband dies, the woman relies much on the son because he earns and provides financial support to the family (United Nations 2002). Husbands' desire for having more children and particularly sons decreases the likelihood of contraceptive use. Women who give birth to a girl are expected not to use contraceptives and to keep giving successive births with the hope of giving birth to a baby boy (Sato 2007). A study on son preference in India showed that husband's approval for contraceptive use, longer birth intervals and fewer subsequent births is common among couples who have given birth to one or two sons. The second birth is not delayed unless the first child is a son. A study in India showed that if there is no sex preference, the proportion of couples who prefer contraceptive use will increase by 4.4%, and there will be a 5.0% increase in couples who accept sterilization (Malhi 1997).

3.4 **INTERPERSONAL FACTORS**

3.4.1 **Spousal communication**

Apart from some ethnic differences, generally the social position of women is alike throughout Afghanistan. Men are head of the family and the main decision makers, particularly regarding having or not having children. Women and children are part of the patrimony and are considered as property of the extended family into which a woman marries (Sato 2007). These challenges impose huge hurdles to effective spousal communication, and prevent women and men from reaching consensus on the number and timing of their children. A study on the role of spousal communication in five Asian countries found that the chance for adoption of modern contraceptives is high if a couple openly discusses the issue of fertility desire. Communication can be effective if a woman discusses the financial cost associated with having more children. Reduced spousal communication undermines women's ability to negotiate contraceptive use, which leads to high fertility (Mason et al. 2000). Studies in Pakistan show that failure for initiation of communication with husband on contraceptives results in high unwanted pregnancies. Effective spousal communication on family planning leads to positive policy modifications which affects mass media coverage and family planning acceptance (Khan et al. 2010). A study in Nepal showed that

husbands' approval for contraceptive uptake will increase from 54.0% to 85.0% if women initiate open discussion on fertility and the benefits of contraception with their husbands (Yue et al. 2010). In African countries, poor spousal communication causes furtive use of contraception which leads to increased level of violence (Adekunbi et al. 1999). Husbands' attitude influences contraceptive uptake, for example if a women wants her husband to wear a condom she faces the risk of misbehavior from her husband (Mason 2010). There is no specific study on this issue but it resembles to the situation of Afghan women. During my residency in maternity hospital I witnessed multiple cases similar to it , when women desired birth spacing but failed to do so due to husband's misbehavior.

3.4.2 **Peer influence**

Peers, husbands, mothers-in-law, other family members and health care providers may influence a woman's decision to use family planning services. In Afghanistan, in particular the mother-in-law influences family size especially when men are not permitted to appear in health facilities where women go for reproductive health matters. Therefore the accompanying mother-in-law influences the contraceptive uptake, for example by scorning contraceptives and discouraging the uptake if a baby boy is not produced (Egmond et al. 2004). Regarding health care providers, misbelief among them concerning contraceptives leads to misinformation provided to the women and affects adoption of family planning (Huber et al. 2010).

A study in Haiti showed that doctor-patient relationships also influence the use of contraceptives. The likelihood of listening to a doctor's advice is high when women perceive their doctor is caring, trustworthy, and conveys appropriate information. However, discriminatory behavior discourages women and decreases the possibility of establishing an effective relationship and use of health supplies (Mason et al. 2000).

3.4.3 **Religious leaders influence**

Perhaps surprisingly, *Mullahs* – the religious leaders - play an effective role in promoting contraceptive use which contradicts earlier assumptions about *Mullahs* as blockades to family planning. The two years of breast feeding mentioned in the Holy Quran points to acceptance of birth spacing in Islam (Sato 2007). On the other hand, some conservative Islamic clergies consider family planning to be anti-Islam and claim it as an infanticide act and argue that the higher the Islam population the stronger their power. They also provoke beliefs that family planning is a western plot to reduce the population of Muslims (Roudi-Fahimi 2004).

