# A Comprehensive
# Family Planning
## Needs Assessment in the Islamic Republic of Afghanistan
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FROM THE AMERICAN PEOPLE

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# ACRONYMS

AFGA ..... Afghan Family Guidance Association
ANDS ..... Afghanistan National Development Strategy
ASMO ..... Afghanistan Social Marketing Organization
BCC ..... Behaviour Change Communication
BHC ..... Basic Health Centre
BPHS ..... Basic Package of Health Services
CFPNA ..... Comprehensive Family Planning Needs Assessment
CHC ..... Comprehensive Health Centre
CHW ..... Community Health Worker
CMR ..... Child Mortality Rate
CPR ..... Contraceptive Prevalence Rate
CYP ..... Couple-Years of Protection
EPHS ..... Essential Package of Hospital Services
FHAG ..... Family Health Action Group
FP ..... Family Planning
GCMU ..... Grants and Contract Management Unit
GII ..... Gender Inequity Index
GIRoA ..... Government of the Islamic Republic of Afghanistan
HDI ..... Human Development Index
HMIS ..... Health Management Information System
HSC ..... Health Sub-Centre
ICPD ..... International Conference on Population and Development
IMR ..... Infant Mortality Rate
IEC ..... Information, Education, Communication
IUCD ..... Intrauterine Contraceptive Device
LAM ..... Lactational Amenorrhoea Method
LMIS ..... Logistics Management Information System
MDG ..... Millennium Development Goal
MMR ..... Maternal Mortality Ratio
MoPH ..... Ministry of Public Health
MSI ..... Marie Stopes International
NGO ..... Non-Government Organization

NRVA.....National Risk and Vulnerability Assessment
QA.....Quality Assurance
QI.....Quality Improvement
PHD.....Provincial Health Directorate
RH.....Reproductive Health
RHC.....Reproductive Health Coordinator
RHCS.....Reproductive Health Commodity Security
RHD.....Reproductive Health Directorate
SBCC.....Social and Behaviour Change Communication
SEED.....Supply-Enabling Environment-Demand
STI.....Sexually Transmitted Infection
TFR.....Total Fertility Rate
THE.....Total Health Expenditure
UNFPA.....United Nations Population Fund
UNICEF.....United Nations Children's Fund
USAID.....United States Agency for International Development
WHO.....World Health Organization
YHDO.....Youth Health and Development Organization

# Map of Afghanistan

**Source: Afghanistan Mortality Survey 2010**

# EXECUTIVE SUMMARY

This report documents the results of the Comprehensive Family Planning Needs Assessment (CFPNA) in Afghanistan. The assessment was undertaken with technical support from UNFPA and financial support from USAID, and was guided by the Reproductive Health Directorate (RHD), Ministry of Public Health (MoPH), Government of Islamic Republic of Afghanistan (GIRoA).

The Human Development Index (HDI) of Afghanistan has improved over the years, but the country's position is still low (175th out of 187 in 2013) and poverty remains a major challenge. With a population of 27.5 million, Afghanistan has one of the highest rates of population growth in the world, with a total fertility rate of 5.1. Nearly half the population is below 15 years of age.

The GIRoA has made tremendous progress in establishing and monitoring a Basic Package of Health Services (BPHS); according to the National Risk and Vulnerability Assessment (NRVA) Report 2011/2012, 91.2 percent of the population had access to a health post and 86.9 percent to a public health clinic within two hours. An increase in the number and capacity of skilled health workers is key to this success. The private sector is also an important player in the delivery of health services, particularly in urban areas.

While there has been progress in fertility and family planning (FP) indicators, these services have a long way to go. The challenges are multifaceted, with health system gaps particularly in human resources (especially female providers), FP commodities, poor quality of FP services, cultural, economic and social factors contributing to underutilization, and inadequate demand due to informational gaps.

The CFPNA is based on the Supply-Enabling Environment-Demand (SEED) Programming Model developed by EngenderHealth. The sampled provinces are Bamiyan, Parwan, Takhar, Jawzjan, Kandahar, Paktia, Nangarhar and Farah, with Herat added at a later date as not enough facilities could be assessed in Farah. Kabul was included for comparison at the request of the Deputy Minister of Health. The private sector was assessed in five provinces: Kandahar, Nangarhar, Balkh, Herat and Kabul. The assessment was completed in May 2015, with delays due to weather and insecurity as well as the addition of Kabul and private sector.

The assessment was designed and led by international consultants and the field assessment was done by Youth Health and Development Organization (YHDO) in Kabul. The data collection methods included a literature review; key informant interviews; facility assessments; observations of counselling, Intrauterine Contraceptive Device (IUCD) insertion and administration of injectable contraceptives; client exit interviews; focus group discussions and case studies. The private sector assessment included all of the above except observations of skills in administering injectables and focus group discussions.

# Key findings

## Enabling environment

### Supportiveness of development policies and strategies towards FP

Political commitment to FP as a strategic development factor affects resource allocations to the programme.

#### *Reproductive health (RH) policies*

- The RH Strategy includes FP as a key element, with indicators for monitoring. Other related policies include FP under maternal health as part of the continuum of care but with no monitoring indicators. The RH Strategy does not restrict the use of contraceptives by adolescents, or the use of any method. It promotes a wide choice of methods.
- While the quality improvement process of the MoPH focuses on FP-related skills such as counselling and method-specific provision of services, monitoring is limited to postpartum IUCD.
- The RH Strategy mentions integration with child health, HIV/AIDS and STIs; however FP is not well integrated. The National HIV/AIDS Strategic Plan does not mention integration with FP services. Guidelines for prevention of mother-to-child transmission focus mainly on treatment and care, and do not include primary prevention amongst women of childbearing age, or prevention of pregnancy amongst women living with HIV where FP has a critical role to play.
- While the national guidelines on FP are comprehensive and efforts have been made to distribute them in facilities, availability and adherence to recommended practices is a concern.

### Stewardship

The MoPH FP Unit falls under the RHD and is impacted by structural issues affecting the RHD. These have an impact on its leadership role. In particular:

- Overseeing and guiding the overall provision of FP services in the public and private sector appears weak.
- The oversight and intelligence role seems appears to be weak or virtually non-existent.
- There is not much to report on the stewardship role of the Provincial Health Directorate (PHD) as full transfers of administrative power and fiscal transfers have not taken place. There appears to be no active promotion or active monitoring of FP by provincial officers.

### Other enabling elements

#### *Allocation of financial and other resources*

- Financial allocation to a programme is an indicator of government commitment towards that programme. In the case of FP, there is no budget line for commodities; while 16 percent of expenditures were for FP activities in 2013, these were fully funded by external sources. FP is not analysed separately under the RH sub-account analysis but 78.5 percent of the total health expenditure for RH is through households.
- Shortage of human resources is a concern.

### *Use of evidence for decision-making*

- Decision-making and development of strategies is not evidence-based. Aside from a study on the role of FP in reducing maternal mortality, not many studies have been undertaken to illustrate the development benefits of FP.

### *Advocacy*

- While efforts have been made to advocate with religious leaders, advocacy with parliamentarians and the adoption of multisectoral approaches has been limited.

### *Community engagement*

- Efforts are made to advocate with community leaders and religious leaders directly and through health *shuras* but the impact is not known.

### *Reproductive health commodity security*

- FP commodities are part of the essential drug list and are not subject to import taxes (except for social and commercial marketing), but commodity security remains a concern. There is no strategy in place for FP commodity security. The draft Reproductive Health Commodity Security Strategic Plan has not yet been approved. No national standards on logistics management exist, and there are issues related to procurement, warehousing, distribution, forecasting, and the Logistics Management Information System (LMIS).

### Conclusion

Positive policies exist and could have been converted to reality if the leadership had been more supportive and adequate financial resources allocated. The inadequacy of the government's financial support for promoting reproductive health and FP has implications for sustainability as donor support decreases. The commitment of political decision-makers across all sectors to manage Afghanistan's demographic growth and reap its potential dividend is not yet evident.

# Supply

## Availability

### *Service delivery modalities for provision of FP methods*

- Quantitative assessments (facility assessment and client exit interviews) and qualitative assessments (in-depth interviews and focus group discussions) showed that at least three FP methods were available in more than 90 percent of facilities in the nine provinces, Kabul and the private sector. Only 80 percent of Basic Health Centres (BHCs) provided IUCD insertion, perhaps related to availability of skilled providers. Tubal ligation facilities were available in less than 20 percent of district and provincial hospitals and in 66 percent of regional hospitals, perhaps related to availability of skilled providers.
- While the findings indicate availability, the stock-outs described under commodity security raise concerns as to whether commodities are available every day of the week.
- Distance and waiting time were identified as concerns by women in focus group discussions.
- Social marketing of contraceptives appears to be successful in the urban areas where these concerns operate.

- Although the assessment did not focus on referral systems, triangulation of information from facility assessments, client exit interviews and focus group discussions suggests that referral among BPHS facilities and between BPHS and Essential Package of Hospital Services (EPHS) facilities is not efficient.

### *Adequacy of facilities to provide quality services*

- Infrastructure: General cleanliness was found to be good. The major gaps identified were functioning toilets, examination tables and lack of a separate room for FP services. The latter was identified as a concern by women in focus group discussions.
- IUCD insertion kits were available in most facilities.
- The focus group discussions with Community Health Workers (CHWs) indicated that the majority of health posts lack basic furniture.
- Autoclave was found to be available in most facilities but was functional in very few, including district hospitals, due to availability of power/fuel. This is a major concern with regard to infection prevention.

### *Visibility of FP services, availability of client education material and national guidelines for FP*

- Visibility of FP services was low in BHCs and Comprehensive Health Centres (CHCs) compared to district hospitals, and lower still in Kabul and in private facilities.
- Client education materials were not available in all facilities. The situation was worse in Kabul and the private sector.
- National guidelines on FP were available in 60 percent of facilities but the proportion was significantly lower in Kabul and worst in private sector facilities.

### *Contraceptive commodity security*

- Storage conditions were not adequate in the major warehouses in Kabul. Stock-outs were reported in all facilities during the six months prior to the assessment, and were highest in BHCs and Health Sub-Centres (HSCs). Maximum stock-outs were for IUCDs in the nine provinces and in private facilities, and for condoms in Kabul. However, on the day of the visit to facilities, adequate stock was found in the pharmacy. Client exit interviews reported that clients got the supplies they wanted. The differences in findings could be due to the time period covered by the questions (client exit interviews covered the day of the visit).
- The inventory showed stocks of condoms, pills, injectables and IUCDs. Most products were nearing expiry (also found in warehouse visits) and discolouration of condoms, pills and IUCDs were noted as well as the crystallization of injectables. Recording errors were noted, with differences between registers and the actual count on the day of the assessment.
- While a stock and consumption system existed in most facilities, the practice of indenting varied between facilities and provinces (the MoPH guideline is three-monthly indents).
- The conditions of stores varied at different facility levels. Major gaps found related to availability of a functioning exhaust fan and thermometer to control humidity and temperature.

## Accessibility

- There is no discrimination in service provision and the national strategy supports universal access to FP services. However, the access of young people to FP information and services is an issue.
- Afghanistan has a high child marriage rate and a third of girls start to bear children by age 19. Contraceptive use in this group is low (8 percent). Focus group discussions with young people showed limited knowledge about contraceptives. The cultural bias towards having a child immediately after marriage is reinforced by the negative attitude of providers towards provision of contraception to young people.
- Geographical access is an issue in some areas. While there is no cost for services, transportation costs may be a barrier in accessing services.
- Information accessibility is a concern particularly for women and young people. Access to printed materials is limited. Even where these exist, low female literacy is a barrier to accessing information. Access to information through television and radio is limited.

## Acceptability

- Client satisfaction levels were found to be high, according to exit interviews and focus group discussions. However, clients may have poor understanding of their entitlements, which can lead to low expectations.
- The continuation rate is an indicator of acceptability, but the recording system does not allow clients to be easily tracked.
- The unavailability of separate rooms for FP services that affect privacy is a concern.

## Quality of services

### *Realization of clients' rights*

- Access to information and informed choice:
  - → Information accessibility is a concern.
  - → With regard to informed choice, there were gaps observed in terms of information provided, particularly with regard to rumours, side effects and method-specific advice for both new and continuing clients. Counselling scores in Kabul and the private sector were even lower than in the provinces.
- Access to safe services and safety of services:
  - → While access to most FP methods was not a major issue, infection prevention is a major concern due to lack of functioning autoclaves and waste disposal mechanisms. The scores for infection prevention were better in private facilities.
  - → Screening of new and follow-up clients for medical eligibility is a concern.
  - → Observations of IUCD insertion showed that skills in procedure and post-procedure were high, however there are concerns about pre-procedure skills such as screening for reproductive tract infections, ruling out abdominal tenderness and bimanual examination – critical steps in assuring medical eligibility for use of the method. The scores of private sector midwives were lower.
  - → Observations of CHWs providing injectables found many gaps in procedures and post-procedure tasks. Disposal of syringes and needles and other wastes is a concern as CHWs operate from home.

- ➔ These findings point to a lack of adherence to national standards and could be related to gaps in training.

- Dignity, comfort and expression of opinion:
  - ➔ Client satisfaction was found to be high though, as noted earlier, this might be due to client perceptions of limited entitlement and the resulting low expectations. Client satisfaction levels were low for the private sector.
  - ➔ Client feedback mechanisms have been instituted by MoPH but it is not known whether these are used to improve services.
- Continuity of care:
  - ➔ Records do not enable follow-up and recording of information on discontinuing clients. Through their home visits, CHWs should be in a position to follow up if they are trained to do so.

**Conclusion:** Despite the MoPH's efforts to ensure client rights through Quality Assurance (QA) mechanisms and monitoring of quality through the Balanced Score Card, many of the rights of clients are not realized.

### *Meeting the needs of providers*

- Facilitative supervision and management:
  - ➔ Interviews and focus group discussions with midwives and CHWs indicated that there is interaction between supervisors and supervisees; however the regularity and quality of the supervision is not known. The CHWs reported weekly interactions with supervisors but whether the supervision is supportive is not known.
  - ➔ While the system of reporting is fairly regular (particularly in Kabul), there is no system for analysing reports and providing feedback.
- Information, training and development:
  - ➔ The skills gaps found in counselling, IUCD insertion and administration of injectables indicate possible training gaps.
  - ➔ In-depth interviews and focus group discussions suggest the need for more training.
  - ➔ The quality of training provided by the national training centre was found to be good. There is no mechanism for trainee follow-up. The quality of training by regional training centres is not known.
  - ➔ The distribution of trained midwives is not equitable as the current system focuses on coverage but not on achieving a critical mass of midwives in particular areas.
  - ➔ There are concerns about the role of the training coordinator under RHD.
  - ➔ Lack of clarity in job descriptions and the roles and responsibilities of providers at various levels is another concern.
  - ➔ The quality of training of CHWs is not known.

