

Final draft



National Family Planning/ Birth Spacing Strategy

2006 – 2009

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Reproductive Health Task Force
Ministry of Public Health
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List of Acronyms

BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
CHW	Community Health Workers
CPR	Contraceptive prevalence rate
CYP	Couple years protection
FP	Family Planning
HDI	Human Development Index
HIV/AIDS	Humana Immune- deficiency Virus/ Acquired Immune-deficiency Syndrome
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Population
IUD	Inter Uterine Device
LMIS	Logistic Management Information System
MCH	Maternal& Child Health
MMR	Maternal mortality ratio
MNH	Maternal Newborn Health
MoPH	Ministry of Public Health
MSH	Management Science for Health
NGOs	Non-Governmental Organization
PHDs	Provincial Health Directors
PID	Pelvic Inflammatory Disease
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RTIs	Reproductive tract Infections
STIs	Sexually Transmitted Infections
TFR	Total fertility Rate
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

Family Planning Definitions, Notes and Explanations

Contraceptive prevalence rate (CPR) is the percentage of woman in union aged 15-49 years currently using contraception¹.

Emergency Contraception refers to the prevention of pregnancy after unprotected sexual intercourse. Research over past 30 years has shown that emergency contraceptive pills (recommended doses of ordinary contraceptive pills) are safe and effective when used within 72 hours. As stated by WHO, "Emergency contraceptive pills do not interrupt pregnancy and thus are no form of abortion."

Sexually Transmitted Infections (STI) are treatable, many of these are undiagnosed and go untreated because of lack of accessible services. Untreated STIs are leading cause of infertility. There is **gender difference** in diagnosing and treatment of STIs. Women are at greater risk of infection than men, and screening is more difficult: 70 percent of women with STIs do not have symptoms compared to 10 percent as in men. Management of STIs could be an important opportunity in the provision of family planning services. Where equipment is not available to test for STIs, health workers use a "syndromic approach" to diagnosis, based on risk factors and client symptoms. But the approach has limitations, and infections often go undiagnosed and untreated.

Total fertility rate is the number of children that would be born per woman if she were to live to the end of her child bearing years and bear children at each age in accordance with prevailing age-specific fertility rate¹.

Unmet need refers to women and couples who do not want another birth within the next two years, or ever, but are not using a method of contraception. Unmet need result from growing demand, service delivery constraints, lack of support from communities and spouses, misinformation, financial costs and transportation restrictions.

Social marketing² is the planning and implementation of programs designed to bring about social change using concepts from commercial marketing.

Among the important marketing concepts are:

- The ultimate objective of marketing is to influence action;
- Action is undertaken whenever target audiences believe that the benefits they receive will be greater than the costs they incur;
- Programs to influence action will be more effective if they are based on an understanding of the target audience's own perceptions of the proposed exchange;
- Target audiences are seldom uniform in their perceptions and/or likely responses to marketing efforts and so should be partitioned into segments;
- Marketing efforts must incorporate all of the "4 Ps," i.e.:
 - Create an enticing "*Product*" (i.e., the package of benefits associated with the desired action);
 - Minimize the "*Price*" the target audience believes it must pay in the exchange;
 - Make the exchange and its opportunities available in "*Places*" that reach the audience and fit its lifestyles;
 - *Promote* the exchange opportunity with creativity and through channels and tactics that maximize desired responses;

¹ The State of World's Children 2005

² Social Marketing Institute, 2005

- Recommended behaviors always have competition which must be understood and addressed;
- The marketplace is constantly changing and so program effects must be regularly monitored and management must be prepared to rapidly alter strategies and tactics.

[suggest more]

1. Family Planning in the Context of ICPD

ICPD promotes **human rights** of every woman, man and child to enjoy a life of health and equal opportunity. In many parts of the world, extreme **poverty** subjects women and men to a lack of real choices, opportunities and the basic services needed to improve their situations. Women often suffer disproportionately, due to violence, discrimination and the burden of poor **reproductive health**, which is the leading cause of death and disability for women in their reproductive years.

Every minute, one woman dies during pregnancy and birth because she did not receive adequate care and prompt treatment. By increasing interventions for **safe motherhood**, we can save the lives of half a million women and seven million infants, and prevent millions of women from suffering from infections, injury and disability each year.

We must also step up efforts for **family planning**, which has a direct impact on maternal health. When couples can choose the number, timing and spacing of their children, they are better able to ensure there are enough resources for each family member to prosper and thrive. Worldwide, families are having half as many children today as they did in the 1960s, but fertility remains high in the poorest countries. Some 350 million couples still do not have access to a range of effective and affordable family planning services, and demand for these services is expected to increase by 40 per cent in the next 15 years.