3.4.4 **Violence Against Women (VAW)**

Violence against Afghan women is well known but poorly understood. Women endure dreadful acts of violence, abuse, coercion, sexual

harassment and intimidations (Alvi 2011). There is a paucity of statistics about violence against women as such studies are discouraged by authorities due to political reasons. However it is known that 80.0% of Afghan women undergo some type of domestic abuse even during pregnancy. Women's disempowerment affects their contraceptive demand. In fact the essence of violence is the lack of power among women to claim their fundamental rights. Such inequalities are also shown in the high number of forced and child marriages (Medica Mondiale 2008). According to the Afghanistan Human Rights Commission, between 60% to 80% of marriages in Afghanistan are forced .Violence is not restricted to its domestic forms but it encompasses threats to the lives of women who work as teachers and health workers to educate women on family planning and other health issues (UNAMA 2009).

3.5 **INDIVIDUAL FACTORS**

3.5.1 **Age of women**

Marriage age impacts women's reproduction. On average those who marry early have a longer childbearing period and are more exposed to pregnancy risks. In Afghanistan marriage happens rather early. Generally 92.0% of women of 25 years of age are married, and by the age 19 one-third of girls have given birth to their first baby. The Age Specific Fertility Rate (ASFR) is high among the age category of 15-24. Young women are in initial stages of building a family; hence have the lowest use of contraceptives. Early child bearing means that the girls' schooling is interrupted so they have less knowledge and utilization of contraceptives. According to the AMS, family planning knowledge increases with age; 9.0% of women age 15-19 use contraceptives, while 29.0% women age 35-39 are the major users of contraceptives. Permanent family planning methods are used only by women older than 35 (MoPH 2011a). A Pakistani study found a positive relation between women's age, number of living children and contraception use (Khan et al. 2010).

3.5.2 **Knowledge and practice of contraceptives**

The gap between contraceptives knowledge and use is huge. 92.0% of women have family planning knowledge but only 21.0% use a method of contraception (MoPH 2011a). A study by the Church World Service (CWS 2011) in one of the southern provinces showed that only 10% of couples opt for child spacing and family planning methods. The current rate of couple year protection is 23.2% and the aim is to increase it to 40% by 2016 (MoPH 2012a). Also in Nepal, 99.0% of women have family planning knowledge but only 66.5% use contraceptives (Tiwari 2012) Despite improvement in family planning knowledge the information about sexual

health is lacking; the results of a KAP study in Afghanistan showed that only 16.0% of women knew "how babies were made" (Egmond et al. 2004).

3.5.3 **Education**

According to ANDS (2011), only 18.0% of Afghan women are literate, (GIRoA 2013a).There is a strong positive correlation between education, socioeconomic status and contraceptive uptake. The difference is evident even between different levels of schooling. Contraceptive use increases from 20.0% among uneducated to 44.6% among higher educated women (MoPH 2011a). 35.0% of women with higher education and only 19.0% of women with no education use any of modern contraception methods (MoPH 2012b). Policies targeting access to education, particularly for girls, have the potential to positively affect maternal health (Seyfried 2011). Women's education not only supports their autonomy but allows them to control their fertility and practice self-caring skills. The median age at first birth increases by four years among educated women compared to uneducated women (MoPH 2011a).

In India education is also considered a main empowerment tool that enables women to decide and negotiate adoption of family planning methods (Saluja et al. 2009). In this country more literate women know the importance of contraceptive use and the advantages of small families (Dixit et al. 2012).

3.5.4 **Social network & acculturation**

During thirty years of war a huge number of Afghans migrated to neighboring countries (Alvi 2011). During the past five years four million Afghans have repatriated from these countries, especially Iran. As a result of exposure to societies with better availability and utilization of contraceptives, their attitude and mentality regarding family planning changed (Piran 2004). The results of a focus group discussion with male Afghan refugees in Iran highlighted that family planning acceptance rate increased noticeably, especially among ethnic groups of *Hazara* and *Tajik* couples who later returned from Iran (Sato 2007).

3.5.5 **Number of living children**

In most of south Asian countries marriage and having children guarantees a women's status and respect (Khan et al. 2010). Culturally Afghan women are expected to give birth after being married for one year. One of the reasons for polygamy is the inability of woman to bear a child (Tayler 2002). A woman who is not able to give birth to a good number of children particularly son feels ashamed, faces hardships in life and is not treated properly by her in-laws. The highest contraceptive uptake of 29.1% is among women with five or more than five children. Only 16.9% of women with 1-2 living children use contraceptives (MoPH 2011a).