### *Quality assurance/quality improvement mechanisms*

- The MoPH has established mechanisms for quality assurance and improvement which are being implemented systematically. A baseline survey currently underway will provide information on quality gaps.

### *Integration of FP with other services*

- Interviews with facility managers suggested that FP is well integrated with primary care and maternal health but that integration with child health services is not strong.
- At the policy and service levels, FP is not integrated with STI and HIV/AIDS services. While National FP Guidelines do mention screening for STIs and HIV, observations of counselling and IUCD insertion showed that the recommendation is not followed.

**Conclusion:** The key health system gaps identified relate to poor quality of services with regard to informed choice and access to all methods of contraception, lack of access of young married, stock-outs of contraceptive commodities and poor quality of commodities and lack of effective monitoring system for FP indicators.

## Demand

### Current perceptions about, and barriers to, FP

- The desired family size is as high as four even among young people and may contribute to continuing high fertility. The underlying reason could be lack of information about the advantages of a small family size.
- Knowledge of FP was found to be high among married women but there were gaps in knowledge among men, young men and young women.
- The preferred method was found to be injectables followed by pills. The preference for injectables was due to the long period of protection. Among men condoms were preferred. Though health service providers indicated that they promoted all methods, there appears to be a bias towards injectables, perhaps due to the longer period of protection. Demand for IUCD and sterilization is limited, as they are probably not actively promoted.
- A very positive finding is that the benefits of FP for maternal and child health and its economic benefits were known to various groups interviewed including community leaders.
- The main sources of information for women were CHWs and midwives and friends, and for men, CHWs, pharmacies, radio and television. For young people, the sources of information were CHWs, midwives, radio and television.
- The main source of contraception for women were health facilities and, for men, pharmacies.
- Focus group discussions among women indicated that mothers-in-law were the main decision-makers about contraceptive use, followed by husbands. Women's inability to visit the facilities on their own without permission from their husbands was identified as a barrier to accessing services. Long waiting hours, shortage of contraceptives, etc. were mentioned by some as reasons for not using FP services.
- Women, men and young people stated that the ideal age at marriage and first pregnancy should be above 18 years.
- School teachers stated that they would like to teach their students about FP and needed training in FP information, and that television and radio were the best channels for communicating messages to young people.
- Community leaders were supportive of FP and felt that the attitudes towards FP are more positive. They promoted FP through *shuras*.

### Elements of demand

#### *Strategy for Social and Behavioural Change Communication*

- A behaviour change communication (BCC) strategy for reproductive, maternal, newborn, child and adolescent health is being developed and includes FP. However it is not known whether it includes key elements such as the identification of target audiences, barriers, communication channels appropriate for various audiences and strategies for dealing with rumours.
- Strategies for male involvement have been identified in the National RH Strategy, but it is not known whether implementation is effective.
- Social marketing programmes run by the Afghanistan Social Marketing Organization (ASMO) and Marie Stopes International (MSI) are successful in urban areas but the rural penetration of such programmes is limited. Currently MoPH has no mechanism to continuously monitor responses to social marketing.

#### *Use of mass media approaches by FP programme*

- Radio and television were identified as sources of information on FP but an evaluation of the impact of mass media has not been carried out.
- A youth phone line established by MoPH is popular and receives many queries related to FP. It provides counselling and also advises young women on how to contact health facilities in their respective provinces.

#### *Community engagement and use of champions*

- Community engagement occurs through CHWs, health *shuras*, Family Health Action Groups (FHAGs) and through discussions between health facility managers and community leaders. It is not known whether FP is actively and regularly promoted through these channels.
- UNFPA and social marketing organizations have been supporting the involvement of religious leaders in FP in support of the strategic element of the National RH Strategy. These initiatives are implemented in collaboration with Ministry of Hajj and Religious Affairs. Few studies have been carried out to understand religious perspectives on FP and areas of misunderstanding.

#### *Use of peer educators*

- There is no strategy for utilizing peer educators for FP. The Deputy Ministry of Youth Affairs peer educators intended to promote adolescent sexual and reproductive health programmes in urban areas are not active due to lack of support.

## Monitoring

Indicators for monitoring the implementation of the RH strategy include Total Fertility Rate (TFR), adolescent fertility rate, crude birth rate, Contraceptive Prevalence Rate (CPR) and Couple-Years of Protection (CYP). However, among the service related indicators only CYP is monitored regularly and whilst it does give information on commodities distributed, it does not help ascertain the number of actual FP users. The number of new and continuing users is not available, nor is data on unmet need or wanted levels of fertility. The NRVA data provides information on access to facilities but it is difficult to assess whether the information is applicable to FP services.

The Balanced Score Card for reproductive, maternal, newborn and child health reported on facilities with FP commodities available (88 percent) and CYP (12 percent). The CYP estimates appear to be incorrect, perhaps due to the method of estimation.

## Conclusions from a human rights perspective

Policies and strategies articulate human rights principles, equity, gender-sensitivity and sociocultural dimensions. The Balanced Score Card for monitoring the BPHC includes six domains – client and community, human resources, physical capacity, quality of services, management and overall mission. Though not specific to FP, these domains cover all 10 areas of FP rights. Comparison of scores since the implementation of the Balanced Score Card indicates a decrease in client satisfaction index, worker satisfaction index and infrastructure, which have implications for FP from a rights perspective.

### FP effort index

USAID's FP effort index (focusing on inputs), last conducted in 2009 gave a total score to Afghanistan of 50.7 percent, with 56 percent for services, 53.4 percent for evaluation and 41.8 percent for access.

## Key recommendations

Afghanistan is a focus country under the FP 2020 partnership to support the right of women and girls to decide freely whether, when and how many children to have. Although MoPH officials were invited to the 2012 London Summit, the country did not make any commitments at the time. However, GIRoA has committed to the UNSG Global Strategy in 2010 to increase CPR to 50 percent. The MoPH leadership has constituted a Country Committee for FP 2020 with UNFPA and USAID as partners, and made a commitment which has been recognized by the Global Committee.

The CFPNA findings provide an opportunity to take stock of the implementation of the various policies and strategies and to make mid-course corrections. The early years of implementation of the SEHAT project provides another opportunity to use the findings and recommendations. The study may also contribute to developing a rights-based strategy for FP to help achieve developmental goals under the umbrella of FP 2020.

If it is to achieve its FP goals, it is necessary for Afghanistan to improve its enabling environment, strengthen supply, and create demand to reduce unmet need.

### Improving the enabling environment

#### Strengthening policy based on evidence

- Considering the importance of FP in socio-economic development and in reaping the demographic dividend, a rights-based FP strategy should be considered. The proposed strategy, while emphasising continuum of care, will focus on integration with STI and HIV services. It will focus on four areas: availability of equitable and quality FP services, demand creation, enhanced stewardship at all levels of administration and enabling environment for effective, equitable and sustainable FP programming and fostering and applying innovations and evidence for improving efficiency and effectiveness of programmes. The strategy should be costed. The

strategy document could be used for advocacy with national and international institutions to increase funding and to ensure a long-term future for the programme. The document should be developed under the leadership of the proposed FP 2020 country committee. The proposed strategy will cover most of the recommendations in the following sections.

- While efforts are required to delay the age at marriage, equal emphasis should be placed on delaying first pregnancy and developing specific strategies to provide FP to married adolescents.
- Review and revision of current indicators in national health and RH strategies should be undertaken to ensure key FP indicators are included.
- The draft Reproductive Health Commodity Strategy should be reviewed and revised. The procurement policy should be reviewed for quality assured procurement – this is a focus area under SEHAT. UNFPA, in its global role in quality assured procurement, should support the MoPH in building its capacity.
- Review of the HIV/AIDS and STI strategy should be undertaken to ensure FP services are provided in STI clinics and HIV/AIDS counselling and testing and care facilities. An investment of US$ 1 in FP could save up to US$ 25 in HIV/AIDS treatment and reduce the cost of prevention of mother-to-child transmission activities.

### Strengthening capacity for stewardship at all levels of administration

- The SEHAT project has a component on stewardship and efforts should be made to include FP. In the context of decentralization, the capacity of the PHDs for stewardship should be enhanced. Leadership capacity within the RHD, as well as the capacity to effectively plan, coordinate and communicate FP and RH programmes should be strengthened.
- The RHD is under-resourced and should be reviewed in terms of the adequacy of its human and financial resources.
- The RHD's oversight mechanism should be strengthened through the establishment of a central database for national data on FP and other RH services, closely linked to the Health Management Information System (HMIS) Department. Indicators should be reviewed and revised to include key indicators, disaggregated by age. FP 2020 has identified several core indicators which should be considered. In addition, indicators for tracking the implementation of policy reforms should be developed; examples are available on the World Health Organization (WHO) High Impact Practices in Family Planning website as well as in Annex 1.6.
- An advocacy plan to improve the visibility of FP programmes should be developed with a clear communication plan for national institutions such as the Ministry of Planning, Finance and the President's Office as well as international institutions.

### Fostering an enabling environment

- Tracking expenditures: Allocations for FP are not known. A system of tracking of expenditures for FP and RH should be established by the Health Economics Division in collaboration with RHD (including at the provincial and district level).
- Performance-based incentives for CHWs should be considered.
- Operations research: The capacity for operations research in FP should be strengthened and technical assistance provided to RHD and the Research Division.
- Engaging religious and community leaders: Ongoing activities by MoPH and Ministry of Hajj and Religious Affairs as well as those supported by donors and social marketing organizations should be reviewed to identify best practices and gaps. Consultations between the ministries,

religious and community leaders and political groups should be supported to reconcile religion and the practice of FP as a tool to reduce poverty and maternal mortality and to improve family health. Studies should be supported to identify misinterpretations of religious teachings with regard to birth spacing and FP. Such consultations will require development of evidence-based documents clearly illustrating the role of FP in improving maternal and child health.

## Strengthening supply

In addition to the recommendations above, the following are critical to reduce unmet need.

### *Reduce unmet need through sustained support to current users of FP*

- Sustained support to users through follow-up, counselling and managing problems, if required, is critical and should be strengthened as part of quality improvement (QI) initiatives.

### Overcoming barriers and improving quality of care

Most of the interventions for improving quality of care focus on providers and infrastructure. While these are prerequisites for providing services, client-related barriers are given little attention. Active participation of clients in selecting a method (informed choice) and receiving the method they want is important for new and continued use.

### *Improving access to information and informed choice*

- The CHWs and midwives should be provided with client-friendly educational material (such as the WHO's Decision-making Tool) to provide accurate and unbiased information, and should be oriented on the use of these materials.
- With increasing number of women becoming literate, efforts should be made to provide client education materials in health facilities and health posts.
- The use of radio to convey messages should be expanded. Best practices on how to reach women using this medium from other countries in the region are available.
- Mobile applications to convey FP messages should be piloted.
- The quality of counselling should be improved through training, emphasizing informed choice. The training should include counselling for continuing clients and those with problems.

### *Improving access to safe services*

- Infection prevention including waste disposal should be strengthened. Since the irregular availability of electricity and fuel make it difficult to use autoclaves, alternate means of sterilization of instruments should be explored.
- Waste disposal in health posts should be reviewed and mechanisms for better disposal (especially used needles and syringes) should be developed.
- The MoPH should support PHDs to ensure that standards for different types of facilities and health posts are met by implementing NGOs. The SEHAT project should provide an opportunity for this.
- Means of providing separate spaces that ensure privacy for FP services should be explored (e.g. using curtains or screens). This should be part of the monitoring under the MoPH's QA mechanisms.
- Improving the skills of providers is critical and should be ensured.

### *Strengthening continuity of care*

- A system of tickler files or similar mechanisms should be set up in health facilities to enable health service providers to follow up with clients.
- Regular discussions with CHWs during monthly meetings at BHCs or through CHW supervisors on discontinuing clients should be instituted.
- The training of providers should include the importance of continuity of care.

Further recommendations are provided under the discussion of the HMIS system.

### *Improving geographical accessibility*

- The functionality of facilities should be mapped to assess availability, including availability of skilled providers.
- Based on the findings, plans should be developed to improve access through different channels – training of CHWs particularly female, community-based distribution, Family Health Houses, etc.

### *Strengthening involvement of private sector*

- Under the private-public sector agreement and through international and national NGOs, the private sector should be encouraged to follow the recommendations related to informed choice, safe services and capacity building.

### *Integration of services*

- While providing FP services clients should be screened for STIs and HIV. The QA mechanisms should include integration as one of the indicators for monitoring.
- Similarly, services for FP should be provided as part of voluntary counselling and testing services for HIV and in intervention for key populations (currently the prevalence of HIV intravenous drug users is not high).

These recommendations will help prevent intimate partner transmission of HIV, based on evidence from countries with concentrated epidemics among intravenous drug users.

### *FP services in situations of intimate partner violence*

- Traditionally, the management of victims of intimate partner violence does not include FP services (except emergency contraception in some situations). Health service providers should be aware of the importance of preventing unwanted pregnancy as part of the health sector response. NGOs involved in care of victims of violence should provide FP services (directly or through referrals) to victims of violence.

Availability of supplies is crucial for reducing unmet need.

### *Contraceptive commodity security*

The SEHAT project provides an opportunity to strengthen several elements of contraceptive commodity security. The recommendations below should be considered under the SEHAT improvement plans.

- The revision of the strategy is recommended.
- Standards for warehouses and storage places should be developed and standards developed by ASMO should be reviewed for potential use by MoPH. Monitoring plans should be developed.

- Quality assurance of products through adherence to manufacturers' standards for storage should be monitored regularly.
- The LMIS should be reviewed and improved to avoid stock-outs.
- Inventory practices and records as well as indenting practices should be standardized.
- Capacity building plans for warehouse managers and store keepers should be developed.

All the above recommendations are also applicable to the private sector.

## Capacity building

### *Health service providers*

- The job descriptions of midwives, nurses and doctors should be reviewed to ensure that FP is a focus area.
- The basic curriculum for midwives should be reviewed to expand the time allotted to FP as part of the increasing support for midwifery from various agencies. Similarly the doctors' basic training curriculum and the nurses' curriculum should be reviewed to include FP.
- In-service training should be comprehensively reviewed, including assessments of training institutions in Kabul and other provinces. The assessment should include capacity and capability of institutions to provide competency-based training. The gaps in skills identified should be given focus.
- Strategies should be developed to build the capacity of doctors in providing permanent methods of sterilization, as lack of capacity may be the reason for lack of demand.

