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OCCASIONAL PAPERS

Challenges and Successes in Family Planning in Afghanistan

From 2003 to 2006, Management Sciences for Health carried out technical assistance, systems development, capacity building, and applied research through the USAID-funded Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program, and, from 2004 to 2006, through the Hewlett Foundation–funded Accelerating Contraceptive Use Project. REACH, which worked in 13 of Afghanistan's 34 provinces with a $138-million budget, increased the contraceptive prevalence rate from 16% to 26%, while the smaller project, which worked in three areas, achieved increases of 24–27 percentage points.

Although misconceptions about family planning and cultural factors such as son preference presented some obstacles to progress, both projects found that religion in Afghanistan (which is 99% Muslim) is not a barrier to expanding family planning services. It was critical to engage clinicians and communities (men, women, religious leaders, and health committees) in culturally sensitive ways. Emphasizing the use of birth spacing to protect the health of mothers and children was especially effective. Activities to empower women—including a health-oriented literacy program—and increase the number of female community workers supported rapid scale-up of contraceptive use.

Birth spacing is an internationally proven strategy to save both children's and women's lives. In Afghanistan, which has a high total fertility rate (6.8) and infant mortality rate (166 per 1,000 live births, Population Reference Bureau 2007), as well as one of the highest maternal mortality rates in the world (1,600 per 100,000 live births, UNICEF), birth spacing is critical to progress in health and quality of life. Although more trained birth attendants and better access to emergency obstetric care (EOC) for rural women are also needed, birth spacing can reduce maternal and infant mortality in the short term (Setty-Venugopal and Upadhyay 2002 and USAID 2002).

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Management Sciences for Health (MSH) has managed two recent projects that addressed birth spacing and family planning: the Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program (2003–06), funded by the US Agency for International Development (USAID) and the Accelerating Contraceptive Use Project (2004–06), funded by the William and Flora Hewlett Foundation. When MSH began work on the REACH Program in 2003, the contraceptive prevalence rate (CPR) was estimated at 8%. We aimed to increase that figure to 12% by 2006

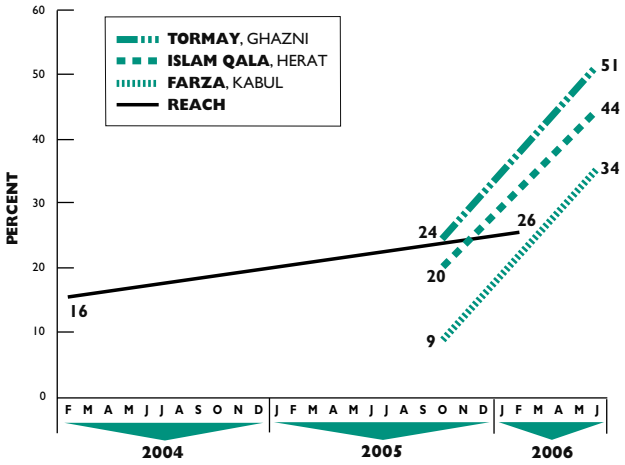
in the 13 (of 34) provinces served by REACH. The estimate was made taking Afghanistan's recent history into consideration. After contraceptive services were banned under the Taliban regime between 1996 and 2001, the already low CPR declined further.

We revised our estimate when the results of a baseline household survey revealed that the average CPR was 16.2% in REACH project areas (Ameli et al. 2004). The same survey demonstrated that 10 of 27 programs managed by nongovernmental organizations (NGOs) funded through REACH grants reported CPRs of over 20%. These rates were higher than the CPR of 10% found in an earlier multi-indicator cluster survey (Afghanistan Transitional Authority and UNICEF 2003).

After delivery of family planning services at the community level for more than two years, the REACH final survey found a CPR increase of 10 percentage points. Likewise, in nine months, the CPR increased an average of 25 percentage points in the three rural communities where the Hewlett Foundation–funded project was implemented (MSH 2007, p. 2). See Figure 1.

These dramatic increases can be explained because contraceptives, supplied by male and female community health workers (CHWs) based in Afghan villages, finally became available to meet demand. As Cleland and Sinding (2005, p. 1899) assert: "If information and services are provided in a culturally sensitive manner, modern contraceptive methods can be widely and successfully used, even in the poorest and least literate countries."

Figure 1. Progress in Contraceptive Prevalence Rates, Accelerating Contraceptive Use and REACH Projects



Note: Accelerating Contraceptive Use Project in 3 comprehensive health centers or health posts only; REACH in 3,900 service delivery points

This paper provides an overview on family planning in Afghanistan in its sociocultural context and explores what constitutes culturally sensitive family planning services in Afghanistan. Sociocultural factors—and an understanding of them—have contributed to the surge in the use of modern contraception in Afghan communities, particularly in the Accelerating Contraceptive Use Project sites. In addition to providing quantitative information, the paper uses qualitative information to elucidate what Afghans think about family planning.