In Pakistan couples with three or more children tend to adopt family planning. Contraceptive use increases by seven percent with the birth of a new child in the family (Khan et al. 2010). The shift from giving birth to six children with the possibility of losing several of them to giving birth to two babies with a higher possibility of survival for all of them is considered a reproductive revolution which has not yet happened in Afghanistan (Cleland et al. 2006).

CHAPTER FOUR

4 DISCUSSION

In this part I will discuss how to optimize the uptake of contraceptives in Afghanistan while referring to best practices and evidences of successful family planning programs in Iran and Bangladesh.

4.1 BEST PRACTICES FOR FAMILY PLANNING

In this section I legitimize my choice of referring to the best practices and evidences of successful family planning programs in Iran and Bangladesh as an inspiration for further development of family planning programs in Afghanistan. Both countries Iran and Bangladesh are similar in their approximate geographic characteristics, traditions, religion and social composition to Afghanistan. They also stand out for their policies, strategies, community-based approaches and strong political commitment regarding successful family planning programs.

4.1.1 Iran: Multidisciplinary approach to enlarge scope of family planning

Iran, a Middle Eastern country, challenged the statement that the demographic transition in traditional societies ruled by Islamic law is sluggish. Iran is the first country to integrate family planning within its development plan. The success story of Iran's family planning is praised as the "Iran Miracle" (Hettige 2012). The Middle East's only condom factory operates in Iran. In 1967 the government acknowledged family planning as a human right and highlighted its social and economic importance. Iran's annual population growth rate declined from 3.9% in 1986 to 2.0% in 1996, with a current rate of 1.2%. Similarly the fertility rate declined from 5.6 children per woman to 2.0 in 2000. In two decades multiple factors influenced this remarkable achievement which coincided with the success of family planning at the national level. During the Islamic revolution of 1979, the family planning concept was considered a western scheme, while the professional and technical staff approached the clergies and convinced them of the importance of family planning. During the war with Iraq (1980-1988) some officials were content to have the highest annual population growth rate of 3.0% in the world. However, after the war the gray picture of the countries' economy showed that it is not easy to reconstruct and support the social and welfare services of country. Iran launched a publicity campaign to influence policy makers and politicians of the importance of a national population and family planning program. In the next step they involved

religious leaders in a culturally sensitive manner; with their support the judicial council announced that "there is no Islamic barrier to family planning". Religious leaders played an active role in advocating for family planning and reproductive health (Roudi-Fahimi 2000). Over the course of 10 years with social and religious leaders' support and information sharing mechanisms, Iran created a successful family planning program with increase in CPR from 43.0% to 73.3% (Todd et al. 2009). Religious leaders promoted couples counseling for uptake of contraceptives and assured them that FP methods are reversible. The government trained health care providers to perform reversible operations (IRIN 2014).

Even though initially the family planning program of Iran was established in response to population growth, the issue of unintended pregnancies, unmet need and reproductive health soon came on board (Mehryar et al. 2007). The average marriage age increased from 19.7 years to 22.4, this had a remarkable impact in contraceptives uptake. Free family planning services enabled urban and rural couples to access services, particularly those who could not access it due to financial barriers. Equal participation of couples before marry in government sponsored family planning classes became mandatory. It became a prerequisite for them to access their marriage certificate, this approach promoted men's participation in the issue of family planning and reproductive health. Family planning was included in adult literacy programs and university students had to take two credits on it. The government repealed some social and economic benefits to large families and instead confined them only to the first three children of a family. The huge information and communication program on population and family planning was triggered through media. A demographic and health survey conducted in 2000 showed that 77.0% of rural and 94.0% urban households have television which helps in promotion of contraceptives uptake (Roudi-Fahimi 2000).