### *CHWs*

- The current training of CHWs in FP (basic and in-service) should be reviewed and revised as needed. Counselling skills should be a focus.
- The training provided to female CHWs in administering injectables should be reviewed including selection criteria, trainers, whether training is competency based, etc.
- The training of supervisors should be reviewed for technical content and to develop their supervision skills.

### *Supervisors*

- The RHC job description should be clarified and they should be trained in supportive supervision as part of the MoPH's QA mechanism.
- Implementing NGOs have designated supervisors. Their job descriptions should be clarified and training in supportive supervision (including FP) should be provided.

### *Managers of implementing NGOs and health facilities*

- An assessment of the skills in programme management focusing on FP services should be undertaken and capacity building plans should be developed based on the gaps identified. Management is one of the domains of the Balanced Score Card.

### *Private sector*

- The skills of private sector providers in FP should be improved.

### Health Management Information System (HMIS)

- The HMIS should be reviewed to see whether CPR data can be collected regularly.
- The recording system of FP services should be modified to capture information on discontinuing clients, e.g. through the use of tickler files.
- The quality of the HMIS review and feedback at various levels of services should be reviewed and actions taken based on the findings.
- Data quality assurance mechanisms should be built at various levels of health care. A good model is the USAID-supported 'Strengthening national FP information systems through data quality assessment' project in Bangladesh.
- The capacity of supervisors at various levels, and CHW supervisors, to take action on based on review of reports should be strengthened.

### Adolescents and young people

In addition to the ongoing initiatives to provide information and services to young people:

- Pilot projects on premarital counselling should be developed, keeping cultural and religious sensitivity and technical accuracy in view. The premarital counselling programme of Iran is recognized as a best practice.
- A training package for teachers in birth spacing (both knowledge and capacity building in conveying the information) should be developed and built into ongoing initiatives to involve teachers.
- Peer education should include the importance of birth spacing/ FP and of delaying first birth.

### Functional accountability system

- The capacity of the facility, health post and women's *shuras* should be built by increasing awareness of clients' rights and to create awareness among women about their rights.
- Capacity of *shuras* to monitor whether these rights are violated should be monitored.
- Client feedback mechanisms should be reviewed and strengthened to facilitate regular feedback and actions.

## Creating demand

- A comprehensive BCC strategy for FP should be developed (as part of the RMNCH communication strategy presently under development). It should include male involvement, involvement of young people, community engagement through various channels and monitoring and evaluation.
- Once the strategy is approved, plans for orientation of the provincial health officers and implementing NGOs should be developed.
- Incorporation of FP messages in antenatal clinics, postpartum and child health clinics should be promoted and monitored.
- Community-specific materials should be developed and disseminated using strategic channels with maximum reach. These materials should be based on core messages which address cultural and religious barriers and rumours about contraceptives, as relevant.

- Community engagement: The role of the FHAGs and women's *shuras* in promoting FP should be reviewed. A plan for promoting FP messages through these channels focusing on mothers-in-law and elderly women in the community should be developed and implemented. Women's *shuras* should play an active role in sharing information with young women about the importance of delaying the age at first pregnancy, birth spacing, etc. The group also should be trained to monitor availability and access to services and become a part of the MoPH's quality assurance initiatives.
- Innovative approaches for male involvement should be developed, implemented and evaluated.
- Use of traditional media for promoting FP messages should be considered.
- The reach of channels and impact of messages should be regularly reviewed.

# 1. INTRODUCTION

## 1.1 Context

Afghanistan is a landlocked country located in South Asia and bordered by Pakistan, China, Tajikistan, Uzbekistan, Turkmenistan and Iran. Afghanistan is an Islamic state and a parliamentary democracy. While some functions are decentralized to the 34 provinces, the majority are retained at the central level.

The general health of the Afghan people is poor and is exacerbated by inadequate water supplies, poor sanitation and hygiene practices, an unstable security situation and inadequate policies on harmful products, unsafe drug use, uncontrolled waste disposal, noise and air pollution and food insecurity. The fragile public health system has further been eroded by a long period of conflict and recurrent natural disasters. It is against this backdrop that health services are delivered.

## 1.2 Human development

With a Gross National Income (GNI) of US$ 1,904 per capita, Afghanistan's HDI ranking is 175th out of 187 countries. Despite being below average for countries in the low human development group and other countries in its region, there has been a steady improvement in key indicators since 1980.[1]

**Table 1: Afghanistan's HDI trends based on consistent time series data**

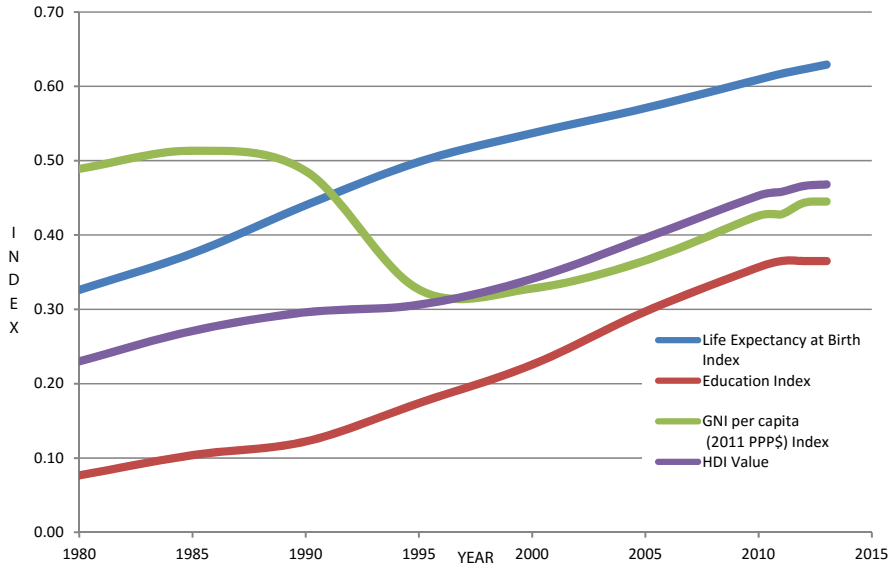
| | Life expectancy at birth | Expected years of schooling | Mean years of schooling | GNI per capita (2011 PPP$) | HDI |
|---|---|---|---|---|---|
| 1980 | 41.2 | 1.8 | 0.8 | 2,548 | 0.230 |
| 1985 | 44.4 | 2.3 | 1.2 | 2,991 | 0.271 |
| 1990 | 48.6 | 2.6 | 1.5 | 2,497 | 0.296 |
| 1995 | 52.4 | 4.1 | 1.8 | 0,869 | 0.306 |
| 2000 | 54.9 | 5.6 | 2.1 | 0,877 | 0.341 |
| 2005 | 57.1 | 7.7 | 2.5 | 1,126 | 0.396 |
| 2010 | 59.6 | 9.0 | 3.2 | 1,677 | 0.453 |
| 2011 | 60.1 | 9.3 | 3.2 | 1,698 | 0.458 |
| 2012 | 60.5 | 9.3 | 3.2 | 1,882 | 0.466 |
| 2013 | 60.9 | 9.3 | 3.2 | 1,904 | 0.468 |

*Source: UNDP. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Human Development Report 2014*

1. UNDP (2014). *Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience.* Human Development Report 2014. Available at: http://www.undp.org/content/dam/undp/library/corporate/HDR/2014HDR/HDR-2014-English.pdf

Figure 1 below shows the contribution of each component to Afghanistan's HDI since 1980. While progress has been made, poverty remains a major challenge.

**Figure 1: Trends in Afghanistan's Human Development Index 1980–2013**




*Source: UNDP. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Human Development Report 2014*

According to the Multi-dimensional Poverty Index which covers three domains (health, education and living standards), 58.8 percent of the population is poor while an additional 16 percent lives on the borderline of poverty.[2] As the HDI and MPI show, Afghanistan's intensity of deprivation is the highest in the South Asia region.

## 1.3 Socio-economic indicators

Afghanistan's socio-economic indicators show both progress and challenges, with some of the latter remaining major concerns.

The lives of rural Afghans are considerably different from those in major urban centres such as Kabul, Mazar-e-Sharif, Herat, Jalalabad and Kandahar. Rural poverty levels are significantly higher than in urban centres: the rural poverty head count ratio in 2011 was 38.3 percent, compared to 27.6 percent in urban areas – three-quarters of the Afghan population lives in rural areas.[3] An Afghan living in Kabul has far better access to education, health facilities and diversified employment opportunities, while those in rural areas often have reduced access to services and limited job opportunities which are almost exclusively in the agriculture sector.

2. Ibid.

3. World Bank Development Indicators. Available at: http://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS.

Worsening socio-economic conditions, insecurity and criminality in rural areas often lead households to migrate to safer urban areas or to neighbouring countries. These rural challenges as well as migration to urban areas and pressure on urban absorption capacities require a balanced but contextualized approach to health programming.

## 1.4 Gender

Gender inequity remains a challenge in Afghanistan, even in comparison to other countries in the region, and is reflected in all facets of Afghan life (see Table 2).[4] The Gender Inequality Index (GII) reflects gender-based inequalities in three dimensions: reproductive health, empowerment, and economic activity. Afghanistan ranks low on this list, and was 150th out of 152 countries in the 2013 index.

**Table 2: Afghanistan GII (2013) relative to selected countries**

| | GII value | GII rank | Maternal mortality ratio (deaths per 100,000 live births) | Adolescent birth rate (births per 1,000 women aged 15–19) | Female seats in parliament (%) | Population with at least some secondary education (% ages 25+) | | Labour force participation (% ages 15+) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Female | Male | Female | Male |
| Nepal | 0.479 | 98 | 170.0 | 73.7 | 33.2 | 17.9 | 39.9 | 54.3 | 63.2 |
| Pakistan | 0.563 | 127 | 260.0 | 27.3 | 19.7 | 19.3 | 46.1 | 24.4 | 82.9 |
| Afghanistan | 0.705 | 150 | 460.0 | 86.8 | 27.6 | 5.8 | 34.0 | 15.7 | 79.7 |
| South Asia | 0.531 | – | 202.0 | 38.3 | 17.8 | 33.4 | 48.5 | 30.7 | 80.7 |

*Source: UNDP. Sustaining Human Progress. Reducing Vulnerabilities and Building Resilience. Human Development Report 2014*

## 1.5 Population and demographic trends

In 2014–2015 Afghanistan's population was estimated at 28.6 million (51 percent male), of whom 27.1 million were settled and 75.3 percent lived in rural areas.[5] The population growth rate is one of the fastest in the world at 2.8 percent.[6] While the fertility rate has dropped in all sub-groups, at 5.1 per woman, Afghanistan is one of only two countries with a fertility rate exceeding 5 in the Asia-Pacific region.[7]

Figure 2 shows Afghanistan's population distribution by age group. Due to its high fertility rate and a consequent annual population growth rate of 2.8 percent, the demographic age structure is pyramidal (see Figure 2). The large youth population at the base and the reduced population at older ages depicts the classic appearance of a country with a significant 'youth bulge'.

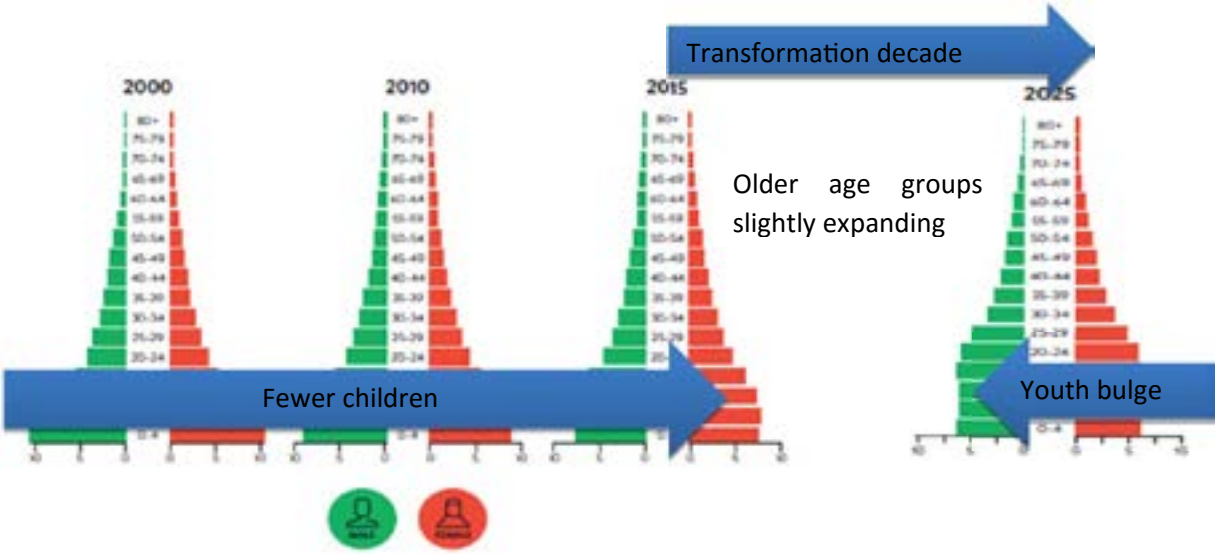
4. UNDP (2014). *Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience.* Human Development Report 2014. Available at: http://www.undp.org/content/dam/undp/library/corporate/HDR/2014HDR/HDR-2014-English.pdf.

5. Central Statistics Organisation. *Afghanistan Statistical Yearbook 2014–2015.*

6. PRB Dataset 2011. Available at: http://www.prb.org.

7. UNFPA (2014). *State of the World's Population 2014: The Power of 18 Billion - Adolescents, Youth and the Transformation of the Future.* Available at:http://www.unfpa.org/swop-2014.

## Figure 2: Afghanistan's demographic structure: current and expected




*Source: UNFPA Afghanistan. Investing in Youth: How to Realize Afghanistan's Demographic Dividend, 2014*

Though the 2015 structure depicted in Figure 2 does not show much evidence of a demographic transition, recent analysis and projections provide evidence of early transition in certain sections of the population.[8] The slow transition has important implications for the economic and social development of the country.

As Figure 2 shows, Afghanistan has a very young population, with nearly half (47 percent) below 15 years of age and 16 percent under the age of 5.[9] An estimated 27.8 percent of the population is between 15 and 30 years of age, with almost 15 percent at the threshold of entering the 15–20 age group.[10] This large population is fast approaching employment age, providing the country with a solid human resource base. Every year, 400,000 Afghan youth enter the labour market in search of stable employment opportunities.

Afghanistan's 'youth bulge' thus offers a potential demographic dividend: the accelerated economic growth that may result from a decline in a country's mortality and fertility and the subsequent change in the age structure of the population.