SECTION I: The Influence of Islam on Family Planning

It is simplistic to speak of a single culture in Afghanistan, where many ethnic groups live, but Afghanistan—whose official name is the Islamic Republic of Afghanistan—can be characterized as a traditional as well as Islamic state. According to the US Department of State, 99% of Afghans are Muslims (Sunni Muslims constitute 80% and Shi'a Muslims 19% of the total population of Afghanistan). Because "Islam is not merely the religion but it is also a social system, a culture and a civilization" (Omran 1992, p. 59), it is the cornerstone of daily life among Afghan people. Although Islam and family planning are often seen as incompatible, the success of family planning programs in several Islamic countries is evident (Boonstra 2001, Roudi-Fahimi 2002 and 2004, UNFPA, n.d.). Examples include Iran, whose successful national family planning program had the firm support of Islamic clergy, and Bangladesh and Indonesia, which have made extraordinary progress in reducing their total fertility rates over the past 40 years, with support from USAID.

The next section considers aspects of Islam—sectarian differences, and pro–family planning religious texts and leaders—that affected how the family planning program was introduced to Afghans and how they received it.

SECTARIAN DIFFERENCES IN ACCEPTANCE OF FAMILY PLANNING

Tober et al. (2006, p. 53) observe the difference in acceptance of family planning between Shi'a believers (mostly the Hazara ethnic group)[1] and Sunni followers (who are members of most of the other ethnic groups in Afghanistan):

> According to health officials and health workers, though, Afghan refugees in Iran do not use these [family planning] services to the same degree or they reject them outright. The most common explanation for this among Iranian informants in the health sector is that "Shi'ism allows for a more flexible interpretation of the Qu'ran, incorporated with an emphasis on using individual reasoning when applying Islamic law to one's life." Sunnism, they argued, requires a more literal regarding of the Qu'ran and hadith (for Sunnis, the hadith is only from the teachings of the Prophet, not his successors as in Shi'ism). According to this argument, most Sunnis would disagree with many of the fatwas issued by Shi'a clergy if they are found to be too far from a literal reading of Islamic texts.

Sunni Afghan health professionals expressed similar views when we discussed Iran's successful family planning programs, which gained support from high-level religious leaders. While acknowledging Iran's success, they mentioned the concern that most Sunnis in Afghanistan (including themselves) might be reluctant to accept fatwas issued by Shi'a clergy.

In contrast, the REACH Program and Accelerating Contraceptive Use projects found that in the communities where there was a demonstrated increase in CPR, *mullahs* (religious leaders) play a key role in advocating contraceptive use. In the three sites of the Accelerating Contraceptive Use Project, all 37 mullahs interviewed by project staff agreed to promote birth spacing after they had received accurate information about modern contraceptives (MSH 2007). In some cases, mullahs are serving as community health

[1] There are a minority of Hazaras who follow Sunni Islam.

workers and educating men about contraceptives. Community religious leaders are also taking actions that help expand contraceptive use.

ISLAM'S POSITIVE INFLUENCE ON FAMILY PLANNING

Islam per se is not incompatible with family planning. Visiting Afghan communities, one finds that many people, both men and women, are aware of Islamic verses on lactational amenorrhea, about which the Qur'an says:

> "And mothers shall suckle their children two full years for those who wish to complete breast-feeding."
>
> —al-Baqara (Sura 2: 233)

> "And his weaning is in two years."
>
> —Luqman (Sura: 31:14)

> "His bearing and weaning is thirty months."
>
> —al-Ahqaf (Sura 46:15)

Ibn Sina and the International Centre for Reproductive Health (2002, p. 33) mention that "in Islam the use of contraception is accepted for 'spacing' of pregnancies, but not for 'planning' the number of pregnancies and children." This is a common idea among Afghans, many of whom regard children as gifts of God (thus not to be planned). However, many people are not aware of the fatwa issued by the Grand Imam of Al-Azhar, Sheikh Jadel Haq Ali Jade Haq, in 1983, which states that "A thorough review of the Qur'an reveals no text prohibiting the prevention of pregnancy or diminution of the number of children" (quoted in Omran 1992, p. 6).

Because Islam is the foundation of Afghans' lives, the Accelerating Contraceptive Use Project (MSH 2006a, 2006b) crafted messages to promote birth spacing, based on scientific evidence of the benefits of birth spacing, using Qur'anic verses that justify birth spacing. Likewise, in communities in Afghanistan, the sensitive introduction of family planning for birth spacing to protect the health of mothers and children is more acceptable than emphasizing planning for a smaller family that will have a better future economically.

In Sections I–III, we examine attitudes and behaviors at three levels of Afghan society: household, community, and health facility. Understanding the sociocultural dimension of family planning illuminates the factors that influence the contraceptive decisions of Afghans.

SECTION II: The Introduction of Family Planning to Afghan Communities: The Household Level

THE SOCIAL ORDER AND THE LOW STATUS OF WOMEN

Who influences a couple to make a contraceptive decision in a rural Afghan household? Understanding the social structure of Afghan households and the low status of women in them is essential to answer this question. Boesen (2004, pp. 8–9) summarizes the patrilineal nature of rural Afghan society:

> Although the situation of Afghan women may vary according to different ethnic groups and social and practical contexts, it is similar in essential aspects. The extended family, lineage or sub-lineage (khaum) [*qaum*] play a central role in the traditional Afghan social order, which is based on the principle of kinship relations. The patrilineal family is thus to a large extent the focal point and the main framework of personal and social identity to its members. Marriage and marriage alliances between related or non-related lineages or sub-lineages are a basic element of social structure and strategies of alliance, especially among tribal groups.
>
> In this order, which is predominantly organised on the basis of male blood-relations, women—and the children that they bear in marriage—are construed as being part of the property and patrimony of the extended household.