1.1 Reproductive Rights

Attaining the goals of sustainable, equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the rights to:

- Reproductive and sexual health as a component of overall health, throughout the life cycle, for both men and women
- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

Defining Reproductive Rights

...reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

—ICPD Programme of Action, paragraph 7.3

2. Family Planning Situation in Afghanistan

The value of Human Development Index (HDI), the standard measuring progress in human development, for Afghanistan is 0.346³. This falls at the bottom of the list of low human development countries. The human development concept promotes people at the centre of development. Human development is measured by three of the most important basic and universal capabilities namely the ability to lead a long and healthy life, to have access to and make use of knowledge and to earn to a decent standard of living. Family planning, in fact, has strong impact in all three elements.

The estimated total fertility rate (TFR) is 6.25 per woman and the average population growth rate is 2.5 percent per year. At this rate Afghanistan will double its population in approximately 28 years. Maternal mortality ratio (MMR) in Afghanistan is very high and this has been discussed in the Maternal and Neonatal Health Strategy. Lack of information about and access to family planning services is one of the causes of high maternal mortality. Extreme weather also limits access of women to health services. For example, harsh winter limits women's ability to access services in the northern parts of the country; similarly, hot summer also limit access in the southern provinces.

In Afghanistan, contraceptive prevalence rate ranges from 2-12% in different provinces. Use of oral contraceptive and injectable was 10% and 2% respectively. Use of other method was negligible⁴. Information about trained family planning service providers is limited and level of competency is also not known. According to Afghanistan Reproductive Health Resources Assessment (2002), family planning services were available to 76% facilities that are covered by BPHS. Counselling services accounts 60% of all family planning services; and only at 29% facilities offered three family planning methods. Among those 29% facilities, only in 7% percent facilities women service providers provided all three methods. In the same survey it was found that only 12% pharmacies had condom. However, availability of condom was not even. For example, in some provinces none of the pharmacies had condom. On the other hand availability of condom was 40% in Herat. More than two-thirds of married women are not aware of any method to delay pregnancy. The awareness is greater in urban areas (45%) than in rural areas (22%). Of those who are aware, less than half are practicing some method of delaying pregnancy⁵. These statistics do not include the consistent use of methods. The age structure of Afghanistan is very young. Adolescents and youths that is age group of 10 to 21 comprise little more than 28 percent of total population³. Literacy rate and school enrolment rate of this age group is not available. However, in 2003 male literacy rate stood at 43.2 percent and female literacy rate at 14.1 percent, while only 8 percent of rural women are literate⁶.

Table 2: Selected Family Planning Related Indicators

Total fertility rate ⁷	6.6 per woman
CPR (modern method) ²	10 percent
Proportion of unmet need for FP ⁸	22.6 percent
CPR among married girls 15-19 years ²	3 percent
Knowledge about contraception among ever married women ²	28 percent
Desired number of children ⁹	4 per family

³ Afghanistan National Human Development Report 2004

⁴ Multiple Indicator Cluster Survey (MICS), Islamic State of Afghanistan and UNICEF, 2003

⁵ Multiple Indicator Cluster Survey (MICS), Islamic State of Afghanistan and UNICEF, 2003

⁶ Common Country Assessment for the Islamic Republic of Afghanistan, 2004

⁷ MICS Unicef 2003 and Best Estimates, Unicef 2005

⁸ PSI 2002

⁹ Strategic Family Planning Assessment, WHO 2005 (unpublished)

2.1 Family planning needs for special population

In this document special population refers to population living in un-served or underserved areas, Kuchi population, people living in geographical areas where access become difficult especially in winter, people that would be effected by natural disasters, internally displaced population (IDPs) and returnees. Up to end of 2005 twenty-three percent population was not covered through BPHS. The process has begun to introduce the services and it will take some time to cover all the un-served areas.

In the National Multisectoral Assessment of Kuchi the definition of Kuchi used as ‘A Kuchi is either migratory, or has settled recently due to loss of livestock during the last drought’¹⁰. In Afghanistan total number of Kuchi population is 2.4 million living in estimated 240,000 households. The long range migratory Kuchi are predominant (52%), followed by short-range migratory Kuchi (33%) and lastly the settled Kuchi (15%).

The Kuchi, the study mentioned, seems to have highest level of trust in the religious leaders and shrines. However, the traditional birth attendant, the private doctor and hospital are also used relatively often. Even though trust level are low. The health facility most used by men is the private doctors, followed by hospitals and the religious healer or shrine. Women also use private doctor most, but for women the traditional birth attendants are of equal importance. In response to willingness to work as health worker, both men and women showed great interest.

Between 1991 and 2002, in addition to the severe disruptions caused by political conflict, Afghanistan experienced nine significantly large natural disasters. Since the early 1980s, natural disasters in Afghanistan have killed an estimated 19,000 people and displaced 7.5 million people¹¹.