Both the positive and negative impacts of Afghanistan's population structure can be wide-ranging. A pessimistic analysis would point towards an economic crisis due to an educated but unemployed workforce vulnerable to either a mass exodus of skilled labour from the country or recruitment by insurgent groups which offer an alternative channel for participating in governance. A more optimistic analysis highlights the intellectual capacity for entrepreneurship, skills development, technological innovation and cultural ambassadorship.

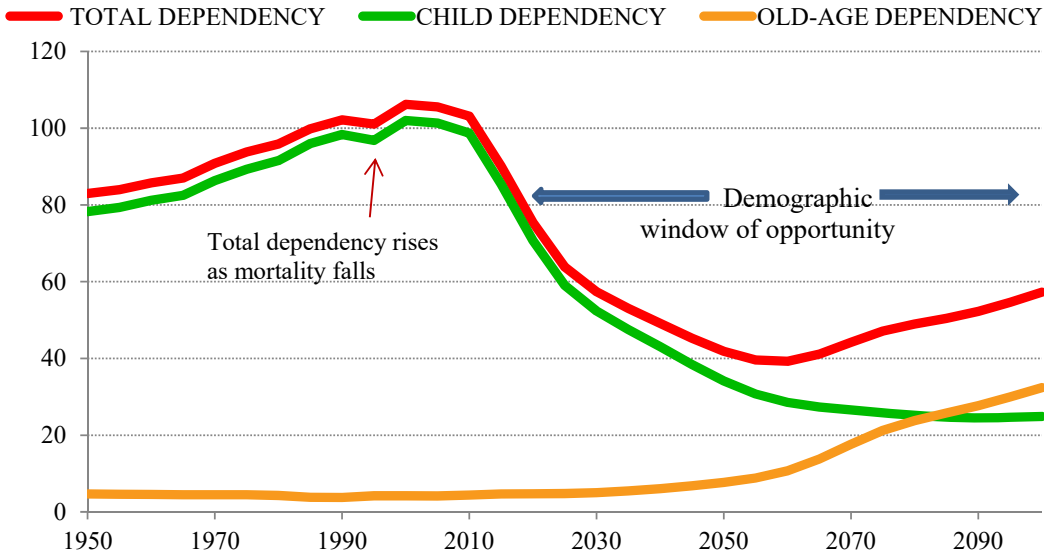
Figure 3 shows the demographic window of opportunity, which, if not utilized efficiently, will be a great missed opportunity for Afghanistan's development.

8. UNFPA Afghanistan (2015). *Investing in Youth: How to Realize Afghanistan's Demographic Dividend.* Available at: http://afghanistan.unfpa.org/publications/investing-youth-how-realize-afghanistans-demographic-dividend

9. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*

10. Central Statistics Organisation. *Afghanistan Statistical Yearbook 2012–2013.*

## Figure 3: Afghanistan dependency ratios (1995–2100)




*Source: UNFPA Afghanistan: Investing in Youth. How to Realize Afghanistan's Demographic Dividend, 2014*

As large numbers of young dependants enter the workforce a window of opportunity opens for the country's government to capitalize on the resources released by the shrinking dependent population and to use them for economic development and growth. This creates the conditions for higher economic productivity and rising personal incomes: the demographic dividend.

However, this dividend is not automatic and its potential can be realized only if the government adequately invests in health and education and stimulates new economic opportunities. As long as the TFR and population growth remain high and the young dependent population outnumbers working-age adults, families and governments will not have the resources needed to invest adequately in each child and realize the country's full economic potential. Afghanistan's window of opportunity is only just opening. A wider window offers longer opportunity to harvest the bonus if increased investments in FP, education, skills development and employment are made. Delaying the age at marriage also contributes to reduced population growth.

The youth bulge is a key concern in the development and stability of poor nations. In 2004, the World Bank released a paper titled 'The Devil in the Demographics: The Effect of Youth Bulges on Domestic Armed Conflict' which showed that the combination of a youth bulge and poor economic performance can be "explosive".[11] At a time of transition in Afghanistan –with the withdrawal of international forces beginning in 2014 – the youth's relationship and contribution to Afghanistan is a central concern.

Unusually in the region, the sex ratio at birth (the number of males per 100 females) in Afghanistan is high, at 105:100,[12] apparently due to the under-reporting of female births.[13] Across the age groups, boys outnumber girls in the early years of life, with higher mortality among females during their childhood and reproductive years (due to maternal mortality).[14] This gap steadily closes with increasing age.

11. Lavender, L (2011). *The Youth Bulge in Afghanistan: Challenges and Opportunities.* Civil-Military Fusion Centre.
12. Central Statistics Organization (2014). *National Risk and Vulnerability Assessment 2011–12.* Afghanistan Living Condition Survey. Kabul: CSO.
13. Ibid.
14. Ibid.

## 1.6 Reproductive health indicators

GIRoA's indicators and targets under Millennium Development Goal (MDG) 5 'Improve maternal health' at the time of reporting are shown in Table 3.

### Table 3: Afghanistan's progress towards achieving MDG 5

| Indicator | Baseline 2003 | 2010 | Target: 2015 | Target: 2020 |
|---|---|---|---|---|
| Maternal mortality ratio (per 100,000 live births) | 1600 (only four districts, hence not comparable with 2010) | 327 (Afghanistan Mortality Survey 2010) | 315 (reset) | 400 (target based on the baseline and will be revised) |
| Proportion of deliveries attended by skilled health personnel (%) | 6 | 34 | 43 | 75 |
| Contraceptive prevalence rate (%) | 5 | 20 | 50 | 60 |
| Adolescent fertility rate (per 1,000 women aged 15–19) | 146 | 80 | – | – |
| Fertility rate | 6.2 | 5.1 | 4.7 | 3.1 |
| Antenatal coverage (at least once visit) (%) | 5 | 60 | 65 (reset) | 100 |

*Source: Ministry of Economy: Afghanistan Millennium Development Goals 2012*

### 1.6.1 Fertility and its determinants

The TFR has dropped among all age groups in Afghanistan. The age-specific fertility rate is highest among age groups in the 20–34 range (257, 262 and 209 for five-year age groups).[15] The TFR of 5.1 children is influenced by early marriage, polygamy, and desire for male children. Fertility levels vary by place of residence (rural: 5.2; urban: 4.7), and significantly by level of education (no education: 5.3; higher education: 2.8). Fertility is high among all wealth quintiles (richest: 4.8; poorest: 5.3). The Eastern and South-Eastern regions report higher fertility levels than the national average.[16]

Birth intervals are often short, with 37 percent of births occurring less than 24 months after the preceding birth.[17] The median age at first birth is 20, with lower ages of first birth in the Northern, North-Eastern, Western and Central Highland regions. About 12 percent of girls aged 15–19 years have already begun childbearing, with higher levels in the Western, Central Highland and Eastern regions. The median age at marriage is 18.1 years, with lower ages in the Northern, North-Eastern, Western and Central Highland regions, where age at first pregnancy is also lower.[18]

The CPR has increased over the years, from a baseline of only five percent in the Multiple Indicator Cluster Survey (MICS), 2003. The Afghanistan Mortality Survey 2010 reported 22 percent for all methods (20 percent modern methods); the MICS 2010/2011 reported 20 percent for all methods (18 percent for modern methods) and the MoPH Factsheet reported 13.8 percent.[19] These differences in reported CPR, in surveys conducted at fairly close intervals, could be due to differences in methodologies and sampling. Afghanistan's CPR is low compared to most other South Asian countries which report CPRs exceeding 40 percent.[20] Many studies from Afghanistan provide only partial information on FP indicators, with no information on unmet needs, trends in use, user profiles, or detailed analysis of factors determining use and non-use of FP.

15. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*
16. Ibid.
17. Ibid.
18. Ibid.
19. MoPH (2014). *Afghanistan Health Indicators Fact Sheet.*
20. UNFPA (2014). *State of the World's Population 2014: The Power of 18 Billion - Adolescents, Youth and the Transformation of the Future.* Available at: http://www.unfpa.org/swop-2014.

A comparison of fertility rates with some determinants, such as age at marriage, age at first pregnancy, postpartum infecundability and contraceptive use shows an interesting but inconsistent pattern (Table 4). Fertility rates are lower than the national average of 5.1 in Western and Central Highlands and as expected, CPRs are higher (9–10 points higher). Knowledge of contraceptives (i.e. those who have heard of any modern method) appears to be good. The other two determinants – median age at marriage and postpartum infecundability – are the lowest in the Central and Western regions. The number of months since the last pregnancy (birth interval) is also lower here than the national average. The lower levels of these variables are not consistent with the lower fertility level in these two regions.

**Table 4: Differentials in fertility and its determinants in Afghanistan's regions**

| Region | TFR | CPR % | Median age at marriage in years | Birth interval <18 months |
|---|---|---|---|---|
| North-East | 5.1 | 14.1 | 17.1 | 18.3 |
| North | 4.9 | 12.2 | 17.9 | 16.2 |
| West | 4.9 | 29.6 | 16.6 | 15 |
| Central Highland | 4.6 | 35.3 | 15.7 | 13.7 |
| Capital | 5.1 | 30.2 | 18.8 | 22 |
| East | 5.6 | 15 | 18.1 | 19.1 |
| South | 4.7 | 22.4 | 19.3 | 8.5 |
| South-East | 5.5 | 8.5 | 19.5 | 12 |
| National | 5.1 | 19.9 | 18.1 | 17.2 |

*Source: APHI, CSO, ICF Macro, IIHMR and WHO EMRO. Afghanistan Mortality Survey 2010*

The level of knowledge about at least one method of modern contraception exceeds 90 percent in all regions except the South and South-East, where the level is below 80 percent (Table 5). The CPR is also the lowest in the South-East and lower than the national average in the Northern, North-Eastern and Eastern regions. The South-East and East also have high levels of fertility.

Knowledge is lowest among married women in the 15–19 year age group, of whom only 84.8 percent have heard of any modern method of contraception.[21] Generally, rural women are less likely to have heard of a contraception method than their urban counterparts (90.4 percent and 97.6 percent, respectively).

**Table 5: Knowledge about modern methods of contraception, CPR and fertility**

| Region | Heard of any modern method of contraception | CPR | Fertility |
|---|---|---|---|
| North-East | 91.2 | 14.1 | 5.1 |
| North | 95.9 | 12.2 | 4.9 |
| West | 97 | 29.6 | 4.9 |
| Central Highland | 95 | 35.3 | 4.6 |
| Capital | 94.9 | 30.2 | 5.1 |
| East | 93.2 | 15 | 5.6 |
| South | 80.7 | 22.4 | 4.7 |
| South-East | 75.3 | 8.5 | 5.5 |
| National | 91.6 | 19.9 | 5.1 |

*Source: APHI, CSO, ICF Macro, IIHMR and WHO EMRO. Afghanistan Mortality Survey 2010*

21. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*

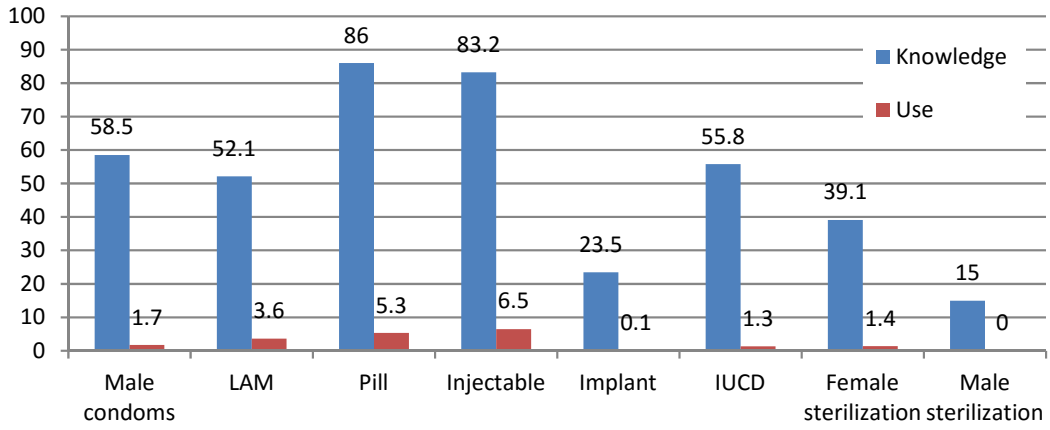
The relationship between knowledge and use of modern methods of FP and the educational, wealth and remoteness quintiles are significant, with the lowest levels of knowledge among those with no education, poor and in most remote locations – education and wealth quintiles had the strongest association. A similar pattern is reported among contraceptive users.

Thus, it is clear that high levels of knowledge of FP have not been translated into higher levels of contraceptive use.

## 1.6.2 Contraceptive method mix

Figure 4 shows the gap between the level of knowledge and method specific use. More than 80 percent of married women aged 15–49 years reported possessing knowledge of pills and injectables; however the proportion actually using these methods was less than 10 percent. More than 50 percent of the women had knowledge of IUCDs, but use was negligible (1.3 percent). The implant was less widely known, perhaps because it has only been introduced in recent years. The level of knowledge and use of permanent methods was very low (female sterilization: 1.4 percent; male sterilization: zero).

**Figure 4: Knowledge and use of specific contraceptive methods amongst currently married women aged 15–49**




*LAM: Lactational Amenorrhoea Method*

*Source: APHI, CSO, ICF Macro, IIHMR and WHO EMRO. Afghanistan Mortality Survey 2010*

Unlike in other demographic health surveys, the fertility aspirations of women is not available from Afghanistan surveys.[22] As shown in Table 6, a significant proportion of women in the 25–29 year age group and above had more than three children, reaching 90 percent from those aged 30+ years. The use of long-acting and permanent methods of contraception in these age groups is negligible.

## 1.6.3 Unmet need for family planning

Women with unmet need are defined as those who want to stop or delay childbearing but are not using any method of contraception. There is no data on unmet needs in any of the surveys conducted to date, but it is likely to be high considering the low CPR. A *Lancet* paper on national,

22. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*

region and global trends in CPR and unmet need for FP between 1990 and 2010 suggests that Afghanistan's unmet need in 2010 was 29.5 percent (an increase of 1.2 percent from the 1990 value of 28.1 percent).[23]

It is also important to consider the qualitative dimensions of unmet need. Two key dimensions in Afghanistan are related to access and deeply entrenched sociocultural attitudes. The equity-related dimensions of access, such as education, wealth and remoteness quintiles, have been discussed in section 1.6.1. Though information on intention to practice FP is not available, it is probably safe to assume that the gap between knowledge of contraceptives and practice is an indication of unmet need. Intermediary factors such as sociocultural and religious factors influence attitudes and hence practice. The mismatch between low CPR and high levels of knowledge in the South-East, North-East and North could be a reflection of poor access due to security reasons (in the South-East) or difficult terrain (North-East). Use of traditional methods is about 5.5 percent in Afghanistan and is considered to represent unmet need for modern methods of FP.[24]

That information gaps on specific methods exist, particularly implants and permanent methods, is evident from the analysis presented earlier, and is an important dimension of unmet need. Experiences from countries in the region point to provider bias as a major determinant of method-specific unmet need, favouring methods such as injectables which are easy to administer. While there is no data available on discontinuation rates in Afghanistan, demographic health surveys from other countries have reported high rates with short-acting methods such as pills and injectables. In addition to method-specific knowledge, there are also informational gaps about where specific methods can be obtained.