A bride becomes the "property" of the family into which she marries, and her decision-making power in the household is extremely low. Reproductive decision-making among couples reflects this power imbalance between husbands and wives, as illustrated by the statements of Afghans:

> "In Afghanistan more right belongs to men, and a women's idea isn't important, and the man likes [a] large number of children."
>
> —A 30-year old woman (Sahni 2003, p. 3)

> "If a husband lets her, it is her right, otherwise she cannot."
>
> —A community man (MSI 2004, p. 6)

> "I am compelled to have more children because, if I don't have more, my husband will take another wife. When it comes to family planning decisions, the right to decide lies with my husband; he must be informed and he must be satisfied."
>
> —A 25-year-old woman (Sahni 2003, p. 6)

When a couple cannot have children, the wife is often blamed and faces the possibility that her husband will take another wife unless she produces many children, especially sons. Nonetheless, we did encounter mothers-in-law and members of community health committees[2] in Afghan villages who support women who choose to use birth spacing:

> "I encourage my daughter-in-law to use contraceptive pills. I myself had too many children and I do not want her to repeat the same."
>
> —A mother-in-law in Herat (notes from field visit, 2005)

[2] REACH encouraged its NGO implementing partners to establish community health committees (shura-e-sehi) at health posts and health facilities to support health activities at each level. The members include people who are respected in the community and have decision-making power. Traditionally those committees have been composed of male members. REACH encouraged NGOs to involve women in these meetings (Sato 2006).

> "*Shura* [community health committee] members support the CHWs when they have difficulties. If mothers-in-law won't accept the use of family planning methods by their sons and daughters-in law, shura members go to talk to them."
>
> —A female shura member in Ghazni (Sato 2006, p. 7)

When it comes to decision-making about family planning, husbands dominate their wives. Yet husbands are also strongly constrained by the pressure of traditions (Altai 2004, p. 34). Furthermore, many women who are disadvantaged by lack of power either accept their situation or do not find it unfair. Ibn Sina and the International Centre for Reproductive Health reported that 75.5% of the women agree with the statement "It is a wife's duty to have sex with her husband, even if she does not want to" and 56.6% agree with the idea "A husband has the right to beat his wife if she disobeys him" (2002, p. 9).

LITERACY SKILLS TO INCREASE WOMEN'S POWER TO NEGOTIATE CONTRACEPTIVE USE

REACH implemented Learning for Life (LfL), a health-focused, accelerated adult literacy initiative. One of LfL's activities, entitled Communicating with Family about Birth Spacing and Family Planning, aimed to build women's skills in dealing with common complaints and pressures from the family and society. Many LfL students found this activity helpful in bringing up birth spacing and getting the point across to their husbands and mothers-in-law.

Women's empowerment is critical for them to negotiate birth spacing with their spouses. Until a woman has the capacity to do so, she may choose to use a contraceptive method without the knowledge of her husband. Tober et al. (2006, p. 62) report in their study among Afghan refugees in Isfahan, Iran, that approximately half the Hazara women who had four or five children used Depo-Provera injections, a method not easily detected by their husbands. Among REACH provinces in Afghanistan, the most commonly used contraceptive is oral contraceptives, followed by injectable contraceptives (Ameli et al. 2006).[3] As more women have access to injectables, it is likely that they will become the most common contraceptive method, as was the case in two of the three Accelerating Contraceptive Use Project areas (MSH 2007, p. 3).

SON PREFERENCE: AN OBSTACLE TO FAMILY PLANNING

Son preference is another significant factor that influences contraceptive decisions in Afghanistan. Marie Stopes International (MSI 2004, p. 4) explains son preference as follows:

> Traditionally, sons stay in the family home when they get married, whereas daughters go to live in the home of their in-laws. The research shows that sons are regarded as important and should ideally outnumber daughters, as they will be the ones who will earn and support the family.

The same report mentions that more women than men reported that sons are important, suggesting that wives may feel pressure to bear male children for a better economic future because if a woman's spouse dies, she will be dependent on the son.

A married woman is likely to be under constant pressure from her husband and in-laws to deliver a son. Regardless of educational

[3] The National Risk and Vulnerability Assessment (2005, p. 17) also reports that among women up to 49 years of age who said they were using any methods to avoid pregnancy, 44% use the pill, 37% use injectables, and 8% use condoms. We do not know the number of women among injectable contraceptive users who use the method without their husbands' knowledge.

background or social status, son preference is deeply ingrained in Afghan society. I observed a compelling example of this situation, a female Afghan professional who used birth spacing but continued getting pregnant until she had a son as her sixth child.