Advancement in education levels of women and the role of community health workers (*Behvarze*) has been crucial in this success. Dramatic rise in education level of women from less than 25.0% to the current level of 70.0% also improved uptake. The health workers helped promote the idea of small family size, knocked on women's doors, and educated women on contraceptives and referred them to health facilities. Parallel with these interventions, strengthening of the health care system and capacity building of health care providers helped the government to assure high quality FP services and enhanced client satisfaction (Roudi-Fahimi 2000).

4.1.2 **Bangladesh: More family planning health workers in remote communities**

Because of its "reproductive revolution", Bangladesh receives substantial attention of media and international communities. Its family planning program is named a "great success in a challenging environment" (The Bangladesh Chronicle 2013). Bangladesh is one of the densely populated poor south Asian countries, but is a successful example of improved utilization of contraceptives. During 1970-1980 a different set of pragmatic (culturally sensitive) approaches were adopted to accommodate the gender inequalities that influence poor contraceptives uptake (Ahmed 2014). As a result of those interventions the annual population growth rate declined from 3.0% in 1970 to 2.3% in 1991. Likewise, the fertility decreased from more than 6 in 1976 to 3.4 in 1993 (Schuler et al. 1995). Evidence from the successes of Bangladesh in improved contraceptive uptake highlights the importance of community-based approaches. Women's access to health services was improved with the deployment of an additional 35,000 female field workers and the establishment of satellite clinics to deliver contraceptives door to door. The improved FP commodity logistical system is mostly overlooked but has had a great impact on Bangladesh's family planning success story. This system enabled the government to monitor the stock flow and identify commodity shortages in time. Visibility of family planning issues in public media such as radio and TV and other education material triggered by IEC campaigns resulted in improved contraceptive knowledge and utilization. For example, by 1989 about 95.4% of women had knowledge about at least four methods of contraception. The average age at first pregnancy increased from 16.3 in 1974 to 17.7 in 1989 (Schuler et al. 1995). Public private partnership for family planning services was promoted to minimize the duplication in coverage of activities, and to maximize the effectiveness of quality FP interventions. Another effective approach was decentralization of family planning services in which involvement of grass-root communities were promoted. This strategy helped communities to make action plans for contraceptive needs of their neighborhood (Stewart 1992).

Bangladesh's unique success in reduction of under-five mortality from 151 in 1990 to 65 per 1000 live births in 2006 helped with strengthening the FP program (Sayem et al. 2011). A study in 2009 found that despite low skilled care at delivery, improved family planning programs and expanded education programs for women significantly contributed to decline of maternal mortality (Chowdhury et al. 2009). There has been a steady decrease in maternal deaths from 650 in 1975 to 197 per 100,000 live births in 2010 (Ahmed 2014). Advocacy efforts like cost-benefit analysis of family planning services and contraceptive prevalence studies were performed in order to evaluate the quality of FP programs (Pinkham 1995). The prerequisite to obtain all of motioned successes in widespread family

planning adoption has been a strong political commitment (World Bank 2005).

4.2 DISCUSSION ON THE APPLICATION OF THE BEST PRACTICES IN THE AFGHAN CONTEXT

In this section I will discuss what Afghanistan can learn from the best practices of Iran and Bangladesh to overcome the identified gaps for effective uptake of family planning. I will evaluate whether the implementation of these programs or at least particular elements of these programs could be effectively applied in the Afghanistan context in order to narrow the gap in family planning uptake. The section is structured according to the human right dimensions for contraceptives service and information provision and their indicators as identified by the WHO (2014b) in its document entitled 'Ensuring human rights in the provision of contraceptive information and services'. These dimensions are successively availability, accessibility, acceptability and quality (Annex 1).

4.2.1 **Availability**

Once demand for contraceptives is created, the focus should be to supply the demand and make the services available. Supply-oriented contraceptives distribution does not warrant uptake. Use of highly effective methods, even in small proportions, impacts fertility decline (Khan et al. 2010).