The regular availability of contraceptive commodities is another dimension of unmet need. A recent HMIS report showed that 79 percent of health facilities had stock-outs of essential medicines in the preceding six months. Although no specific data is available on the availability of FP commodities, it is counted amongst the 30+ essential medicines and supplies list.

Table 6 gives a sense of the unmet needs of women with more than three children who, ideally, should be using long-acting methods or permanent methods. Reasons for not using such methods could be related to incomplete or erroneous information (rumours and myths) or social attitudes towards contraception. Besides social opposition from women themselves, perceived or real attitudes of husbands and mothers-in-law towards family size, use of contraception, use of specific methods, etc. may be major barriers, but are often not captured in surveys. For cultural reasons, it is not considered appropriate for others to know about the use of FP methods. Unmet needs are as much a reflection of primary social relations as of individual attitudes and experiences.

The unmet needs of young married women are a concern. Pervasive social attitudes, that put pressure on young women to prove their fertility get reinforced as individual and familial attitudes discourage the use of contraception early in marriage. Coupled with this negative attitude is the low level of knowledge about contraception, where to obtain contraceptives, etc. Another dimension of unmet need relates to the unavailability of information and services for the unmarried.

23. Leontine A, V Kantorova, C Menozzi, A Biddlecom (2013). National, Regional, and Global Rates and Trends in Contraceptive Prevalence and Unmet Need for Family Planning between 1990 and 2015: A Systematic and Comprehensive Analysis. *The Lancet 381* (9878) 1642–1652. DOI: 10.1016/S0140-6736(12)62204-1.

24. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*

**Table 6: Contraceptive use among women aged 25+ years with more than three children (percent)**

| Age group | More than 3 children | CPR | LAM | Condom | Pill | Injectables | IUCD | Female Sterilization | Male Sterilization |
|---|---|---|---|---|---|---|---|---|---|
| 25–29 | 46.4 | 19.3 | 4.6 | 2.1 | 5 | 5.8 | 1.3 | 0.4 | 0 |
| 30–34 | 77.4 | 23.3 | 4.3 | 2.3 | 5.7 | 8.5 | 1.7 | 0.6 | 0 |
| 35–39 | 89.1 | 26.6 | 3.3 | 1.8 | 7.3 | 10 | 1.7 | 2.3 | 0.1 |
| 40–44 | 90.8 | 25.4 | 1.5 | 1.2 | 7.4 | 9.3 | 1.8 | 3.8 | 0.1 |
| 45–49 | 90.8 | 19.5 | 0.7 | 0.5 | 4.2 | 7.8 | 1.6 | 4.3 | 0.2 |

*Source: APHI, CSO, ICF Macro, IIHMR and WHO EMRO. Afghanistan Mortality Survey 2010*

Poor quality of care is a major contributor to unmet needs and the dimensions discussed above are related to quality of care from the perspectives of both client rights and provider needs. Quality of care, both at the time of acceptance of a method, and during subsequent visits, has a profound impact on the continuation of contraceptive methods and reduction in unintended pregnancies. MoPH's QI mechanism has identified gaps in quality (section 3.2.4).

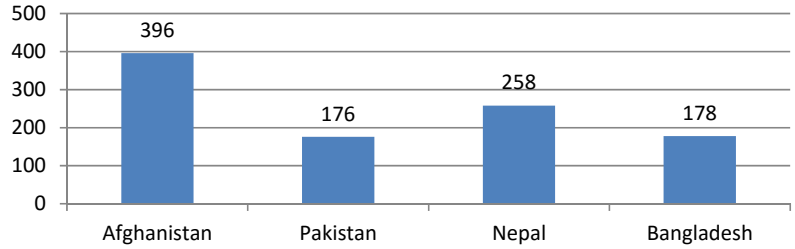
Another dimension of unmet need is the missed opportunity to promote FP services. Postpartum IUCD is promoted and monitored, however, the choice of FP offered at this time appears to be limited to this method. Though there is no data available, there may be opportunities missed to promote FP through channels such as child health clinics, management of clients with STI or HIV/AIDS, etc.

In conclusion, despite improvements in fertility and FP indicators, the progress towards achieving MDG 5 indicators related to CPR and fertility, is not satisfactory and Afghanistan is unlikely to achieve its targets in this area, including 50 percent CPR (see Table 3).[25] Experience and research from other countries shows that identifying the qualitative and quantitative aspects of unmet need and satisfying even a fraction could have significant demographic impact.

## 1.6.4 Maternal and child mortality

Afghanistan's health sector has made significant progress over the last decade, which has translated into significant improvements in life expectancy at birth (female: 64.2 years; male: 63.6), substantial decline in Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and Child Mortality Rate (CMR) (MMR: 327 per 100,000 live births; IMR: 77 per 1,000 live births; CMR: 97 per 1,000 live births).[26] [27] The neonatal mortality rate is 25 per 1,000 live births. Despite the marked decline, Afghanistan's rates remain high in comparison to other countries in the region (Figure 5).

**Figure 5: Maternal mortality in the region (deaths per 100,000 live births)**




*Source: WHO, UNICEF, UNFPA, World Bank, UNPD. Trends in maternal mortality 1990–2015. Figures differ from those in Table 2 as the latter are based on 1990–2010 data.*

25. Ministry of Economy. *Afghanistan Millennium Development Goals 2012.*
26. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*
27. Ministry of Economy. *Afghanistan Millennium Development Goals 2012.*

### 1.6.5 Adolescent reproductive health indicators

The adolescent fertility rate is 80 per 1,000 women aged 15–19 years and is high compared to many countries in the region.[28] Knowledge about contraception is lowest among married women in this age group, while the CPR is 8 percent.[29] Moreover, 23.9 percent of all pregnancy-related deaths occur in this age group. Studies conducted elsewhere show that preventing pregnancy in this group would have saved lives and contributed to the national Gross Domestic Product. Reports indicate that median age at marriage and the age at first birth have increased.

### 1.6.6 HIV/AIDS and STIs

The prevalence of HIV is less than 0.5 percent in the general population; however, there is reported to be a concentrated epidemic among people who inject drugs.[30] [31] One-third of these cases are women. The prevalence of STIs is reported to be high, but the prevalence in the general population is not known.[32]

## 1.7 Health system

### 1.7.1 Structure

The MoPH has organized health service delivery through three major divisions, each headed by a deputy minister (see Annex 1.2 for the organizational structure at the time of the assessment).

The Deputy Minister for Health Care Service Provision is responsible for five directorates, including the Provincial Relation Directorate (which includes the Provincial Health Directorate; PHD), Curative Medicine General Directorate, Preventive Medicine General Directorate, Reproductive Health Directorate (RHD) and the Emergency and Disaster Response Department.

The RHD is headed by a director assisted by three coordinators for planning and administration, programme planning and monitoring and thematic areas. The full organizational structure of the RHD at the time of the assessment is illustrated in Annex 1.3.[33] The Reproductive Health Commodity Security Officer is posted under planning and administration; the training coordinator is posted under planning and monitoring; and FP team leader and maternal and newborn health coordinator are posted under the thematic area coordinator. The FP unit has an officer for promotion and an officer for service.

The Curative Medicine General Directorate includes the Nursing and Midwifery Department, Private Sector Health Services Department and Essential Package of Hospital Services (EPHS) Directorate. The Preventive Medicine General Directorate includes National HIV/AIDS Control Unit under Communicable Disease Control Directorate, Child and Adolescent Health Department and Community Health Department.

The Deputy Minister for Policy and Planning is responsible for three directorates: the Policy and Planning General Directorate, Afghan Public Health Institute General Directorate and Pharmaceutical Affairs General Directorate. The Policy and Planning General Directorate includes the Health Economics and Financing Directorate, Policies Department, Health Systems Strengthening Department and HMIS Department. The Afghan Public Health Institute includes the Public Health Research Directorate and Health Promotion Department.

28. Ibid.
29. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey 2010.*
30. MoPH. *National Strategic Framework on HIV/AIDS for Afghanistan I* – 2011–2015.
31. MoPH. *Revised National Health and Nutrition Policy.* August 2015.
32. MoPH. *National Strategic Framework on HIV/AIDS for Afghanistan I – 2011–2015.*
33. MoPH. *National Reproductive Health Strategy 2012–2016.*

The Deputy Minister for Finance and Administration is responsible for the Human Resources General Directorate, Procurement and Supply Directorate, Finance and Administration General Directorate, Ghazanfar Institute of Health Sciences and the Gender Directorate.

Health services are delivered through Provincial Health Departments.

## Basic Package of Health Services and Essential Package of Hospital Services

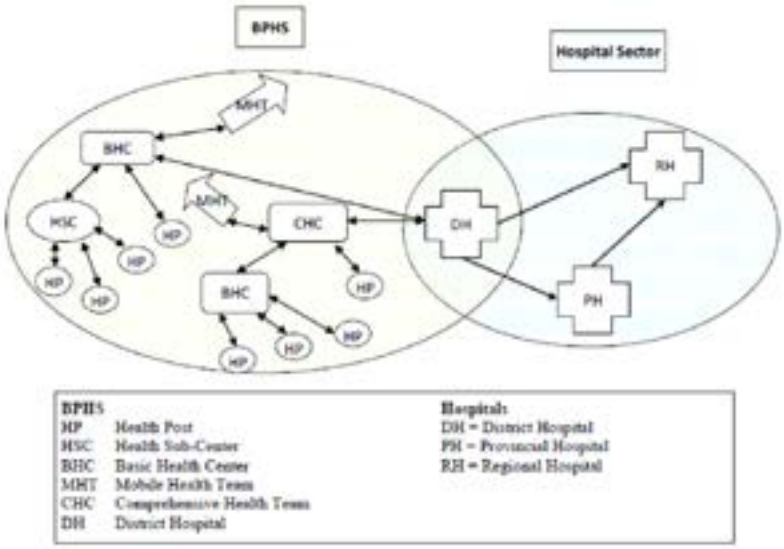
Health services in Afghanistan operate at three levels through BPHS and EPHS,[34] [35] with a well-defined referral chain from primary to secondary and tertiary care.

At the primary care level, the BPHS is delivered through health posts, BHCs, CHCs and through HSCs and Mobile Health Teams in selected geographical areas (see Figure 6).

Secondary care services are delivered through EPHS through District Hospitals (also included under BPHS) and Provincial Hospitals.

Tertiary services are delivered through Regional Hospitals and Specialty Hospitals (included under EPHS).

### Figure 6: Structure of the Basic Package of Health Services




*Source: Basic Package of Health Services, MoPH, 2010*

The BPHS has seven key elements, one of which is maternal and child health. FP is included within this element and interventions include counselling, screening for and treatment of STIs, advice on LAM, provision of condoms, pills, injectables, IUCD, and male and female sterilization. IUCDs are provided only where trained providers are available and sterilizations are only available in district hospitals. In recent years, postpartum IUCD and implants have been introduced. The EPHS also includes FP services and provides short-acting, long-acting and permanent methods of contraception.

34. MoPH. *Basic Package of Health Services (BPHS) for Afghanistan* 2010/1389. Revised July 2010.
35. MoPH. *Essential Package of Hospital Services for Afghanistan* 2005/1384.

The BPHS is largely delivered through performance-based partnership agreements and other grants; in 31 of the 34 provinces delivery is through contracts with NGOs and in the remaining three through contracts with MoPH.[36] Till recently, the European Commission supported service delivery in 10 provinces, the World Bank in 11 provinces (including three under the MoPH strengthening mechanism), and USAID in the remaining 13 provinces. Approximately 85 percent of the population is covered by primary care services provided by NGOs.[37]

The creation of a Grants and Contracts Management Unit (GCMU) within the MoPH to manage and oversee contracts has been critical to the success of the BPHS.[38] Substantial funding and technical assistance to the GCMU has built its capacity for effective contract management and monitoring of service delivery, and enabled the MoPH to demonstrate leadership and guidance to a variety of non-public health providers. The BPHS has enabled the ministry to perform its governance/stewardship role as the designer and regulator of a system for unified service delivery.

The monitoring and evaluation of the BPHS includes contraceptives distributed as one of its utilization indicators (output indicator), CPR as an outcome indicator and fertility as an impact indicator.

The Balanced Score Card, a third party monitoring mechanism for BPHS implementation, has been used since 2004. Its domains and indicators were revised in 2011 and now include six domains comprising 22 indicators and an additional three summary indicators on the performance of health providers in delivering the BPHS (Annex 1.4).[39] The revision dropped an indicator related to FP availability, however contraceptive methods are included under the indicator on Pharmaceuticals and Vaccine Availability Index.20 There is no indicator for monitoring the adequacy and quality of FP commodities.

Support to BPHS and EPHS is ongoing through the System Enhancement for Health Action in Transition (SEHAT) project funded through the International Development Association and the Afghan Reconstruction Trust Fund; the latter is administered by the World Bank. Funds from the European Commission and USAID are channelled through the Afghan Reconstruction Trust Fund.[40] The project also supports strengthening the MoPH's stewardship functions and building systems at both the central and provincial levels.

In the absence of mechanisms for national procurement and quality assurance, procurement is a concern. Implementing NGOs do procurement, except in USAID-supported provinces, and there is evidence from UNFPA assessments that there are major quality concerns. In the past USAID did the procurement for the 13 provinces it supported. Now, under the SEHAT project, responsibility for all procurement mechanisms is with the MoPH and raises concerns about quality assurance of procurement in the absence of such mechanisms.

36. Belay, T. (ed) (2010). *Building on Early Gains in Afghanistan's Health, Nutrition, and Population Sector: Challenges and Options.* Washington, DC: World Bank.

37. MoPH. *Revised National Health and Nutrition Policy.* August 2015

38. Schemionek, K (2009). *Expanding Health Service Delivery and Developing Institutional Capacity: Getting the Balance Right in Afghanistan.* HLSP Institute.

39. MoPH, JHBSPH, IIHMR. *Basic Package of Health Services Balanced Score Card. National Report* 2012–2013.

40. World Bank (2013). *Afghanistan - System Enhancement for Health Action in Transition (SEHAT) Project: Emergency Project Paper.* Washington DC : World Bank. http://documents.worldbank.org/curated/en/2013/02/17368947/afghanistan-system-enhancement-health-action-transition-sehat-project-emergency-project-paper.