A bride who does not bring a son into the family receives negative attention from family members as well as from the community, as Altai (2004, p. 17) explains:

> If a woman doesn't bear enough children, especially sons, she will feel "shame," not only in front of her in-laws but also in front of the whole community. There is also this fear that her in-laws will be tough on her, that her life will become hard and that she will go through depression.

For these reasons, a husband's approval of family planning often depends on one or two sons being born. The findings of Ibn Sina and the International Centre for Reproductive Health (2002, p. 32) illustrate son preference, because the mean age of the users of any family planning method was 32.7 years, while their mean age at marriage was 17.2 years. Quotations from two married women illustrate their husbands' wishes to delay the use of family planning until the birth of a son (MSI 2004, p. 5):

> "He [the husband] says I must not use family planning until having a son."
>
> —A current user of family planning

> "He [the husband] doesn't want more children and tells me after giving birth to a son we will stop producing."
>
> —A young woman

DIFFERENCES AMONG ETHNIC GROUPS IN ACCEPTING FAMILY PLANNING

Tober et al. (2006, p. 63), in their research on family planning acceptance among Afghan refugees in Isfahan, Iran, indicated that there are differences in accepting family planning among different ethic groups:

> Interestingly, though, Afghans from other ethnic groups [than Pashtun] (e.g., Hazara, Tajik, and Parsi) voiced a higher degree of acceptance to using contraception, regardless of whether they identified as Shi'a or Sunni or lived in urban or rural locations. Thus, cultural and situational differences between various Afghan groups influence reproductive behavior. Among the Pashtuns, these cultural differences are expressed through the language of religion and cultural identity.

The same study states that Pashtun refugees in Iran have more reservations about using family planning than other ethnic groups. The national reproductive health surveys conducted in 2003 and 2005 support this point: "Hazara and Tajik women had the highest rates of use overall" (Richter et al. 2004, p. 15, Ministry of Public Health and PSI 2005, p. 8). Table 2 summarizes demographic information from nearly 7,000 users of family planning.

What religious and cultural factors might preclude some Pashtuns from using contraceptives? A possible answer is the Pashtuns' adherence to the Pashtunwali, the pre-Islamic code of honor of the Pashtun that is essential to their identity. As Kakar puts it, "[t]here is no distinction between practicing *Pashtunwali* and being Pashtun" (Kakar 2004, p. 2). The section on *purdah* (the physical separation of men and women)[4] and *namus* (honor) of the Pashtunwali defines social boundaries for men and women.

While these boundaries apply to both men and women, purdah is considered the "defense of the honor of women" (Dupree 1978, p. 126,

[4] Purdah is also observed among other ethnic groups.

Table 2. Users of a Modern Birth Spacing Method by Demographic Characteristics, 2003

Percentage	*Males (N=3,472)*	*Females (N= 3,443)*	*Total (N= 6,915)*
Total	15.3	21.9	18.6
	Residence		
Urban	26.7	33.9	30.3
Rural	10.2	16.2	13.2
	Ethnic Group		
Pashtun	11.2	14.9	13.0
Tajik	19.0	27.3	23.2
Hazara	22.1	27.2	24.8
Uzbek	6.3	10.5	8.4
Other	9.0	15.8	12.3

Source: Richter et al. 2004, p. 16

quoted in Kakar 2004, p. 4). Where purdah is strictly followed, it prevents women from leaving their homes, severely limiting their access to education and health care, including family planning services. Pashtun individuals who are strong adherents of the Pashtunwali may also have difficulty following the interpretation of Islam that favors family planning, particularly if it was developed by a Shi'a group in Iran.[5]

[5] The majority of the Pashtuns are Sunni Muslims. There are two subtribes of Pashtuns who are Shi'a Muslims.

By the end of the REACH Program, community health workers (CHWs) were providing 2.5 times as many family planning services as health facilities: CHWs performed 71% of all family planning visits in the REACH provinces between April 2004 and March 2006. These data show that CHWs were indeed the key actors in promoting contraceptive use in Afghan communities. This section looks at the roles of CHWs and community health committees and at views of family planning at the community level.

COMMUNITY HEALTH WORKERS

NGO service providers introduced family planning to REACH-supported communities as one of the components of the Basic Package of Health Services. By the end of the project, 6,300 CHWs, 53% of whom were female, had been trained (USAID and MSH 2006). Community leaders selected CHWs based on criteria set forth by the Ministry of Health (2003a):

1. The CHW must be a full-time resident of the community he or she will serve.
2. The CHW should be able to serve a population of 100 to 150 families.
3. The CHW must be prepared to provide services to all members of the community without exception.
4. Basic literacy is advantageous, but is not mandatory for the CHW.

Although literacy was frequently a criterion for selecting male CHWs, it was very difficult to find literate women in rural Afghanistan. Male CHWs included schoolteachers and mullahs who held leadership positions in the community. Female CHWs were often the wives of male CHWs or traditional birth attendants (*daiyas*). Predictably, male CHWs promoted family planning to male community leaders and men in general, while female CHWs provided health education and contraceptives to females.