Afghans comprise the second largest number of refugees and IDPs in the world¹². At the beginning of 2002, there were approximately 6 million Afghan refugees. Since the fall of the Taliban, over 2.2 millions Afghans have returned. Yet an estimated 3.4 million Afghans remains outside the country. The IDPs were estimated at 1 million at the beginning of 2002. During the course of 2003 some 70,000 IDPs returned to their places of origin. Health care for these returnees and IDPs are from the existing service delivery sites. Due to many causes existing health care services are not appropriate and adequate for especial needs of these population.

2.2 Barriers to contraceptive use:

Globally many countries have been facing different barriers to contraceptive use. The eight barriers below are most common among those.

- Lack of accessible services, and shortage of equipment, commodities and personnel;
- Lack of method choice appropriate to the situation of the woman and her family;
- Lack of knowledge about safety, effectiveness and availability of choices;
- Poor client-provider interaction;
- Lack of community or spousal support;
- Misinformation and rumours;
- Side-effect for some, and insufficient follow-up or ensure proper use and dosage;
- Financial constraints

¹⁰ National Multisectoral Assessment on Kuchi, MRRD & WFP, May 2005

¹¹ Report on Natural Disaster, IFRC/RC, 2002

¹² Afghanistan National Human Development Report 2004, UNDP

In Afghanistan empirical evidences show that the above mentioned barriers exist profoundly in this country. In-depth analysis of knowledge, attitude, behaviour, and practices of communities might reveal many other causes.

3. Objectives of the Family planning/Birth Spacing Strategy

There are five specific objectives of the strategic framework of family planning¹³ programme.

Objective 1: Increase availability of high quality family planning by strengthening the capacity of providers to counsel, provide services and manage side effects and complications, especially for people in rural and hard-to-reach areas, and nomad populations

Objective 2: Improving the enabling environment for the provision of high quality family planning services

Objective 3: Promote involvement of males, religious and community leaders and communities to achieve higher demand for and use of family planning services by couples

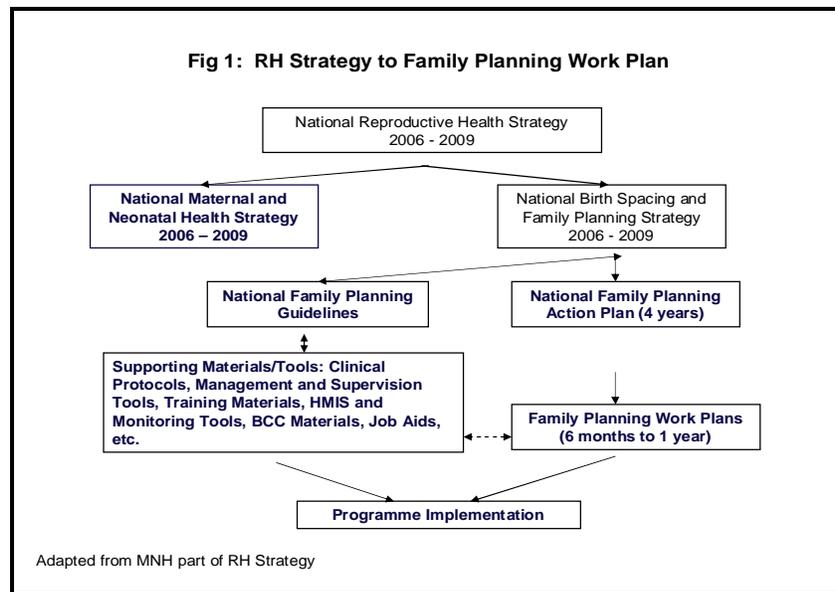
Objective 4: Strengthening behavioral change communication (BCC) to increase demand for and use of family planning, and social mobilization among different sectors and populations to support a rapid demographic transition

Objective 5: Expanding the variety of ways that couples can access family planning services both within and outside of the health sector

3.1 Strategic plan for programme implementation

It is imperative to do develop a plan based on strategic directions for programme implantation. Figure-1, which has been adapted from the MNH part of the strategy, describes the flow of actions leading to implementation of the family planning part of the strategy.

During this programme period it is necessary to review the existing guidelines, standards and guidelines, training curricula, different tools used for monitoring and supervision, different BCC materials and job-aids used in the programme. Then it should be decided what documents/tools need revision and what is needed to be developed. Emphasis should be given to complete the stock-taking at the beginning of programme implementation and incorporate all revisions and development of documents/tools in the four-year plan.



¹³ Adapted from the National Reproductive Health Strategy for Afghanistan 2003-2005

3.2 Operational Principles

Operational principles for family planning/Birth Spacing strategy include the following:

- Family planning service is an integral part of reproductive health services
- Though there will emphasis on some specific family planning activities, but this will not be developed as a vertical programme.
- For sustainable family planning demand creation a long-term social mobilization plan should be developed. For this activity political commitment, participation of different civil societies and professional bodies are essential.
- Community participation and support from the religious perspective also necessary.
- Long-term funding commitment especially for commodity security should be ensured.