One of the main secrets for Bangladesh's successful FP program has been the launch of a commodity security system which enabled the Ministry of Health to be update of stock-outs and to provide timely contraceptive supplies. The public private partnership approach of Bangladesh can be a good model to learn from; the mutual efforts between the government and the private sector assured contraceptives availability in health facilities. In Afghanistan the role of NGOs in supporting the national family planning program and making contraceptives available have also been effective, but only to a certain extent (Sato 2007). After 2005 a USAID funded social marketing program emerged and promoted the sale of condoms, oral pills and injectables. This program soon got popular among people. It was accompanied by BCC, including media broadcast. The program also trained *Mullahs* with support from Ministry of Haj and Religious Affairs, who played a remarkable advocacy role in promotion of contraceptive use (Aitken 2009). The scale up plan of this program throughout the country did not take place due to security and political challenges; otherwise the success of this intervention would have filled some of the current gaps in family planning program.

In order to make the health care services including contraceptives available throughout the health facilities and communities, the government of Afghanistan focused on rapid multiplication and distribution of female health care providers including community midwives and CHWs. This approach was effective; but the scope of work for non-paid CHWs is broad, they perform different set of activities in addition to distribution of contraceptives. This prevents the universal contraceptive coverage and makes achievement of set targets difficult. In Bangladesh 35,000 health care workers were deployed merely to deliver contraceptives to communities and provide information and counseling to couples.

4.2.2 **Accessibility**

The literature review showed that poor access to health care services is one of the main factors affecting the demand for contraceptives. The BPHS and CHW approach improved access especially in hard to reach communities (Newbrander et al. 2014). Evidence shows that the launch of BPHS has been successful in post-conflict contexts such as Cambodia, Bosnia and Herzegovina, Rwanda and Uganda (Michael et al. 2011). Likewise in Afghanistan, with the BPHS the coverage of health care services increased to 85.0% and barriers to access health services were removed to certain level. To further tackle the challenge of access and enhance the linkages between communities and health facilities the government committed itself to community-based expansion of family planning through community health workers, family health action groups and community health supervisors. This intervention resembles the successful FP program in Iran and Bangladesh where community health workers promoted community-based distribution of family planning commodity free of cost. This intervention triggered with IEC and BCC campaigns significantly improved access to contraceptives and created demand for FP especially among poor and marginalized couples. In Afghanistan also CHWs distribute contraceptives for free; this improves access of poor couples to family planning commodities; however, due to security reasons the CHWs cannot cover the entire country (Aitken 2009). Due to security as well as financial and geographical reasons the health care providers still don't want to work in remote provinces of country where there is great need for health services which means ; the coverage of health services including family planning is not yet universal (Sultani et all 2009).

Afghanistan can learn from the Iran model regarding mainstreaming of family planning in country's development plan and allotment of social and economic bonus to families with a limited number of children. This innovation from one hand will help with promotion of small family size and from the other hand will enable poor couples to have decent living circumstances.

Unmet need of contraceptives only does not include poor access to family planning services, it also includes unmet need for relevant information; appropriate methods for users of an ineffective contraceptive or unmet need of unmarried youths (Ashford 2003). The data for contraceptives unmet need from 194 countries including Afghanistan does not exist at all, which in itself is a barrier for appropriate program design (Alkema et al. 2013). Iran's approach was successful because through the family planning program not only government controlled the population growth but, also addressed unmet need and unintended pregnancies (Mehryar et al. 2007). In the Afghanistan context such an approach is lacking, in case it is adapted, it would help reduce the high burden of maternal and child mortality.

Adolescents' access to contraceptives, though difficult, but will provide them with more opportunities to prevent unintended pregnancy, maintain education, have job, and contribute to the reduction of poverty and the promotion of women's status in the society (Singh et al. 2012). In Bangladesh, as a result of political commitment and community mobilization, the average age of marriage increased, which helped to improve access of adolescents to contraceptives and reduced maternal deaths (Stewart 1992). Despite a bulk of policies for support of women's position in Afghanistan there has not been any decline in forced or early marriages and the violence against women increases day by day. A 30% reduction in the burden of maternal mortality between 1979 and 2005 in Bangladesh is attributable to the adoption of contraceptives (Chowdhury et al. 2009).