Provision of injectables by CHWs. Among REACH provinces, injectables were the second most used method of contraception. Injectables did not become the preferred method because Depo-Provera injections were available only at health facilities under the original Basic Package of Health Services (Ministry of Health 2003a, p. 27). In 2005, the Basic Package and the job description of CHWs were revised so that CHWs could administer follow-up injections of Depo-Provera (MOPH 2005, pp. 5, 64); however, reluctance among clinic staff prevented CHWs from having Depo-Provera in their kits.

The Accelerating Contraceptive Use Project piloted the administration of the first Depo-Provera injections by CHWs. The result showed that female CHWs can manage the screening, counseling, and administration of injectables to female clients. The Ministry of Public Health quickly responded to this encouraging finding and is in the process of changing its policy to authorize CHWs to administer injectable contraceptives.

COMMUNITY HEALTH COMMITTEES

After recruiting CHWs, REACH NGO grantees established or reorganized community health committees (shura-e-sehi), whose role included supporting the CHWs in their day-to-day work. REACH promoted the participation of women in these committees by setting a standard that one-third of the community health committee members must be women so that female CHWs would also have a support group.

Quotations from a few CHWs and shura members show how effective this support can be:[6]

"We feel strong and comfortable talking on any issues, including family planning, because the shura is supporting us."
—A male CHW in Herat

"Shura members ask different types of questions in the meetings, such as why some children are not vaccinated, are there any pregnant women with danger signs, why tetanus toxoid [vaccination] is not increasing, the number of clients referred to facilities, why family planning users are not increasing, etc."
—A male CHW in Kabul

"We are in charge; it's our job to supervise or oversee the work of the CHW. If a CHW faces a problem in visiting a particular house, for example, if the family doesn't want to talk to the CHW about family planning, the CHW can come to consult me about this issue and I go to talk to the head of the household."
—A male shura member in Herat

"One hand does not make a sound. When we support our CHW, it is like having one more hand, which makes a sound. We have learned how CHWs can help us and this is our responsibility to show to others that they are not alone and we are supporting them."
—A male shura member in Kabul

Due to the lack of literate females in rural Afghanistan, relatively young unmarried women who were still attending school were often selected to be CHWs because they were literate. It was a challenge, however, for these young women and awkward for their clients to discuss contraceptive use, since these CHWs were not married and were often younger than the clients. Community health committee members were quite effective in this situation; often a CHW and a shura member jointly delivered messages to the client, combining the CHW's knowledge with the shura member's seniority and credibility in the community.

Most male shura members are community leaders. There are, for example, shura members who are mullahs and promote family planning among male community members during or after Friday prayers. Mullah members represent a minority of the shura members, but as community leaders they play an essential role in promoting health activities, including use of contraceptives, in their communities.

ISLAM AND FAMILY PLANNING IN AFGHAN COMMUNITIES

Although there was concern among staff members of REACH, NGOs, and the Ministry of Public Health that promoting family planning might have negative repercussions, this concern turned out to be unfounded (MSI 2004, MSH 2007, USAID and MSH 2006). MSI conducted focus group discussions with family planning users, other users of reproductive health services, young and old women, and men and community leaders in rural and urban locations in four provinces (Kabul, Kapisa, Bamyan, and Badakhshan). In these discussions, economic and health benefits outweighed religious concerns about the use of contraceptives. When religion was mentioned in relation to family planning, people expressed the following views (MSI 2004, p. 5):

- Islam permits family planning on the grounds that it furthers the common good.
- Islam does not technically allow family planning, but if a family is very poor and unable to support more children, the use of family planning is justified.

[6] These quotations come from Huber et al. (2004), Sayeed (2006), Sato (2006), and MSH (2005d).

Three individuals' statements illustrate religious arguments justifying contraception:

"Neither elders nor the Koran says that using them [contraceptives] is a sin against God."
—A community man (MSI 2004, p. 5)

"I don't think that religion forbids it [family planning]; people can decide whether they want to use it or not."
—A male community leader (MSI 2004, p. 5)

"Islam has no objection to birth spacing. It has been advised by Muhammad and mothers have been told that they should breastfeed their children for 30 months."
—A mullah from Kabul (MSH 2005b)

The survey by Ibn Sina and the International Centre for Reproductive Health (2002, pp. 33–34) is limited to a sample of married women in Kabul but provides information about women's reasons for not using contraceptives. It reported that among married women who are not pregnant and do know about family planning the most important reason for not using contraception was their unwillingness to limit the number of pregnancies. Furthermore, no one in this group (92 women) mentioned religion as a barrier to family planning.