4. Objective 1: Increase availability of high quality family planning by strengthening the capacity of providers to counsel, provide services and manage side effects and complications, especially for people in rural and hard-to-reach areas, and nomad populations

The Ministry of Public health (MoPH) will ensure women and men have access to quality family planning services.

4.1 Family planning services as part of BPHS

Family planning services should be available at all level as part of BPHS. MoPH and PHDs, in collaboration with BPHS implementing NGOs, should ensure that all the service delivery sites provide these services maintaining set standard. To provide these services level-appropriate training will be necessary to refresh service providers who received training long ago and now out of date, and skill development of service providers who are new to family planning services. Table -2 indicates availability of different methods at different level.

In Afghanistan CPR is low, no information about client satisfaction and discontinuation rate, information about knowledge of family planning methods is incomplete. Anecdotal information suggest that use of Injectable contraceptive is going up, there are IUD acceptors where IUD services are available. It also suggests that male sterilization is not an acceptable method however few cases have reported in the border areas with Iran and Pakistan. Female sterilization service is available in some specialized hospital. The national programme will ensure that each individual and couple gets adequate and correct information and choice of all methods. As demand for injectable contraceptive and IUD is increasing, the programme should ensure supplies of these methods to meet the growing demand. Quality IUD services could be as efficient as permanent methods. At the same time, sterilization services should be available from the specialized hospitals in the selected areas.

4.2 Family planning services from district, provincial and specialized hospitals: Family planning services should be available from every district, provincial and specialized hospitals that are dealing with maternal care. Family planning services should be strengthened at these facilities and should have linkages with the maternity ward of the hospital.

Table-2: Family Planning Methods at Different Service Delivery Level

	Condom	Pills	Injectable	IUD	Female sterilization	Male sterilization
Community level	✓	✓				
Health Post	✓	✓				
Basic Health Center	✓	✓	✓	✓		

Comprehensive Health Center	✓	✓	✓	✓		
District Hospital	✓	✓	✓	✓	✓	
Provincial/specialized Hospital	✓	✓	✓	✓	✓	✓

4.3 Emergency Contraception

Hormonal contraceptives for emergency contraception should be available for the national family planning programme. However, this should not be considered as a usual family planning method. Hormonal contraceptives for emergency contraception will be available from Basic health Centre. The service providers should be trained on this method adequately and supplies should be ensured.

Recommended actions (4.1-4.3):

- Ensure family planning services are available as recommended in BPHS
- Database should be developed indicating availability of skilled service providers at the site level. This will help the NGOs, PHDs and MoPH in developing training plan, facilitating training and monitoring.
- Ensure required logistics especially stock-out of contraceptives at the site level.
- Develop a plan of action for reduction of unmet need
- Train service providers on emergency contraception. Those who have already received training on family planning, using alternative methodology to train them on emergency contraception.
- Ensure supply of emergency contraception.

4.4 Family Planning Services Through Private Physicians/Clinics

Good number of people visits private physicians and clinics. Many of them are family planning clients and potential clients. It would be a good strategy to involve private physicians and clinics in family planning service delivery. MoPH in collaboration with NGOs implementing BPHS identify private physicians and clinics who will be interested in providing family planning services in different geographical locations. Then these physicians will get training on service delivery and logistics supplies. MoPH and NGOs will conduct supportive supervision to those physicians.

Recommended actions:

- Develop a concept note for a demonstration project
- Mobilize fund for the activity
- MoPH take leadership in facilitating implementation of the activity

5. Objective 2: Improving the enabling environment for the provision of high quality family planning services

5.1 Quality of care

The ICPD Programme of Action recognized that in addition to making reproductive health services universal, “family planning programmes must make significant efforts to improve quality of care” (para.7.23). The aim should be to “ensure informed choices and make available a full range of safe and effective methods” (para.7.12). The national programme should improve quality of family planning services in order to meet client satisfaction.

Recommended actions:

- Review existing standards, guidelines and tools etc. and update those documents.
- Develop, as necessary, additional service delivery and other guidelines.
- Increase effectiveness of functional supervision system throughout the programme.
- Ensure adequate supplies and equipment (mentioned in other place as well).

5.2 Human Resource Development

5.2.a Community Health Workers (CHW): Training situation and case load dilemma of CHW has been discussed in the Maternal and Neonatal part of the strategy. In the perspective of family planning interpersonal communication and community-based distribution CHW is and will play a vital role. Careful attention should be given so that CHWs gains skills in interpersonal communication and important messages about different methods including advantages and disadvantages. They should also be able to provide family planning supplies (pills, condoms and injectable contraceptives to the community.