Lessons from Bangladesh showed that decentralization of family planning services enabled deprived couples to afford contraceptives (Stewart 1992). This bottom-up approach motivated community participation and helped couples to identify their family planning needs and find solutions and sustainable approaches to overcome it. Such programs are also required within the health system of Afghanistan so that poor households can afford contraceptives easily and are also involved in appraising their contraceptive need. Integration of family planning services along with other comprehensive public health interventions would enhance affordability, instead of keeping it a stand-alone intervention.

4.2.3 **Acceptability**

The perceived quality and effectiveness of family planning methods is another determinant which impacts contraceptives acceptance. Education and effective counseling is required in order to enhance contraceptives acceptance. In Iran, beside community awareness promotion of women's education was one of the best strategies that helped overcome the cultural barriers and taboos to enhance family planning acceptance (Roudi-Fahimi 2000). In Bangladesh also media campaigns helped educating women regarding contraceptives and improved acceptance. Unfortunately the issue

of education via media is not emphasized in Afghanistan to a wide extent. In Afghanistan a USAID funded project took steps and launched capacity building, awareness campaigns through television and radio spots to address the issue of misconception about contraceptives, which had a positive impact even though at a small scale (Aitken 2009). Development of IEC and BCC strategies and messages for both users and non-users of family planning was initiated by different NGOs (APHI/ MoPH 2010). Yet, the IEC campaigns were not implemented in a systematic manner as was done in Iran where education on sexual health and contraceptives became mandatory for couples before marriage (Roudi-Fahimi 2000). This approach also promoted men's involvement in the issue of reproductive health and family planning and enhanced family planning acceptance.

Findings of this study showed that poor spousal communication is among the pivotal barriers for contraceptive use. An intervention by NGOs in Afghanistan promoted an accelerated adult literacy program, and this helped in giving women power, confidence and communication skills to openly negotiate the issue of contraceptive and family planning with their husbands (Sato 2007). This intervention though helpful was limited and to scale it up following the example of Iran where FP was mainstreamed in the university curriculum and adult literacy programs could be replicated.

In fact *Mullahs* and religious leaders can be great promoters of contraceptive uptake in any Muslim countries. Evidences from Iran showed that involvement of religious leaders has a crucial role in improving the family planning interventions. In Afghanistan also in Islamic debates it is argued that family planning is an appropriate approach which reduces excess fertility that causes health risks to mothers, economic troubles to fathers and proper nurturing problem to the parents. Training of *Mullahs* in different rural communities on the benefits of family planning resulted in increased contraceptive uptake from 16.0% to 26.0% over the course of two years. These religious leaders were preaching about contraception benefits in Friday prayers and their advocacy role in creating demand for contraceptives and promoting open spousal communication was remarkable (Sato 2007). But this intervention was only implemented in 13 out of 34 provinces of Afghanistan.

The successful example of Iran showed that the FP program as part of country's development plan especially after years of war was an appropriate approach in promoting FP uptake and acceptance. The government of Afghanistan also immediately after the period of conflict could have established new programs to prioritize the issue of family planning in existing institutions. Unfortunately this opportunity was missed in Afghanistan. Family planning has not been a priority for the control of population growth nor for the improvement of health indicators.

In Bangladesh a remarkable decline in child mortality convinced people to adopt family planning. In Afghanistan, however, the high under-five mortality and lower chance for their survival makes women continue to give birth in order to replace the dead children.

4.2.4 **Quality**

Provision of affordable, appropriate and high quality contraceptive products is very essential for a successful supply chain system (IPPF 2011). The perception of quality and effectiveness of contraceptives is very much related to misbeliefs towards family planning. Taboos and misbeliefs impact the quality of contraceptives and affects demand for contraceptives use. Findings from this literature review show that not only clients but health care providers have some misconception about contraceptives, which affects client satisfaction regarding the information she receives. Government claims that 81% of health facilities are supplied with three types of contraceptives, whereas only 21% of women adopt family planning. The issue of contraceptives quality, commodity security and stock-out mechanism need to be managed in a systematic way to improve contraceptives uptake.