### Progress in BPHS coverage

In the absence of a functioning public administration, contracting with non-state providers is widely viewed as an effective approach. This approach has been managed and implemented successfully, and the MoPH has gained international credibility and legitimacy.

Since the end of the civil war in Afghanistan in 2001, the MoPH has achieved impressive progress in rapidly expanding basic health services throughout the country.[41] [42] The NRVA 2011–2012 reported that 91.2 percent of the population had access to a health post (rural: 88.4 percent) and 86.9 percent to a public health clinic (rural: 82.7 percent) two hours away.[43] Central to this achievement is an increase in the number and capacity of skilled health workers.

## 1.7.2 Human resources

The main human resources responsible for FP include CHWs, CHW supervisors, midwives, doctors and specialists in obstetrics and gynaecology. Table 7 shows the availability of female and male staff. Though the data may not be accurate due to underreporting, it shows a shortage of female staff at health posts and at BHC and CHC levels. This is a major contributor to poor access, especially at the lower level.

### Table 7: Availability of female and male staff

| Staff/ health facility | Female staff | | Male staff |
|---|---|---|---|
| | national (%) | rural (%) | national (%) |
| Health post | | | |
| - CHW | 67.4 | 58.3 | 79.6 |
| Public clinic | | | |
| - doctor | 63.1 | 52.3 | 93.6 |
| - midwife | 87.9 | 85.5 | - |
| District/provincial hospital | | | |
| - doctor | 89.7 | 87.1 | 96.5 |
| - midwife | 97.9 | 97.1 | - |
| Private | | | |
| - doctor | 79.1 | 72.3 | 94.0 |
| - midwife | 89.5 | 86.3 | - |

*Source: National Risk and Vulnerability Assessment Report 2011–2012*

Both male and female CHWs are expected to promote FP in their catchment areas and to provide counselling. They also have supplies of condoms and pills. Since 2005, selected female CHWs have been trained by NGOs to administer injectables. The quality of training and their skills have not been assessed.

FP is a key topic in pre-service training for midwives. However, the content of the pre-service curriculum for nurses and doctors with regard to FP is not adequate. Midwives are also offered a 10-day in-service course in birth spacing. The training is competency-based and the skills taught include counselling and provision of condoms, pills, injectable and IUCD. Doctors are also provided training in the same topics. With regard to permanent methods, at the time of the assessment only two trainings in female sterilization and no training in male sterilization had been provided to obstetricians and gynaecologists.

41. MoPH, JHBSPH, IIHMR. *Afghanistan Health Survey 2006: Estimates of Priority Health Indicators for Rural Afghanistan.*
42. Peters, D et al. (2007) *A Balanced Scorecard for Health Services in Afghanistan.* WHO Bulletin 85 (2): 85.
43. Central Statistics Organization (2014). *National Risk and Vulnerability Assessment 2011–12.* Afghanistan Living Condition Survey. Kabul: CSO.

Rabia Balkhi Hospital has been developed as a Centre of Excellence for FP training, with support from UNFPA; subsequently four regional training centres were developed in the Regional Hospitals in Herat, Kandahar, Mazar-e-Sharif and Nangarhar.[44] Chapter 3 provides more information on training and training institutions.

### 1.7.3 Health financing

An RH sub-accounts analysis done by the Health Economics and Financing Directorate with support from USAID and the Policy Project estimated that 16.4 percent of the total health expenditure (THE) was on RH.[45] Though comparable to some other developing countries where RH subaccount data is available, it is not clear whether this is adequate to meet the RH needs of the population. The expenditure specifically for maternal and child health and FP is 3 percent of the $THE_{RH}$. Household spending (out-of-pocket expenditure) is 78.5 percent of the $THE_{RH}$. The analysis for FP is not available separately; it is likely that the proportion of household expenditure for FP is negligible.

NRVA data suggests that access to health posts and public health clinics is good (section 1.7.1), however with such low expenditures for maternal and child health, the adequacy of services of the services actually provided is a concern.

### 1.7.4 Health Management Information System (HMIS)

The priority of the HMIS Department is to enhance the use of information and evidence for decision-making across the health sector to improve the services and health outcomes for the most vulnerable and those in greatest need.

The department has developed a routine reporting system and the Health Information Strategic Plan, and oversees its implementation. The department has developed the national core indicators for health and maintains the MoPH core system database with functional links and responsibility for all MoPH databases.

Regarding FP, the HMIS only provides CYP data. FP service statistics are available but not published. CPR data collected through household surveys is not published due to concerns about the quality of the data. The flow of health information is as follows: data from health posts is collected by community health supervisors who send the information to implementing NGOs. These forward the data to Provincial Health Offices. Currently the District Health Officer does not have a major role in the HMIS. Regular feedback based on HMIS data is expected to flow back to staff at lower-level facilities via monthly meetings.

### 1.7.5 Behaviour change communication

The Health Promotion Department is responsible for BCC. It monitors health education messages produced by different agencies to ensure that they are aligned with national policies, are culturally sensitive and not religiously offensive. The department has conducted qualitative research on perceptions of the religious position on FP and its influence on the use of modern methods by women of reproductive age as well as on attitudes of religious leaders and mothers-in-law towards

44. Discussions with the training centre staff at Rabia Balkhi Hospital and with UNFPA staff.

45. MoPH (2013). *Afghanistan National Health Accounts with Sub-Accounts for Reproductive Health 2011–2012*. In collaboration with USAID and Futures International.

FP. The department is responsible for clearing all messages related to FP through government-owned radio and television as well as the private sector media. In collaboration with the Child and Adolescent Health Division, the department is also involved in health education on reproductive health for adolescents.

There is no separate BCC strategy for FP. Birth spacing is one of 12 thematic areas identified in the National Health and Communication Strategy which also includes two outcome indicators on knowledge about modern methods and where to obtain contraceptives.[46] A BCC strategy for maternal and neonatal health is currently being developed in collaboration with UNICEF, WHO and UNFPA, in which FP is expected to be a priority area.

### 1.7.6 Contraceptive commodity security

Contraceptives are included in the essential drugs list.[47] Discussions are currently underway regarding the inclusion of implants. There is no import tax on contraceptives except when the products are imported for social marketing.[48] The products have to be registered in-country. There are no national standards for quality assurance.

UNFPA supplies contraceptives to MoPH through its global procurement process. These supplies are distributed to major public hospitals in Kabul and the regions as well as to the Afghan Family Guidance Association (AFGA) (see section 1.7.9). As mentioned elsewhere, there are concerns about commodities procured by NGOs implementing BPHS and EPHS. Socially marketed products are quality assured. There are no national standards for warehousing, but social marketing organizations have developed relevant guidelines and standard operating procedures. There are no national standards for forecasting, LMIS, distribution, etc. A draft of the first national Reproductive Health Commodity Security Strategic Plan 2015–2020 includes coordinated procurement, LMIS, capacity building, etc.[49]

### 1.7.7 Social marketing of contraceptives

Social marketing of contraceptives was introduced through the 'Expanding Access to Private Sector Health Products and Services in Afghanistan' (COMPRI-A) project managed by Management Sciences for Health through a Futures International contract from 2006 to 2010. ASMO was established in 2008 and COMPRI-A merged with it. Socially marketed contraceptives include condoms (Asadgi), pills (Khoshi) and injectables (Depo-Provera) (Khoshi). The organization promotes its products through a network of pharmacies in Kabul and other regions. MSI, an international NGO, is involved in the social marketing of condoms (Aarmesh). The products are also distributed through community-based distributors who provide counselling and products, operating in areas where there are no CHWs.

46. MoPH. *National Health and Nutrition Communication Strategy 2008–2013.*

47. USAID DELIVER PROJECT, Task Order 4. *Contraceptive Security Indicators Data 2014.* Arlington, Va.: USAID | DELIVER PROJECT, Task Order 4. Available at http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CSIndiData2013.xlsx.

48. Ibid.

49. MoPH. *Reproductive Health Commodity Security Strategic Plan 2015–2020.*

## 1.7.8 Private sector and NGOs

The private sector is a major contributor to health care. The Afghanistan Health Survey in 2006 found that 57 percent of those seeking health care went to a private provider first, 67 percent went to private providers for their second visit, and 83 percent went to private providers for their third visit.[50]

A subsequent USAID-funded study on private sector health care underlined the importance of the sector in the provision of reproductive health care.[51] The National Health Sub-Accounts found that 61.8 percent of household expenditure was in the private sector.[52] Studies found that 75 percent of women preferred receiving FP services from a private provider, probably because of privacy concerns; however the same survey showed that only about 30 percent provided FP services (limited mostly to information).[53] Private clinics run by female doctors and midwives did provide contraceptives while hospitals in major cities have FP clinics supported by NGOs such as AFGA. The MoPH has developed strategies for the private sector (section 1.8.2).

AFGA, an affiliate of International Planned Parenthood Federation, is one of the oldest NGOs in Afghanistan and a provider of FP services. It receives contraceptives through UNFPA and supports FP clinics in major hospitals in Kabul City (public and private) and in regional hospitals in Herat, Mazar-e-Sharif and Nangarhar. It also provides training in long-acting and permanent FP methods. AFGA is a key player in youth-friendly reproductive health services.

International NGOs such as MSI support private providers for FP services through capacity building and provision of commodities while ASMO also supports capacity building of private sector providers in FP services. Both agencies support FP services in private hospitals in Balkh, Herat, Faryab and Kabul, and work with religious leaders to support FP and RH services. MSI also supports youth friendly reproductive health services. The Aga Khan Foundation provides FP services through its health sector activities in various districts.

## 1.7.9 Adolescent reproductive health services

The MoPH has established a call centre for youth (married and unmarried) with UNFPA support which provides advice on reproductive health issues. Adolescent corners have been set up in the Children's Hospital in Kabul. It is managed by peer educators and the services are limited to providing information. There are plans to establish Youth Friendly Services in a few health facilities and to expand these to BHCs for married adolescents and youth. As noted in 1.7.9, NGOs such as AFGA and MSI have established counselling and other reproductive health services for adolescents.

### *Challenges in health service delivery*

Although progress has been made in improving access to basic health services, health system development has seen only mixed success; particularly in the areas of human resource development and management, planning and budgeting, the management and administration of the system and delegation of responsibility to provincial teams.[54]

50. MoPH, JHBSPH, IIHMR. *Afghanistan Health Survey 2006: Estimates of Priority Health Indicators for Rural Afghanistan.*

51. USAID (2009). *Afghanistan Private Sector Health Survey 2008.* Available at: http://pdf.usaid.gov/pdf_docs/Pnadq185.pdf.

52. MoPH (2013). *National Health Accounts with Sub-Accounts for Reproductive Health 2011–2012.*

53. USAID (2009). *Afghanistan Private Sector Health Survey 2008.* Available at: http://pdf.usaid.gov/pdf_docs/Pnadq185.pdf.

54. World Bank (2013). *Afghanistan - System Enhancement for Health Action in Transition (SEHAT) Project: Emergency Project Paper.* Washington DC: World Bank. http://documents.worldbank.org/curated/en/2013/02/17368947/afghanistan-system-enhancement-health-action-transition-sehat-project-emergency-project-paper.

There are also concerns about access and the quality of services. Although progress in the health sector is encouraging, it is not sufficient to ensure that Afghanistan will achieve the health MDGs, particularly MDG 5b.

## 1.8 Government response

### 1.8.1 National development policies

The Afghanistan National Development Strategy (ANDS) 2008–2013 is structured around the MDGs and includes as a goal the reduction of maternal mortality by 50 percent by 2015.[55] ANDS recognizes high population growth as being detrimental to poverty reduction and accepts the need to encourage FP as part of its poverty reduction strategy despite cultural barriers. However, neither fertility nor CPR are included in the list of ANDS monitoring indicators, though the MDG report includes fertility reduction and CPR as indicators under MDG 5b.

### 1.8.2 National health policies and strategies

The National Health Policy 2008–2013 recognized reproductive health as a priority area, and included FP.[56] However, the National Health and Nutrition Policy 2012–2020 only mentions FP in the context of maternal and neonatal child mortality reduction[57]; fertility and FP indicators are not included in the list of policy targets. Addressing adolescent reproductive health issues is listed as an action under the policy.

The National Strategic Plan for Health 2011–2015 includes FP only in the context of services for youth.[58] The National Priority Programme, developed by MoPH in 2012, includes FP as a key intervention under universal access to RH (sub-component 1.8) and under maternal and newborn care (sub-component 1.9).[59] The National Strategy for Improving Quality in Health Care 2011–2015 lists FP under maternal care, one of its seven priority areas (other areas include neonatal care, child and adolescent health, nutrition, disability, mental health and communicable diseases).[60] FP is mentioned under maternal care as an intervention to prevent unsafe abortion. In the various documents related to implementation, birth spacing and postpartum IUCD are listed separately among the 22 process indicators/ criteria. Standards for various birth spacing/ FP methods are available and are used for monitoring the quality of FP services.

The Community Based Health Care Strategy 2009–2013 mentions FP promotion and services among the responsibilities of CHWs.[61] The job description of the supervisors focuses on processes and does not specifically mention any thematic area. The strategy is currently under revision.

FP is also a key element of the BPHS and EPHS (section 1.7.1).

Policies and strategies related to private sector health care provision do not mention FP, even under maternal care.[62]

55. GIRoA. *Afghanistan National Development Strategy 2008–2013.*
56. MoPH. *National Health Policy 2008–2013.*
57. MoPH. *National Health and Nutrition Policy 2012–2020.*
58. MoPH. *National Strategic Plan for Health 2011–2015.*
59. MoPH. *National Priority Programme 2012.*
60. MoPH. *National Strategy for Improving Quality in Health Care 2011–2015.*
61. MoPH. *Community Based Health Care Strategy 2009–2013.*
62. MoPH. *Minimum Required Standards for Private Sector.*

### 1.8.3 National reproductive health policies and strategies

The National Reproductive Health Policy 2012–2016 emphasizes universal access to FP services at all levels of health care including health posts, commercial services and pharmacies, and defines the FP services to be provided at health facilities of various levels. Emergency contraception is also included,[63] as is counselling as a key element.

The National Reproductive Health Strategy 2012–2016 builds on the policy, and its guiding principles and seven operational principles are applicable to FP services.[64] The strategy includes several targets related to FP, including the availability of at least three methods in all facilities, as well as CYP, CPR and TFR. Component 2 of the strategy relates to birth spacing/ FP, with strategic approaches including:

- Capacity building;
- Expansion of method choice (focus on postpartum/post-abortion FP at facility level and promotion through community-based approaches, inclusion of emergency contraception in the BPHS package, LMIS);
- Strengthening community-based approaches for promotion of services through CHWs and FHAGs, services through CHWs and referral systems;
- Information, education and communication (IEC) focusing on adolescents and young, religious leaders, mothers-in-law, etc.;
- Monitoring and evaluation; and
- Private sector involvement.