5.2.b Service Providers at Facility Level: Community Midwives, Midwives and physicians are family planning service providers from the service delivery sites. All these service providers would be able to counsel clients on family planning and STIs including HIV/AIDS. Female service providers would also be able to provide IUD and injectable services. Permanent methods should be available from the selected sites. At least one service provider from each selected service delivery sites should be able to provide female and male sterilization.

5.2.c Long-term strategy: Pre-service education on family planning including STIs and HIV/AIDS should be provided in Community Midwifery, Midwifery and graduate medical education. The curricula of Community and Midwifery education will be kept up to date and a competency-based, participatory teaching methodology should be followed. For graduate medical education, MoPH should work with the Ministry of higher Education and ensure that these topics are appropriately included in medical curricula.

Recommended actions:

- Establish family planning training centre as part of developing national capacity. The national programme should develop family planning centers of excellence for training in Kabul and other major provinces.
- Compile and update, if necessary, family planning training curricula, get endorsed from MoPH and ensure that all the NGOs use approved curricula.
- In collaboration with the Ministry of High Education facilitate development of pre-service training curricula for graduate medical course.
- Coordinate with the Community Midwifery and Midwifery school authority for continuation of family planning training as part of overall training.

5.3 Commodity security

Family planning programmes are supply-based programmes. Their success relies on women and men having access to a continuous availability of contraceptives. Therefore, the major stakeholders and supporters of sustainable FP programmes are obliged to assure long term commitment for contraceptives and other RH supplies.

The varied strategies for implementing the BPHS programme result in health facilities with non-standardized supplies and contraceptives¹⁴. Facilities managed by USAID funding through MSH receive contraceptives sourced from the US, while other facilities receiving direct grants or supplies from NGOs receive contraceptives and medicines from Pakistan, Iran, China or from wherever supplies are at the lowest cost.

The warehouse system for drug and supplies management is a 30 year old manual “PUSH” system that appears to be still followed very closely. MoPH, neither at central level nor at regional level, have information of contraceptive procured, storage facilities and conditions, stock situation and future procurement plan. This may lead to stock-out and commodity crisis.

Family planning commodity management is part of Reproductive Health Commodity Management which include maternal and neonatal health, family planning, management of STIs, adolescents health etc.

Commodity management is based on four major components. Those are:

1. Increased capacity (Capacity Building) of the Ministry of Public Health (MoPH) so that it takes leadership role in management of RHCS.
2. Standardized procurement system in place.
3. Effective supply system is in place.
4. Monitoring and Evaluation system on RH Commodity Security is in place

5.3.a Capacity Building:

At present, the Directorate of Logistics has been managing commodities related to RH. The Family Planning Unit of MoPH has been engaged in managing contraceptive logistics. Several donors have been providing support for logistics procurement. Some of the donors are directly providing commodities to their respective programs run by NGOs. Several sub-systems have been developed by different stakeholders. Those sub-systems have been working as stand-alone systems. There are opportunities to coordinate among all the partners.

There is shortage of skilled staff both at the national and provincial level in managing commodities. There is need for finding required staff and train them. One standardized system should be in place and proper equipment would be made available to run the programme.

Recommended actions:

- **Develop a long-term national RHCS plan** through participatory process of different stakeholders.
- **Increase number of experienced staff in the Family Planning Unit, if necessary in the Directorate of Logistics and also at the Regional level.** The Country Office will identify the needs and facilitate this process. At present human resource capacity in terms of commodity management is very limited. For that reason staff members would be identified to work on RHCS at the Family Planning Unit and if necessary, at the Directorate of Logistics. Same time, efforts would be given to identify staff at the Regional level that will be responsible for RHCS management.

¹⁴ Reproductive Health Commodity Security Assessment in Afghanistan, Schuler-Repp J, August 2005

- **Identify persons who would be responsible for managing commodity security at the provincial level.** At the provincial level there is a need to identify persons who will be responsible for managing RH commodities. This need substantial negotiation with the Ministry and will be completed in first two quarters in year 2.
- **Skills development of staff members.** There is a need to develop skills of the identified staff members. This includes level- appropriate orientation and skill building. After training there is a need for follow-up of the trainees at their workplace. However, this activity will be covered in monitoring and supervision.
- **Introduction of LMIS.** Information about commodities is fragmented and not available at the MoPH. Different BPHS implementing partners have their own information; sometimes that information is also not adequate to take a decision. So, there is a need to develop a logistic management system.

5.3.b Procurement of commodities:

There is a national procurement policy; however, implementation of that policy is weak. There are several partners procuring RH commodities; there is a great need of coordination among the partners and MoPH would take lead role of coordination. There is no provision of quality check or control for RH commodities.