The successful examples of Iran and Bangladesh showed that capacity building of health care providers, improved public private partnership, and family planning cost-benefit analysis enhanced the quality of FP services. Moreover, the decree of religious leader in Iran on the reversibility of family planning methods helped people to trust the quality of family planning methods and strengthened client retention and satisfaction. These innovative approaches are missing from family planning programs of Afghanistan. However, can be good motivation to learn from and to adapt accordingly in order to strengthen the family planning program.

CHAPTER FIVE

5 CONCLUSION AND RECOMMENDATIONS

5.1.1 **Conclusion**

This thesis made clear that determinants for poor contraceptive uptake among married Afghan couples are diverse. These determinants include a complex set of intertwined factors at national, social, community, interpersonal and intrapersonal level, which altogether impact the demand for and supply of contraceptives.

Policy analysis showed that there are numerous policies and strategies; almost each department at the MoPH has its own policy. Some of the policy documents overlap with each other, which puts the stewardship role of MoPH in question. Only the existence of a strategy is not the solution; there should be concrete action plans and milestones to assure each department's intervention contributes to the overall goal of ministry of health. Policy impact analysis is required to assure the current policies are effective and support the mission and vision of the MoPH. Unfortunately the issue of unmet need for contraceptives, particularly for adolescents, and the consequences of unintended pregnancies have remained untouched in national family planning policies and strategies causing a wide gap in policy implementation. There are also partial gaps in actual implementation and prioritization of policies regarding family planning; such as the involvement of religious leaders and mainstreaming of family planning services into other comprehensive health care services where men can also access it easily. Most of the studies target women and less data on men's perception and attitude regarding family planning exists.

Prominently deteriorating security situation, Political instability, internal conflict and violence have caused the country to face shortfalls in implementing laws and strategies and to lag behind in realization of set targets. However, it is proven that policies with a focus on RH services including contraceptives have the potential to effectively decline maternal deaths, meeting the "unmet need" for contraceptives and achieving MDG 5 (Seyfried 2011). The government is devoted and there is political commitment toward universal access of reproductive health services including family planning. With support of inter-sectoral collaboration, the MoPH can maintain the recent achievements in the sector of health.

Even though the country is a signatory to the universal declaration of human rights and many other treaties, still some of typical human development indicators rank the country low (Kaur et al. 2009). Evidence shows that

political commitments to influence policies and policy makers are main factor for realization of family planning program. Gender transformative policies that prioritize family planning beyond birth and population control and consider it as a tool for rights achievement and empowerment are essential toward achieving the development goals (Seyfried 2011).

5.1.2 **Recommendations**

Below policy recommendations are provided at different levels including individual, community, national; and research institutions.

5.1.2.1 Individual level

- Promote men's involvement in the issue of FP and RH; such as engaging men in institutions and health service delivery points committed to support pro-women laws and policies.
- Promote counseling for couples at all stages of their reproductive life, including before marriage, to create demand for contraceptives and assure a safe reproductive life for women and a better child rearing environment.

5.1.2.2 Community level

- Encourage community-based educational interventions with support of media and technology on the benefits and long term impact of family planning to address decision makers such as mothers-in-law and community leaders.
- Initiate dialogue with religious leaders and faith-based forums regarding family planning and reproductive health in order to attain their support.
- Develop social franchised programs for families with few children to promote the concept of small family size.
- Create a system to query parents who commit child marriage.

5.1.2.3 National level

- Strengthen political commitment and willingness to implement health care policies that are pro-female, promote more prevention and healthy lifestyles approaches instead of being predominantly treatment focused.
- Create an enabling environment through development of targeted and sufficiently financed strategic plans, in order to assure the most vulnerable women living in remote and unsecure areas can freely decide the timing and spacing of their pregnancies and access quality family planning services.
- Promote effective public private partnership to assure decentralization of activities for family planning programs.
- Integrate family planning in the curriculum of high schools and paramedics and other health service delivery points.

5.1.2.4 Research institutions

- Research and further study on the magnitude and characteristic of unmet need for family planning and unintended pregnancies so that local governments and duty bearers plan appropriate programs to accomplish the set MDG goals by 2020.
- Create a standard system to collect, compile and analyze data and information around family planning as a basis to the development and launch of useful family planning programs.