The strategy states that service integration is an underlying principle; however, there is no evidence of integration with STI or child health services.

The National Acceleration Plan for Maternal and Newborn Health 2013–2015 does not mention FP as an element in the continuum of care.[65] FP is mentioned under pre-marriage counselling, young married and postpartum care.

The National Child and Adolescent Health Strategy 2009–2013 includes birth spacing as a key intervention for reducing newborn, infant and child mortality.[66] Under adolescent health, the relevant interventions listed are delaying marriage and information on sexuality, fertility and menstrual hygiene. Revision of the policy is planned.

The National HIV/AIDS Strategy does not mention integration with FP services under services for prevention or the prevention of mother-to-child transmission.[67] This is a serious omission considering that one-third of HIV and AIDS cases are among women.

63. MoPH. *National Reproductive Health Policy 2012–2016.*
64. MoPH. *National Reproductive Health Strategy 2012–2016.*
65. MoPH. *National Acceleration Plan for Maternal and Newborn Health 2013–2015.*
66. MoPH. *National Child and Adolescent Health Strategy 2009–2013.*
67. MoPH. *National Strategic Framework on HIV/AIDS for Afghanistan I – 2011–2015.*

### 1.8.4 Quality assurance policies and strategies

The MoPH has invested heavily in improving service quality. The National Strategic Plan for Health and the RH Strategy focus on quality of care, and there is a separate unit for quality assurance.

As noted in section 1.8.2 above, a National Strategy for Improving Quality in Health Care exists. National standards for quality assurance regarding FP have been developed for district hospital, CHC and BHC levels, covering the full range of methods. Implementation and training guides have also been developed. A baseline survey is underway in selected provinces, based on which specific strategies will be developed. At the time of writing, not all provinces had been covered.

The MoPH has developed a Charter of Patients' Rights which is being introduced across Afghanistan.

**MoPH Charter of Patients' Rights**

- Communication and information
- Participation
- Privacy
- Respect
- Access
- Timely services
- Safety

The Balanced Score Card includes quality of service as one of its domains and is regularly monitored through selected indicators (see Annex 1.4).

### 1.8.5 Non-health sector policies in support of FP

The National Youth Policy developed by the Deputy Ministry of Youth Affairs has been approved and mentions education on birth spacing under adolescent and youth health rights.[68]

The Ministry of Women's Affairs' National Action Plan for the Women of Afghanistan 2008–2018 explicitly supports the promotion of FP and access to contraceptives in its section on health. FP is also a key component of population policy development proposed in the section on economy, work and poverty.[69]

The Ministry of Education and Ministry of Hajj and Religion have no policies that specifically support birth spacing/ FP. There are mixed views on the inclusion of reproductive health in the life skills curriculum.

68. Deputy Ministry of Youth Affairs. National Youth Policy 2014.
69. Ministry of Women's Affairs. National Action Plan for the Women of Afghanistan 2008–2018.

## 1.9 Donor and technical organizations

The European Community, the World Bank and USAID provide major support to FP through support to BPHS and EPHS. Through its various contractors, including JHPIEGO, Management Sciences for Health and the Futures group, USAID also provides technical support. JHPIEGO has provided support to the development of technical guidelines and quality assurance systems. Management Sciences for Health has provided support for strengthening contraceptive logistics. Futures International, working through ASMO, has developed technical guidelines on warehouse management. Futures International has also provided policy support through national health accounts analysis and the development of strategies for private-public partnerships. UNFPA has been a major player in RH and FP and has provided the MoPH with technical assistance for development of policies and strategies for RH and FP, RHCS, training in FP, strengthening capacity for managing logistics and provision of contraceptives.

## 1.10 Professional organizations

The Afghan Society of Obstetrics and Gynaecology and Afghan Midwifery Association play a key role in FP services. Such associations support capacity building of midwives and doctors (mostly related to safe motherhood) and in the development of national guidelines and standards.

## 1.11 Conclusion

While there is progress in fertility and FP indicators and potential impact on maternal, infant and child mortality, FP services have a long way to go, despite the existence of supportive policies. The challenges are multifaceted, with health system gaps particularly human resources (female providers), FP commodities, poor quality of FP services, cultural, economic and social factors affecting underutilization of services (enabling factors) and gaps in demand due to informational gaps.

# 2. COMPREHENSIVE FP NEEDS ASSESSMENT

As the preceding chapter makes clear, the MoPH and its partners face a triple challenge in the provision of FP services. They have to identify and address inadequacies in service provision and gaps in demand creation, as well as identify and address a complicated set of cultural, economic, and social factors that contribute to under-utilization.

## 2.1 Objectives

The purpose of the CFPNA is to map the current status of FP in Afghanistan; to determine the supply, demand, and environmental needs and uncover the reasons for gaps in FP services at the health facility, district, and provincial level. The results of the assessment are expected to be used by the MoPH to draft a FP Strategic Action Plan, which incorporates reproductive health commodity security, to be implemented under the guidance of the RHD across Afghanistan.

The specific objectives of the CFPNA are to:

- Scan and map the current status of FP in Afghanistan;
- Assess the needs for effective and sustainable supply/ provision of FP services;
- Determine the quality of services provided;
- Assess the needs for increased mobilization of the population, especially young people and the rural population, to demand and make use of FP services; and
- Assess the needs for conducive policy, financing, political, and socio-cultural support for FP programmes.

The Terms of Reference for the CFPNA are given in Annex 1.1.

## 2.2 Approach and methodology

The CFPNA is based on EngenderHealth's Supply–Enabling Environment–Demand (SEED) Programming Model. The approach, which is described in the SEED™ Assessment Guide,[70] provides a holistic programming framework based on the principle that FP programmes are more successful and sustainable if they comprehensively address the multi-determinants of health, with synergistic interventions that:

70. EngenderHealth (2011). SEED Assessment Guide. New York. Available at: http://www.engenderhealth.org/pubs/family-planning/seed-assessment-guide-for-family-planning.php.

- Attend to the availability and quality of services and other supply-side issues;
- Strengthen the health system and foster an enabling environment for health seeking behaviour; and
- Improve the knowledge of FP/SRH and cultivate demand for services.

These components are illustrated in Figure 7 below. This model was used as a tool for identifying strengths, weaknesses and gaps in the delivery of FP services, policies and strategies and contraceptive commodity security across Afghanistan.

**Figure 7: The SEED™ Model**

*Source: SEED Assessment Guide*

## 2.2.1 Human rights perspective

This study was underpinned by a human rights perspective. Whilst implicit in the objectives, approach and methodology of the study, the assessment further attempted to strengthen the perspective by assessing whether current FP programmatic inputs at the policy, service, community and individual levels incorporate the principles of human rights (voluntarism, non-discrimination, empowerment, participation and accountability), and public health (beneficence, equity and autonomy).

## 2.2.2 Use of local knowledge and understanding

There is a need to better understand the factors affecting demand and supply of FP in Afghanistan and the context in which FP is delivered in order to design better and more strategic interventions. However, gaining access to service providers and the clients they serve, in order to understand FP needs and how services are delivered, is a challenge; about three-quarters of the population lives in rural areas and access is hampered by geography and security issues. While studies have been undertaken, they do not provide a valid recent analysis of FP needs across the country. To better understand FP needs and issues, local knowledge and understanding is required to collect data in areas where access is difficult.

Recognizing that local institutions exist in several provinces where access is a challenge with experience in undertaking community health surveys, one such, Youth Health and Development Organization (YHDO), was contracted to implement the field assessment. The selection was done jointly by the RHD and Research Bureau of MoPH with UNFPA. Through this partnership, it was possible to access most of the facilities in the sample, despite security issues.

### 2.2.3 Inclusion of contraceptive commodity security

Contraceptive commodity security is an integral part of the rights-based framework and the delivery of RH. There is limited information on the procurement process and status of the supply chain of reproductive health commodities. For this reason, UNFPA mobilized an independent RHCS expert to contribute to the assessment and the findings are expected to be integrated into the final report and action plan.

## 2.3 National level reviews

The national reviews included a study of existing policies, the programme management structure and interviews with key informants. The objective of the policy review was to assess if:

- There is political commitment recognizing FP as a key service for achieving reproductive health as well as development goals;
- The policies and strategies include four elements of right to health – accessibility, availability, acceptability and quality;
- The policies and strategies provide guidance on protecting and fulfilling rights while implementing programmes;
- The policies are non-discriminatory;
- They promote client rights such as informed decision-making, privacy and confidentiality, safe services and follow-up care;
- There is participation by diverse stakeholders including religious leaders, women, socio-economically vulnerable groups; and
- There is accountability.

The programme management structure at the central level was reviewed for its efficiency and effectiveness. Intra-sectoral coordination was reviewed. In addition, policies of the ministries that influence and promote reproductive rights and facilitate supportive social and gender norms were reviewed.

Using the SEEDS key informant discussion guides, discussions were held with key officials from the MoPH, Ministry of Women's Affairs, Deputy Ministry of Youth Affairs and the Ministry of Education. The concerned official of the Ministry of Hajj and Religious Affairs could not be interviewed due to non-availability. In addition, trainers at Rabia Balkhi Hospital, Afghan Midwifery Association and Afghan Society of Obstetrics and Gynaecology office-bearers, and officials from AFGA, MSI, ASMO, Futures International, USAID, World Bank and DFATD were interviewed using SEEDS key informant discussion guides.

## 2.4 Field assessment methodology

This section provides an overview of the methodology used for the field assessment component of the CFPNA. The RHD has established a taskforce to provide guidance to the assessment.

### 2.4.1 Study design

The assessment is a cross-sectional study and entailed visits to health facilities where FP services are provided. As the study included both the supply and demand side of service delivery, clients and selected communities in the catchment area of the health facilities studied were included in the study.

### 2.4.2 Sampling

The original intent was to randomly select 250–300 facilities (40 percent) from 12 randomly selected provinces across Afghanistan. However this was not accepted by the RHD or Research Division of the Ministry of Health. Instead provinces were purposively selected within each region of Afghanistan and health facilities (public) were proportionately allocated as described below.

#### Sample size

A sample size of 237 survey units was calculated with a 90 percent confident level for the assessment:

| | |
|---|---|
| Confidence level | 90% |
| Population size* | 1918 |
| Proportion | 0.5 |
| Sample size: Survey unit | 237 |

**Target population includes the total number of health facilities including HSCs, BHCs, CHCs, Provincial Hospitals and Regional Hospitals (RH) in the country.*

The survey sample was allocated across five domains or strata in proportion to the target population and number of health facilities within the region (see Table 8).

#### Table 8: Sampled health facilities by region

| Sample Size: | 237 | |
|---|---|---|
| Power Value: | 0.800 | |
| **Domain/Stratum** | **Proportion of health facilities** | **Allocation of survey units** |
| North | 645 | 73 |
| South | 238 | 33 |
| East | 233 | 32 |
| West | 235 | 33 |
| Central | 567 | 66 |
| Total | 1918 | 237 |

*Source: YDHO study protocol submitted to MoPH*

#### Selection of provinces for assessment

Eight provinces were purposively selected for the assessment (Table 9). Criteria for the selection of provinces were finalized in consultation with the taskforce established under the guidance of the

RHD, MoPH. The taskforce recommended that if, for security reasons, it was not possible to assess all the facilities in Farah, the shortfall for the western domain should be made up by including facilities from Herat. This turned out to be necessary. In addition at the request of Deputy Minister of Health, Kabul was added for comparison. Table 9 and Figure 8 show the final list of provinces in the study.

In selecting the first eight provinces the following criteria was applied:

- CPR: Provinces with high, middle and low CPR were identified.
- Regional representation: It was agreed in consultation with the RHD to include two provinces from the northern domain, two from the south, two from the central domain, and one each from the eastern and western domains.
- Population: High and low population provinces in the domains.
- Access: Security and accessibility situation.
- Ethnicity: Representation of different ethnic groups.

### Table 9: Selected provinces by selection criteria

| No | Province | Region | Population both sexes | CPR modern methods | Regional hospitals |
|---|---|---|---|---|---|
| 1 | Bamiyan | Central | 439,899 | 25.50 | 0 |
| 2 | Parwan | Central | 653,362 | 35.80 | 0 |
| 3 | Takhar | North East | 966,576 | 6.30 | 0 |
| 4 | Jawzjan | North West | 530,751 | 12.90 | 0 |
| 5 | Kandahar | South | 1,200,929 | 21.20 | 1 |
| 6 | Paktia | South East | 542,896 | 8.40 | 0 |
| 7 | Nangarhar | East | 1,489,787 | 20.20 | 2 |
| 8 | Farah | West | 498,951 | 27.90 | 0 |
| 9 | Herat | West | 1,852,790 | 44.20 | 1 |
| 10 | Kabul | Central | 4,227,261 | 30.40 | 22 |

### Figure 8: Provinces selected for CFPNA

### Sampling at provincial level

Commonly used random sampling was used to select health facilities for inclusion in the study, following the steps listed below:

- A list of health facilities, by type, for each of the target provinces was obtained from the MoPH.
- Urban and rural health facilities were identified using CSO data.
- Health facilities located in inaccessible districts and insecure areas were excluded from the sample frame.
- Health facilities in each province were proportionally distributed to the sample according to whether they were located in rural or urban settings (28 percent urban and 72 percent rural).
- All EPHS health facilities for each province, including BPHS district hospitals, were included in the sample.
- BPHS facilities (BHCs, CHCs and HSCs) in each province were proportionately allocated to the sample.
- The list of BHCs, CHCs and HSCs obtained from the HMIS was used to randomly select health facilities for each province sample.
- Where there was an insufficient number of health facilities to allocate to a province sample, health facilities from neighbouring provinces were included.

Table 10 below summarizes the distribution of health facilities by province, both planned and actual, with the latter in parentheses.