In the MSI study, only a small minority disapproved of family planning (the number is not given), citing the belief that it is a sin to decrease the number of followers of Islam. The following quotation reveals one respondent's strong view that Islam is against family planning:

"I can tell you strongly that Islam doesn't let people use them [contraceptives] because our prophet says to increase Islam's followers and on the judgment day our prophet will be proud of his obedient followers. So when I tell my wife that she has to have more kids, she is left with no choice."
—A man, 32, Kabul (Sahni 2003, p. 8)

MISCONCEPTIONS ABOUT FAMILY PLANNING

Factors preventing people from using contraceptives that emerged in studies conducted during the Accelerating Contraceptive Use Project included wanting to have as many as children or sons as possible for security, difficulty in negotiating with husbands and mothers-in-law, and misinformation about contraceptives, rather than religion. Huber (2004) conducted a survey on misconceptions about family planning among 20 trainers of CHWs. The trainers were asked to list rumors, misconceptions, and obstacles to family planning.[7] Ten of 53 responses indicated the belief that "pills cause mental disease," 4 mentioned the belief that "pills can cause infertility," and 3 mentioned that "injections can cause increased or decreased bleeding." Similar findings are documented in other studies:

"My mother-in-law tells me if I use family planning it will make me sick and cause severe bleeding and death."
—A current female user of family planning services (MSI 2004, p. 7)

"Most people believe that taking the pill causes bad effects, even death."
—A community man (MSI 2004, p. 7)

"The pill makes women crazy. They lose their patience and start behaving badly toward their family. They should not use this method."
—A member of the Ministry of Religious Affairs (MSH 2005b)

[7] Participants could list multiple rumors or misconceptions about or obstacles to family planning.

SECTION IV: The Health Facility Level

Both the results from the focus group discussions by MSI (2004, p. 7) and the findings of REACH (MSH 2005a) indicate that people tended to take doctors' advice into account in making contraceptive decisions:

> "My husband says the doctor is right."
> —A current female user of family planning

> "I told him [my husband] that the doctors are advising fewer children; thus he agreed and said 'the doctors are right.'"
> —A current female user of family planning

This section considers perceptions of family planning among health professionals and suggestions to increase uptake of family planning services at health facilities.

TRAINING FOR DOCTORS, NURSES, AND MIDWIVES ON WOMEN'S FAMILY PLANNING NEEDS

Misconceptions about family planning and misunderstandings about contraceptives are found among Afghan medical professionals as well as clients. Especially during the war and later conflict, medical students faced challenges in obtaining training of adequate quality. Furthermore, clinicians' opportunities to update themselves about recent findings and technologies have been very limited during the past two decades.

It has also been observed that medical professionals have an authoritarian attitude toward clients. Sometimes they provide contraceptives without much counseling or explanation of potential side effects. Changing providers' behavior would enhance the acceptance and continued use of contraceptives by Afghan clients.

To help change the beliefs and practices of practitioners, the Accelerating Contraceptive Use Project produced a simple and clear informational sheet, "Common Myths about Birth Spacing" (MSH 2005a), which covered common misunderstandings among health providers about contraceptives, birth spacing, and family planning, such as the following:

- Injectable contraceptives cause infertility and should be used only by women who have more than four to six children and are over 35 years of age.
- Injectable contraceptives decrease breast milk.
- Breastfeeding women should wait until they have menstrual bleeding before starting injectable contraceptives.
- IUDs should not be given to women who have had six or more pregnancies.
- Women who work hard should not use IUDs.
- Women who have never been pregnant should not use contraception.
- The minipill (progestin-only pill) can be used interchangeably with the standard pill (combined oral contraceptive).

INVOLVING MEN IN FAMILY PLANNING COUNSELING

Based on my observations, it is common in Afghan clinics for female medical staff to give family planning counseling to female clients, but less so for male providers to counsel men.

A female client is usually accompanied to the health facility by her husband or a male family member, who typically waits outside the clinic until she is ready to go home. For family planning counseling, the husband who is waiting for his wife could be invited in to receive counseling with her. Given the respect and authority that medical staff have and a bride's low status at home, counseling for couples will help female clients who want to start using contraception but lack the courage to talk to their husbands or whose husbands do not allow them to use contraceptives.

For couples counseling to take place, medical staff need accurate information and counseling skills; a private space must be available to accommodate couples;[8] and couples need to be comfortable about receiving counseling from a female provider and vice versa. The health facility staff must be creative in involving men in family planning counseling in a culturally appropriate way that is acceptable to the community. If it is difficult to provide counseling to couples, health facility staff could provide information on family planning and other health topics to men while they are waiting.

INTEGRATION OF FAMILY PLANNING WITH OTHER HEALTH SERVICES

Laumonier-Ickx (2006, p. 14) reported that only 12% of health facilities in the REACH program had an integrated health care delivery system (which includes family planning) in place. The REACH end-of-project household survey (Ameli et al. 2006, p. 21) also found that 69% of the women surveyed did not receive postnatal checkups. Of the 31% of women who did receive postnatal care, less than half (43%) of the women said that a family planning method had been offered to them during the postnatal consultation.

Now that NGOs have expanded health care services in rural areas, it is important to improve the quality of services so that clients can take advantage of integrated care at each visit. Offering family planning services should be considered not only during women's postnatal visits but also during immunization of infants and other opportunities when female clients visit health facilities.

[8] In Afghanistan, the female outpatient department is divided by a curtain so that women cannot be seen by men who are strangers to them. If the husband of a female patient wants to see a female practitioner, he needs to come through the curtain unless there is another entrance from the outside. If a male doctor is known to the community and the husband allows his wife to see him, it is possible for a male doctor to conduct couples counseling.