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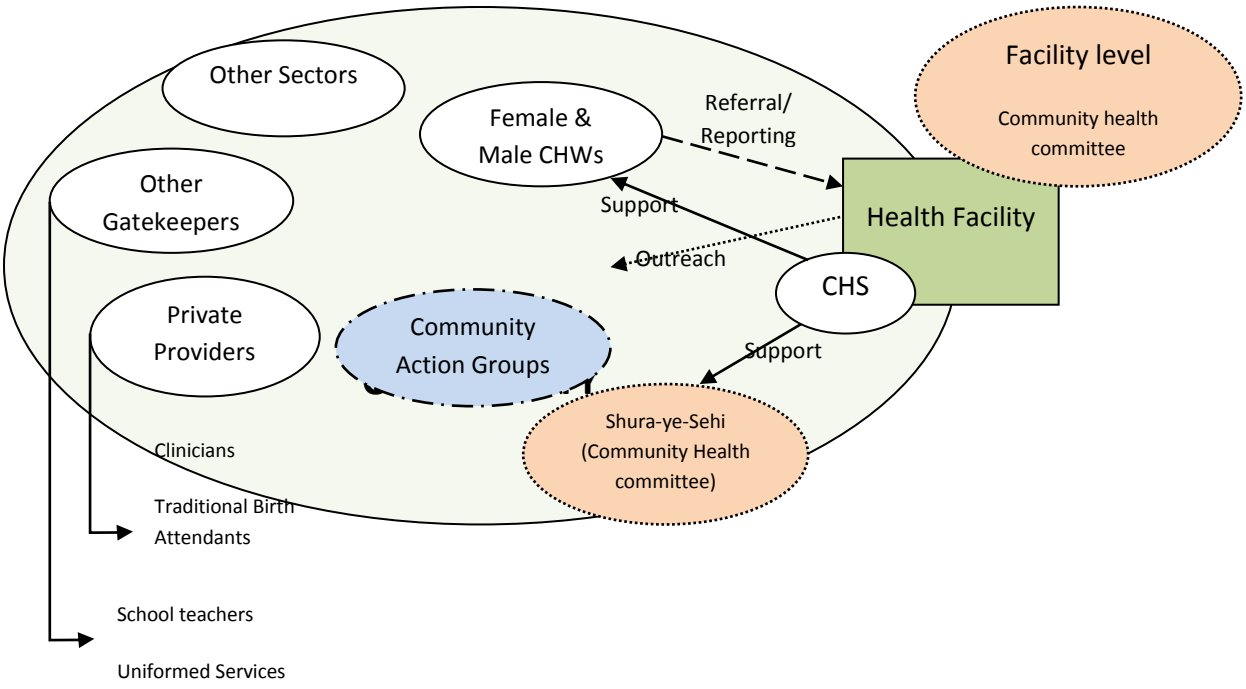
7 Annexes

7.1 Annex 1 Human right dimensions for contraceptives service and information provision

Rights-related outcomes	Measure
Availability	
Functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity	method mix; modern contraceptive prevalence; facilities available; commodity stock-outs; provider capacity; funds budgeted to family planning
Accessibility	
Health-care facilities, commodities and services have to be accessible to all, without discrimination.	contraceptive cost; distance to services; modern contraceptive prevalence; contraceptive uptake by new users; adolescent contraceptive use
Acceptability	
Clients have to be comfortable with the more immutable Characteristics of the provider, and vice versa, to an adequate extent.	client satisfaction; client retention; direct referrals; new users; provider satisfaction; provider retention; community trust in program; demand for services
Quality	
Health-care facilities have to have an adequate standard of medical care, choice of methods, amount of information given to clients, level of technical competence, quality of interpersonal relations, follow-up and continuity mechanisms, and the appropriate array of services	meeting the established standard of care; method mix; range of services available; client satisfaction; provider satisfaction; access to follow-up

Source: adopted from World Health Organization (WHO), Ensuring human rights in the provision of contraceptive information and services (WHO 2014b)

7.2 Annex 2 The community based health care system of the BPHS



Source: Adopted from Basic Package of Health Services 2010 (BPHS) (MoPH 2010)