Recommended actions:

- **Strengthen role of Contraceptives Logistics Working Group.**
- **Develop Quality Control System for Family Planning Commodities.** Identify staff for quality control; develop protocols and guidelines on quality control. Provide appropriate training of the staff on this.
- **Procurement of commodities.** Required RH commodities will be procured through the project period in right time.

5.3.c Storage and supply of commodities:

Storage for commodities has been an issue. Central warehouse (Central Stock) has limited space than required; storage facility is also not up to the standard. There are limited or inadequate storage facilities at the regional level. There is no transportation system for the commodities in place.

Recommended actions:

- **Construct and or refurbish of warehouse.** Based on anecdotal information it can be said that there is a need for construction or extension of central warehouse and five more regional warehouses. Donors should be approached for mobilization of fund for this activity.
- **Develop transportation system for RH Commodity Security.** Over the strategic plan period a transportation system will be developed integrating other transportation mechanisms of MoPH.

5.3.d Supervision, Monitoring and Evaluation of Commodity Management:

A well defined monitoring and supervision system on RHCS should be in place. Different categories of staff, as appropriate, will be trained to carry out these activities. Major activities will include Develop protocols and checklists for supervision and monitoring, training of supervisors, conduction of supervisory visits and evaluation.

Recommended actions:

- Develop protocols and tools
- Provide training for the supervisors
- Evaluate the supervision system

6. Objective 3: Promote involvement of males, religious and community leaders and communities to achieve higher demand for and use of family planning services by couples

6.1 Male Involvement

Some of the most innovative work since the ICPD has aimed to involve men in protecting their partners' reproductive health as well as their own. Through their greater access to resources and power, men often determine the timing and conditions of sexual relations, family size and access to health care. Prior to the ICPD, the population field tended to focus almost exclusively on the fertility behaviour of women, paying little attention to men's roles in its study of the macro dimensions and implications of population growth and fertility rates. As a consequence, basic family planning programmes served women almost exclusively.

Research has long shown that men want to know more about reproductive health and want to support their partners more actively. Men's desire to limit their family size often makes it possible for women who want to use contraception to do so. Research on male attitudes and practices suggests that views of men and women on contraception and family size are much closer than many in the field once believed. Men generally want more and better information and access to services. Those aged 15-24 want fewer children than men 25-34, who in turn want fewer than men in their 50s.

Recommended actions:

- Focuses on men as obstacles to women's contraceptive use and as an untapped group of potential users themselves.
- Programmes emphasis should be given to provide men with sexual and reproductive health care. Programmes can improve men's access to family planning services by making existing services more receptive: welcoming men, both as clients and as supportive partners or fathers, retraining staff, providing information and services for men, and even altering clinic decoration.
- Focus on men as supportive partners of women and seeks opportunities to address the ways that social positions constrain the sexual and reproductive roles of women and men. Address inequitable gender norms that harm the health of both men and women. Work to educate men about the ways in which control over family resources, violence at home, or views of male or female sexuality, for example, can inhibit good reproductive health.
- Programme on Mobilizing Young Men to transform the values that underlie harmful behaviours. Encourage men to discuss their beliefs leads them to question harmful elements of traditional masculinity and that men welcome the opportunity to do things differently. Promote communication and respect between men and women on reproductive health issues.

7. Objective 4: Strengthening behavioral change communication (BCC) to increase demand for and use of family planning, and social mobilization among different sectors and populations to support a rapid demographic transition

7.1 Interpersonal communication and Counseling: The clients must get adequate and accurate information on different family Planning methods so that they can make informed decision. The information should be available at the community level and also at service delivery sites. All service delivery sites should have informational materials for the clients. Many clients are illiterate or less literate. So, informational materials should be made suitable for those groups of people.

Often individuals or couples need details about different family planning options, advantages and disadvantages of different methods, explanation on side-effects or complications etc. For these reasons counseling services should be available at least at the service delivery sites starting from Basic Health Center.

Recommended actions:

- CHWs should receive training to develop communication skills and service content areas;
- Communication materials should be available for the communities;
- Service providers at the clinic level should be trained on family planning counseling and use job-aids during counseling;
- Job-aids should be available to the service providers; and
- Periodical supervision should support the service providers in developing competency in interpersonal communication and family planning information.

7.2 Behavioral Change of Communication (BCC): Earlier it has been mentioned that awareness level on the reproductive health issues including family planning, STIs issues is very limited. A comprehensive approach for BCC activities is necessary to achieve goal for reduction of maternal mortality. There should be strong linkages in terms of approaches and interventions for BCC among all components of reproductive health. BCC activities of one RH component will complement others. The IEC Department of MoPH has drafted a communication strategy and has a plan to finalize the strategy as soon as possible. During finalization attention should be given so that BCC activities for reproductive health bring quick impact.