SECTION V: Key Elements in the Success of the Family Planning Program in Afghanistan

This section summarizes five factors that appear to be leading to a successful family planning program in Afghanistan:

- Establishing community-based health care services in which CHWs are active;
- Expanding access to services with support from community health committees;
- Integrating family planning components into basic health services;
- Providing focused technical assistance to NGOs to increase CPR;
- Working with both men and women using gender-sensitive approaches;
- Educating women and building their self-confidence and self-esteem through literacy training.

Establishing community-based health care services in which CHWs are active. Incorporating family planning into the package of health services and including contraceptives in the essential drug list laid the foundation for community-based provision of family planning. REACH grantees started establishing relationships with the communities where the Basic Package of Health Services was implemented. As trust grew, the communities selected CHWs (both male and female), who distributed family planning information and contraceptives in addition to providing other services and medicines.

Contraceptive education and distribution are only a part of the job of a CHW. Before offering contraceptives, CHWs should begin promoting hygiene and sanitation in the community. How clients receive CHWs and how CHWs provide information to clients affect the uptake of contraceptives. By the time CHWs are ready to provide counseling on birth spacing and distribute contraceptives, their presence should be visible and appreciated.

Expanding access to services with support from community health committees. Working with NGO grantees to establish or reorganize community health committees also helped CHWs make their services available to a wider population. MSH emphasized the importance of women's representation in the committees or, when it was more acceptable, helped establish a separate committee for women. Having support groups working with CHWs simultaneously strengthened community ownership of the health program.

MSH's approach of working within traditional social institutions such as the shura-e-sehi illustrates an understanding of the importance of grounding family planning interventions in the culture in order to promote change and foster sustainability. The members of shura-e-sehi who advocated for family planning were positive deviants. Selecting people who held leadership positions in the community accelerated program implementation because they were already role models and helped convince others to change their behavior.

Integrating family planning components into basic health services. Because family planning is part of the Ministry of Public Health's Basic Package of Health Services, family planning services are offered as an integral component of basic health services at all levels. Thus, in addition to increasing the number of contraceptive users, CHWs involved in the Accelerating Contraceptive Use Project increased

vaccine coverage among children. We also found that there are missed opportunities for family planning services, for example, offering counseling to mothers who bring newborn babies to health facilities for vaccination, which is not commonly done in rural Afghan clinics.

Providing focused technical assistance to NGOs to increase contraceptive use. The REACH team worked closely with NGO grantees to help them produce and analyze data and identify specific interventions to increase the CPR. For example, training in logistics management reduced contraceptive stock-outs, which supported the continuous provision of contraceptives. In addition, introduction of community mapping (see MSH 2007, p. 9) and recruitment of Community Health Supervisors, who are based in health facilities, helped improve the linkages between health facilities and communities, thus contributing to the expansion of contraceptive use in REACH communities.

Working with both men and women using gender-sensitive approaches. A balanced approach based on gender equality was essential to success in the family planning program. To make sure there were enough female health workers to respond to the needs of women and follow the Ministry of Public Health guideline that 50% of CHWs be women, each NGO grantee strove to select female CHWs even in communities where there were few literate women and security was a serious concern. Male community leaders gradually nominated community women to be CHWs. The Ministry policy and men's support in recruiting female CHWs were essential to the deployment of female CHWs in rural Afghanistan. It was more appropriate to have female CHWs talk to women than men and vice versa.

Bawah et al. (1999, p. 64) point out that gender-sensitive approaches to family planning are effective in traditional settings:

> Experience shows that innovations depending solely on the activities of Ministry of Health staff are more difficult to sustain than are those using traditional social institutions. Bureaucracies' resources are constrained. Ministry staff are detached from communities, and services lack social grounding. By contrast, *building gender-sensitive approaches to family planning within traditional social institutions fosters sustainable communication, social interaction, and behavioral change that cannot otherwise occur.* [my emphasis]

Educating women and building their confidence and self-esteem through literacy training. REACH implemented the Learning for Life initiative to create a pool of women and older girls in rural areas qualified for training as CHWs and community midwives. One curriculum covered four learning areas—language, health, math, and religion/social studies—and another curriculum comprised language, health, math, and communications and analytical skills. One of the exercises included communicating with family about birth spacing and family planning. After LfL classes, women became more confident as their skills and self-esteem rose. Those who gained communication skills noted those skills enabled them to bring up issues they needed to discuss with their husbands and they were able to communicate better with their husbands and in-laws.

Recommendations

MSH's experience in both the Hewlett Foundation–funded and USAID-funded activities in Afghanistan uncovered some false assumptions and produced recommendations about the development of appropriate services and messages, the best ways of working in communities and with NGOs, and the empowerment and education of women and girls.

Provide family planning services to help reduce maternal deaths where there are gaps in maternal health services. Providing high-quality family planning services through trained female CHWs and at health facilities can reduce maternal mortality in rural settings where the population has already shown a strong interest in family planning. Family planning services are as important as emergency obstetrical care and training of midwives in saving the lives of mothers.

Emphasize the health of mothers and children in family planning and birth spacing messages. REACH information, education, and communication materials and messages conveyed the viewpoint that a smaller family makes a better economic life for all. While this message is well accepted by many Afghans, traditional Afghan communities with no family planning services may accept the importance of maternal/child health more readily than the economic benefits of family planning. In this setting, the birth spacing aspect of family planning should be emphasized.

Do not assume that local NGOs understand or support community-based health care. While local NGOs usually have a better understanding of the people they serve than expatriates do, there are exceptions. For example, I observed one Afghan NGO that was distrusted by the community and put the project in jeopardy in that area. It is often said that within a 10-minute walk, one comes across communities with completely different cultures and traditions. NGOs that establish rapport and build trust with their communities are more likely to have successful family planning programs in Afghanistan regardless of the nationality of the organization and its staff.

Question unproven assumptions that narrow the potential for success. In the communities where we worked, the real barriers to contraceptive use were lack of understanding among clients, their family members, and providers about how contraceptives worked and misinterpretation of common non-harmful side effects, rather than sociocultural or religious factors. Those who implement family planning projects should not assume that family planning is a taboo subject even in the most traditional communities. They should start working with the community (both men and women) through community members and structures, and design activities that are feasible and acceptable to the community.

Allow time and conduct follow-up to change providers' behavior. One refresher training course or information sheet is not sufficient to change the clinical behavior or improve the counseling skills of health service providers, and many programs neglect follow-up. Monitoring and supervision are prerequisites for improved performance by providers who have received training and new information.

Put technical assistance for family planning in place from the beginning. While REACH technical assistance to NGO grantees was successful, many grantees regretted that

this assistance (such as REACH visits to low-performing NGOs) happened during the last year of the project. They would have benefited from having assistance throughout the project.

Encourage communication between husbands and wives about contraception and promote couples counseling using the media. A study in Nepal demonstrated that women exposed to a radio drama had significantly higher odds of believing that their spouses approved of family planning and of having discussed family planning with them (Sharan and Valente 2002). Radio programs intended to increase spousal communication may also have an impact in Afghanistan, given the large audience of radio listeners throughout the nation. The effectiveness and cultural acceptability of radio programs on birth spacing is yet to be studied in Afghanistan.

Collaborate with projects whose goal is to empower women. Empowering women through literacy education, training in interpersonal communication, participation in groups such as the shura, and income generation activities increases their self-confidence, which makes it easier for them to discuss birth spacing with their spouses. Integrating family planning components into existing women's empowerment projects or incorporating empowerment elements into family planning programs will increase contraceptive use.

Support CHWs in initiating the use of Depo-Provera. Once the new policy that authorizes CHWs to initiate the use of injectables is established, health facility staff need to be informed and trained to support CHWs in providing injectables. This support is as important as ensuring that CHWs have the supplies, knowledge, and counseling skills to administer Depo-Provera.

Integrate messages about the value of girls into family planning programs. In the successful family planning program in Iran, the equal value of boys and girls in Islam was integrated into family planning messages and clinical counseling (Tober 2006, p. 64). Indeed, the Qur'an's first verse exhorts learning: "Learning is a duty for every Muslim [male and female]" (Omran 1992, page 46). Islam also urges equality between males and females from their first day of life: "It is a woman's blessing to have a girl as her first child, for Allah says 'He bestows female children upon whom he will, and bestows male children upon whom he will'" (Sura 42:49 quoted in Omran, p. 49).

Communications underscoring the equal value of sons and daughters based on Islamic principles may enhance the reception of the message to value girls as well as encourage Afghan families to provide equal educational opportunities for boys and girls. Fostering girls' education, in turn, increases their likelihood of employment. This change will contribute to changing social norms by showing that women can support their parents by bringing income to the household.

Conclusion

Involving the people affected by development activities throughout the project cycle has been understood as a basic development principle for a long time, expressed in such phrases as "participatory approach," "bottom-up approach," and "putting people first." Most development practitioners understand this principle, but due to donors' requirements, limited time frames to achieve results, or insufficient funding, development agencies may not fully engage the people whom their activities affect.

Introduction of family planning into Afghanistan required dialogue with and understanding of the Afghan people and building of trust. While it was easy to infer the high unmet need for family planning among women of reproductive age, we had to explore the best approach for providing Afghan men and women with correct information on contraceptives to help them make their own decisions. To do so, we needed to understand their beliefs and others factors that influence their contraceptive choices.

In Afghanistan, while the large-scale REACH Program established the foundation for community-based health care and operationalized the Basic Package of Health Services in 13 provinces, the smaller Accelerating Contraceptive Use (ACU) Project reinforced the family planning component of services in three communities. Building on the foundation established by REACH, the ACU Project developed tools and approaches to address the gaps identified from extensive dialogue with the people. Combined with technical assistance from REACH, the family planning–focused interventions of the ACU Project that were developed in response to people's expressed needs enhanced the increase in CPR in the three project sites. This approach reminds us of the importance of being flexible in order to accommodate people's needs and of understanding not merely sociocultural factors but also the people we serve, which is possible only through meeting, listening to, and establishing trust with them.

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