The following approaches will be considered to bring positive behavioral change of the target audiences.

- Information transmission or propagation aims at change the level of awareness;
- Reinforcement of information through instructions, explanations etc. for development or improvement of knowledge and skills, where applicable;
- Persuasion or influence to change norms and attitudes; and
- Create an enabling environment aims at changing awareness, knowledge, behaviour etc.

Recommended actions:

Though there are opportunities for harmonized BCC activities for all RH components, specific family planning BCC activities will include following:

- Conduct a national campaign focusing on family planning. A national medium-term plan should be developed for this national campaign. Careful attention should be given for opportunities to collaborate with other ministries and institutions.
- Develop national capacity both at the central and provincial level in developing and implementing BCC activities.
- Develop capacity of the media especially in radio, television and print media so that they themselves supplement BCC activities.
- Conduct advocacy as part of social mobilization for the policy makers, managers and senior officials working in different ministries, government offices, private organizations, teachers and other professional groups to raise support for family planning programme.
- Conduct advocacy with the religious and community leaders at different level to increase awareness about family planning and support the programme activities.
- Create awareness on family wellbeing to the school children as part of long-term strategy.

7.3 BCC Programme for Adolescents and Young couples: This is also part of over all BCC activities. However, this strategy underscores importance of delay the age of marriage especially for girls and addressing needs of family planning information and services for the young couples. The recommended actions overlap with the actions mentioned under BCC activities. But in addition to those activities, there is a need for advocacy with the political, religious and community leaders for reduction of early age at marriage. Several organizations have been working on this issue. There should be a strong coordination with those organizations/programmes.

8. Objective 5: Expanding the variety of ways that couples can access family planning services both within and outside of the health sector

8.1 Social Marketing

Social Marketing has been and will play a key role in increasing access to family planning commodities in Afghanistan. Their activities for family planning commodities in the private sector have been going on in Afghanistan for some time. The strategic plan for Social Marketing should be synchronized with the national strategy. A stronger coordination between the National Programme and Social Marketing should be developed.

Recommended actions:

- Develop working relationship with the organization working on social marketing and find areas of cooperation

8.2 Family Planning Services for Special Population

As mentioned earlier, special population here refers to Kuchis, IDPs and returnees, people living in hard to reach areas. Also, this refers to people become isolated for several months during winter and for the population that might be effected due to natural disaster. Reproductive health services including family planning should be available to them. However, due to social, political, and geographical conditions a special programme should be developed with the leadership of MoPH.

Recommended actions:

- A special programme should be developed in consultation with different stakeholders
- Financial resources should be mobilized
- Gradual implementation should be done under guidance of MoPH

8.3 Community Linkages

So far few initiatives have been taken to develop a strong linkage between community and service delivery sites. Health care providers are not used to collaborate and coordinate with communities for service improvement¹⁵. CHWs and TBAs appeared to be main link between communities and service delivery sites. Religious and community leaders, according to that study, have not been involved in support of family planning activities. Activities should be undertaken to develop a strong linkages between communities and the service delivery sites. This will increase number of new acceptors, increase continuation rate and service utilization rate for other RH conditions.

Recommended actions:

- Discuss with the stakeholders and provide emphasis on this intervention

8.4 Meeting unmet need

Available statistics show that unmet need for family planning in Afghanistan is approximately 23 percent. The national programme should give priority to reducing unmet need as a guiding principle in ensuring births by voluntary and informed choice.

In Afghanistan early age marriage rate is very high. Special efforts to be taken in creating awareness among young married couples on family planning, availability of family planning services and motivate them in utilizing services where needed. This effort will be supplementary to reduce early age marriages.

9. Prevention and Management of Sexually Transmitted Infections

The ICPD called for screening and treatment for STIs, along with information and counseling, to become 'integral components of all reproductive and sexual health services. The national reproductive health programme should include management of STIs as one of its important component. Integration of prevention and treatment of STIs within a package of reproductive health services would be the focus for addressing STI issue. The Reproductive Health Task Force should adapt the WHO Sexually Transmitted and Other Reproductive Tract Infections - A guide to essential practice.

Programme components include:

1. Community-based advocacy on the dangers of STIs and ways to prevent them
2. Early diagnosis and treatment (of clients and their partners)
3. Screening of pregnant women is an important aspect of antenatal care, as STIs can be dangerous for both mothers and newborns.
4. Making "youth-friendly" reproductive health information and services readily accessible to young people.
5. Condom promotion and distribution
6. Providing specific services for populations at risk - such as long-distance truck drivers, military personnel and prisoners etc.

10. Infertility

Inability to have children is a personal is a personal tragedy. Millions of couples around the world have been facing this harsh reality and their private agony is compounded by social stigma, which can have serious and far reaching consequences¹⁶. Unfortunately management outcome of infertility is not that promising. However, there are opportunities to prevent secondary infertility.

In Afghanistan information on infertility is virtually non-existent. Efforts should be given to assess the extent of the problem. As a resource constraint country the National Programme will be focusing

¹⁵ Strategic Family Planning Assessment, WHO 2005

¹⁶ Progress in Reproductive Health Research, Vol no. 63, 2003

prevention of secondary infertility and advocacy to reduce social stigma. Accordingly, focus should be given to RTIs that are not diagnosed or adequately treated and prevention of pelvic inflammatory disease (PID) as a consequence of improperly managed deliveries and postpartum care. .

11. Functional information system

Afghanistan is deficient in reliable data of all sectors. The last census took place in 1979, moreover that was not complete. Lack of national level health data causing difficulties in planning, measuring progress or impact of interventions. However, several small-scale surveys have been conducted.

A Health Management Information System (HMIS) is in place. Data are collected on a regular basis. However, there are opportunities to improve data collection process and analysis of those data further and use for decision making by the implementing NGOs, PHDs and at the central level.

Surveys and Research: Special efforts should be taken in this plan period so that operational researches are being conducted according to programme need. At the same time it is expected that several surveys will be conducted to gather more reliable data. MoPH should coordinate for collaboration in conducting surveys and operation researches; and also provide leadership in making use of findings of those efforts.

12. Supervision and Monitoring and Evaluation

Approximately 80 percent population has been covered through BPHS. Remaining 20 percent will be covered soon. At present the MoPH has been implementing BPHS in three provinces under their strengthening mechanism programme. NGOs have been providing BPHS in the remaining provinces.

Respective NGOs has their own supervision and monitoring system. In some occasion this supervision and monitoring sub-system has been developed under guidance of respective donor agencies. It is difficult to compare efficiency and effectiveness of supervision and monitoring system of different NGOs. So far, involvement of MoPH and PHDs is limited in carrying out supervision and monitoring activities. There is a need for developing a unified supervision and monitoring system for the national programme. At the same time MoPH should develop a guideline for evaluation of different activities. However, a list of selected indicators has been included as Annex-1.

Recommended actions¹⁷

- Finalise list of indicators and establish frequency of analysis and collection
- Design informative display options for indicators
- Use indicators to compare with standards, define gaps and allocate resources accordingly
- Combine data sources in HMIS
- Ensure that CHSs understand quality data and can do some basic data analysis
- Train HMIS staff in data analysis and data quality improvement
- Improve link with APhi and HMIS

¹⁷ Adopted from MNH part of the Strategy

Selected Indicators for measuring progress of Family Planning/Birth Spacing Programme

Sl. no	Indicator	Type/frequency of data collection	Definition	Numerator	Denominator	Level of data	Data collection method
1	Total Fertility Rate	Impact/ every 2-3 yrs	Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.	Total fertility rate is directly calculated as the sum of age-specific fertility rates, or five times the sum if data are given in five-year age groups		National	House Hold Survey
2	Contraceptive prevalence rate (CPR)	Output/ every 5 yrs	Proportion of women of reproductive age (15-49) who are using (or partner is using) a contraceptive method at a particular point in time	Number of married women of reproductive age (15-49) who are using (or partner is using) a contraceptive method at a particular point in time	Number of married women of reproductive age (15-49)	National	Contraceptive Prevalence Survey, House Hold Survey
3	Unmet demand for contraceptives	Output/ every 5 yrs	Proportion of women who would like to postpone childbearing but are not using a contraceptive	Number of women who would like to postpone childbearing but are not using a contraceptive	Total number of women who would like to postpone childbearing	National	HHS
4	Availability of modern contraceptives	Input/ yearly	Proportion of service delivery points offering at least 2 modern contraceptive methods	Number of service delivery points offering at least 2 modern method, by category or service delivery point	Total number of delivery points, by category	National, provincial	HFA, RRS
5	Couple years protection (CYP)	Outcome/ yearly	Estimate of the protection against pregnancy provided by family planning services during a period	Number units sold/distributed of each contraceptive	Factor to calculate CYP for each type of contraceptive	National, provincial	RRS

Sl. no	Indicator	Type/frequency of data collection	Definition	Numerator	Denominator	Level of data	Data collection method
			of one year, based on the volume of sales or distribution of contraceptives (free of charge to clients) during that year				
6	Knowledge about modern contraceptives	Output/ every 5 yrs	Proportion of women (married?) who can identify at least two forms of modern contraceptives	Number of (married?) women who can identify at least two forms of modern contraceptives	All (married?) women	National, provincial	HHS
7	Availability of trained health workers	Input/ quarterly, yearly	Proportion of facilities with trained health worker by BPHS components	Number of health facilities with trained health worker by BPHS components	Total number of health facilities	National, provincial, facility	HFA/RRS