**Table 10: Distribution of health facilities by province (planned and actual distribution)***

| Province | Region | CHC | BHC | HSC | DH | PH | RH | Total |
|---|---|---|---|---|---|---|---|---|
| Bamiyan | Central | 5 (6) | 11 (13) | 14 (9) | 2 (3) | 1 | 0 | 33 (32) |
| Parwan | Central | 6 (8) | 15 (12) | 10 (8) | 1 (0) | 1 | 0 | 33 (29) |
| Takhar | North-east | 9 (10) | 26 (24) | 11 (8) | 2 | 1 | 0 | 49 (45) |
| Jawzjan | North-west | 5 (1) | 12 (8) | 4 (0) | 2 (1) | 1(1) | 0 | 24 (11) |
| Kandahar | South | 8 (10) | 7 (4) | 0 (1) | 1 | 0 | 1 | 17 (17) |
| Paktia | South-east | 3 | 5 | 6 | 1 | 1 | 0 | 16 (16) |
| Nangarhar | East | 5 (6) | 19 | 5 (3) | 1 | 1 | 2 (1) | 32 (31) |
| Farah | West | 10 (3) | 4 (2) | 17 (6) | 1 (0) | 1 | 0 | 33 (12) |
| Herat | West | 11 | 11 | 1 | 1 | 0 | 1 | 25 (25) |
| Total | | 51 (58) | 99 (98) | 67 (42) | 11 (10) | 7 | 2 (3) | 237 (218) |
| Kabul | Central | 41 | 43 | 2 | 8 | | 4† | 98 |

*DH: District Hospital; PH: Provincial Hospital; RH: Regional Hospital*

** actual distribution in parentheses*

*† specialist hospitals*

## 2.4.3 Data collection and management

### Data collection tools

Most of the data collection tools are standard discussion guides that have been previously used in other countries. Some of the tools are available in the SEED™ Assessment Guide for FP Programming. The clinical observations used standard FP checklists. Table 11 below provides a summary of the tools. A research protocol was also developed to support each group of tools. The tool are available at the UNFPA Country Office in Afghanistan.

### Table 11: Summary of tools for adaption to the local context

| National Level: International Consultants Tools | | |
|---|---|---|
| Tools | Description | For Use With |
| 5 SEED discussion guides | Global tools adapted to the Afghanistan context. These tools will be used by international consultants at the national level to guide interviews. | 1a Government policy makers and programme planners and managers<br>1b Bilateral and multilateral donors<br>1c Technical organisations (NGOs)<br>1d Professional organizations<br>1e Training providers |
| Integrated tools | 2.a. Capacity of supply chain management – central level<br>2.b. Capacity of supply chain management –facility level<br>Questions are based on USAID Deliver Logistics Assessment Tool; Engender Health SEED Assessment Guide for Family Planning Programmes; Interagency List of Essential Medicines for Reproductive Health; WHO operational package for assessing, monitoring and evaluating country pharmaceutical situations. | 2a Any of the groups above as relevant and those in charge of warehouses/ chief pharmacists.<br>2b Facility storekeepers and managers (incorporated into facility assessment) |
| Provincial Level: Local Institution Tools | | |
| Tools | Description | For Use With |
| 2 in-depth interviews | The criteria for selecting individuals for interviews will be related to the person's experience, position, and willingness to participate in the assessment. | 3a Provincial level managers district health managers, BPHS managers, RH officer<br>3b Heads of health facilities |
| Facility assessment | An integrated tool which includes observation, checklist, and questions for service providers and/or managers. | 4 All FP service delivery points |
| Clinical observation checklist | Observation of skills and quality of care in FP services provision. If enough clients cannot be found then models will be used. | 5a Counselling<br>5b IUCDs<br>5c Injectables (CHW Seeds merged) |
| FP exit interviews | Exit interviews to determine the effectiveness of FP services and to learn about users' satisfaction with FP services. | 6 Clients leaving the health facility |
| Community and focus group discussion | Used to obtain information about a group's beliefs, attitudes and level of knowledge on issues related to FP. If there are not enough participants for some focus group discussions then individual interviews will be undertaken with e.g. teachers and mothers-in-law. | 7a Women's group<br>7b Men's group<br>7c Young people (divided into male and female)<br>7d Community groups<br>7e Teachers |
| Guide for community case studies | 25 crucial programming elements are identified in the SEED Assessment Guide. These elements will be used as a framework for the case studies. A protocol for how quality services will be assessed is also included. | Not a formal tool, rather a guide to undertaking three district case studies |

## Data collection methods

A mix of quantitative and qualitative methods was used to gather information. Data collection teams used multiple techniques for collecting data which was then analysed both quantitatively and qualitatively. Techniques used included:

1. Literature review
2. Key informant interviews
3. Facility assessment
4. Clinical observation
5. Exit interveiws
6. Focus group discussions
7. Case studies

A summary of data collection methods by province can be found in Tables 12a and 12b.

## Table 12a: Numbers by quantitative data collection methods and province

| Province | Region | Quantitative Data Collection Methods | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Facility Assessment | | CO: Midwives | | | CO: CHWs (injectables) | | CEIs | | Total | | % achieved |
| | | Planned | Done | Planned | Assessed | | Planned | Assessed | Planned | Done | Planned | Data collected | |
| | | | | | Counselling | IUCD insertion | | | | | | | |
| Bamiyan | Central | 33 | 32 | 25 | 28 | 25 | 5 | 5 | 170 | 171 | 258 | 261 | 101.2 |
| Parwan | Central | 29 | 29 | 21 | 17 | 17 | 6 | 6 | 170 | 180 | 247 | 249 | 100.8 |
| Takhar | North east | 49 | 45 | 37 | 36 | 36 | 10 | 10 | 250 | 252 | 383 | 379 | 99.0 |
| Jawzjan | North west | 20 | 11 | 14 | 12 | 12 | 5 | 5 | 105 | 101 | 158 | 141 | 89.2 |
| Kandahar | South | 17 | 17 | 7 | 7 | 7 | 3 | 3 | 90 | 88 | 124 | 122 | 98.4 |
| Paktia | South east | 16 | 16 | 11 | 12 | 12 | 3 | 3 | 85 | 92 | 126 | 135 | 107.1 |
| Nangarhar | East | 32 | 31 | 24 | 26 | 24 | 8 | 6 | 180 | 186 | 268 | 273 | 101.8 |
| Farah | West | 17 | 12 | 12 | 3 | 2 | 2 | 1 | 85 | 57 | 128 | 75 | 58.6 |
| Herat | West | 25 | 25 | 17 | 16 | 16 | 5 | 5 | 130 | 130 | 194 | 192 | 99.0 |
| Total | | 238 | 218 | 168 | 157* | 151* | 47 | 44† | 1265 | 1257 | 1886 | 1827 | 96.9 |
| Kabul | Central | 110 | 98 | 60 | 61* | 55* | 31 | 21V | 550 | 504 | 811 | 739 | 91.1 |

*CEI: Client Exit Interviews. CO: Clinical Observation. FA: Facility Assessment.*

** Includes at least one counselling observation and one IUCD observation in a simulated environment (98 BHCs plus 42 HSCs) Total observations of counselling and insertion of IUCDS: 308*

*† Female CHWs at 40 percent of BHCs were assessed for skill in giving injections*

**Table 12b: Numbers by qualitative data collection methods and by province**

| Province | Qualitative Data Collection Methods | | | | | | % |
|---|---|---|---|---|---|---|---|
| | In-depth interviews | | Focus group discussions | | Total | | |
| | Planned | Completed | Planned | Completed | Planned | Completed | |
| Bamiyan | 6 | 7 | 15 | 15 | 21 | 22 | 95.5 |
| Parwan | 4 | 2 | 15 | 10 | 19 | 12 | 63.2 |
| Takhar | 6 | 6 | 25 | 27 | 31 | 33 | 1.1 |
| Jawzjan | 6 | 7 | 10 | 10 | 16 | 17 | 1.1 |
| Kandahar | 4 | 5 | 10 | 16 | 14 | 21 | 1.5 |
| Paktia | 5 | 6 | 10 | 10 | 15 | 16 | 1.1 |
| Nangarhar | 6 | 6 | 15 | 15 | 21 | 21 | 1.0 |
| Farah | 4 | 2 | 10 | 5 | 14 | 7 | 0.5 |
| Herat | 5 | 5 | 10 | 10 | 15 | 15 | 1.0 |
| Total | 46 | 46 | 120 | 118 | 166 | 164 | 98.8 |
| Kabul | 7 | 10 | 25 | 23 | 32 | 33 | 1.03 |

### 2.4.4 Case studies

Case studies were conducted in three districts: Chaab in Paktia, Paghman in Kabul and Herat City in Herat. Each case study was expected to yield lessons from the real life context and provide a sharp and in-depth understanding of how FP services were delivered, including integration into the health system, and institutional links between FP providers and communities.

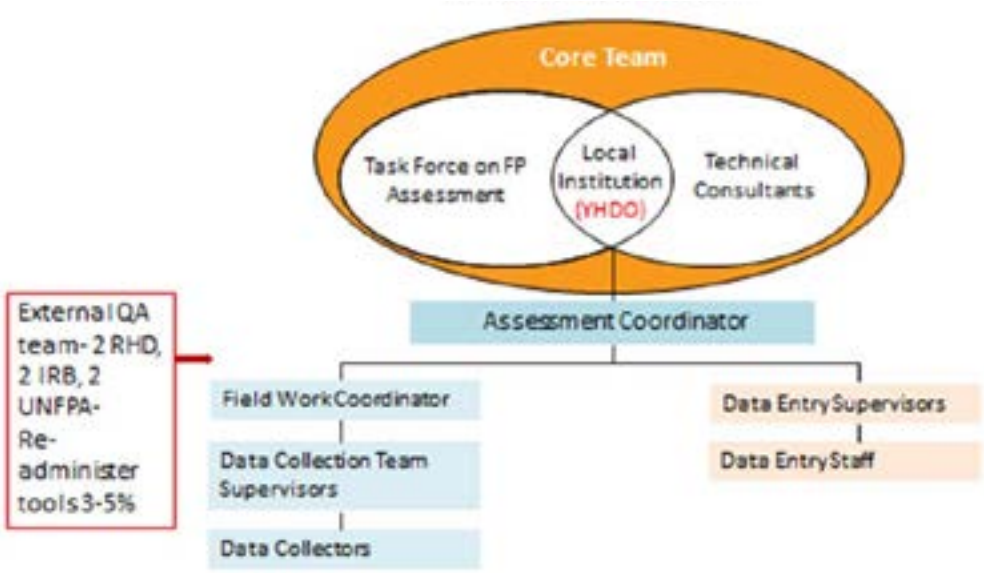
### 2.4.5 Ethical considerations

Ethical clearance was obtained from the MoPH Institutional Review Board. The three most relevant issues for this assessment were informed consent, confidentiality and safety. Ethics of data collection was part of the training of data collectors. At the field level, data collectors were expected to explain the purpose of the assessment and to obtain informed consent from clients who were interviewed and from providers before the observation of their skills started. Respondents' confidentiality was expected to be maintained.

### 2.4.6 Organization of fieldwork

YDHO was responsible for organizing fieldwork and data collection, including permissions from provincial health offices for undertaking the assessment. Figure 9 shows the management of fieldwork.

**Figure 9: Overall management showing organization of fieldwork**




## 2.4.7 Training of data collectors

Data collection training was undertaken in two batches by YDHO (duration was five days). The international consultants and UNFPA staff provided technical support during the training, particularly in clinical observations. The first batch of 30 participants came from the four provinces in the northern and southern regions and the second from the remaining provinces. A total of 51 data collectors and 16 supervisors were trained. Some were also deployed for the Kabul assessment.

As mentioned earlier, the training included ethical aspects of field assessment. Each training session included an overview of the assessment objectives, background information on FP, standard interviewer techniques, appropriate interviewer behaviour, communication skills, a detailed understanding of survey tools and classroom and facility practice. The National Birth Spacing/FP Guide, Monitoring and Evaluation Guidelines for RH (2012) and Quality Assurance Standards were used as the key resource documents for the training.

Data collection started in December 2014 and data collection and analysis, including for Kabul, were completed in May 2015.

## 2.4.8 Data management

Data entry and management were the responsibility of YDHO. Data entry screens were created in CSPro and later exported to SPSS. Qualitative data was analysed using a word processing programme.

## 2.4.9 Quality assurance

Quality assurance was done at different levels. At the field level, the supervisors checked the quality of completed tools and took necessary action. YDHO field coordinators also supervised data collection process and reviewed the completed tools.

An external quality assurance team (see Figure 9) consisting of two representatives each from RHD, MoPH Institutional Review Board and UNFPA visited the field, re-administered 3–5 percent of the tools, and confirmed that the data collectors had visited the facilities as per the sample. They provided reports after each visit.

### 2.4.10 Private sector

Five provinces were selected randomly and within these provinces private sector facilities were randomly selected (see Figure 8 and Table 13). The tools for in-depth interviews, client exit interviews, observation of counselling and IUCD insertion were used. The in-depth interview and client exit interview tools were minimally modified for the private facilities.

**Table 13: Private sector facilities by quantitative and qualitative methods and province**

| Province | Facility assessment | Client exit | Observation counselling | Observation IUCD | In-depth interview | | Total |
|---|---|---|---|---|---|---|---|
| | | | | | Owner | FP-in-charge | |
| Kandahar | 7 | 20 | 7 | 7 | 2 | 7 | 50 |
| Nangarhar | 6 | 49 | 6 | 6 | 1 | 5 | 73 |
| Balkh | 8 | 13 | 8 | 8 | 5 | 8 | 50 |
| Herat | 12 | 78 | 12 | 12 | 1 | 12 | 127 |
| Kabul | 65 | 187 | 65 | 65 | 6 | 65 | 453 |
| Total | 98 | 347* | 98† | 98† | 15‡ | 97‡ | 753 |

** Clients present at the time of the visit were randomly selected*

*† One observation of counselling and IUCD insertion was done in each facility*

*‡ Owners were interviewed if available at the time of the visit*

Data collection in private sector facilities started in April and data collection and analysis were completed in June 2015.

## 2.5 Limitations

The following limitations were noted:

- The scope of the assessment within the given timeframe (three months) was ambitious. Every effort was made to meet this timeline. However researchers had little control over factors such as weather and approvals to proceed, and these contributed to the delay in the analysis.
- Purposive samples can be highly prone to researcher bias. Researcher judgement is not a good defence when it comes to alleviating possible biases, especially when compared with probability sampling techniques. However, this judgemental, subjective component of purpose sampling is only a major disadvantage when such judgements are ill-conceived or poorly considered; that is, where judgements have not been based on clear criteria. To minimize this bias and limitation, clear criteria were developed (see section 2.2). Nonetheless, using purposive selection limited the extent to which findings can be generalized to all of Afghanistan. A multiplier computed on the basis of all facilities in the country was used whenever the nine province data was aggregated, also when analysis was done by type of facility and region.
- CHWs were expected to be interviewed as a group and observed when counselling and administering injectables. During the survey only female CHWs were assessed whilst giving injections. Additionally, observations on counselling were missed.

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# 3. FINDINGS

Though voluntarism has been a cornerstone of FP programmes since its inception, it received greater focus after the ICPD in Cairo in 1994. The Programme of Action ratified at this conference laid the foundation for reproductive health and rights including rights related to FP. The FP 2020 conference in London gave a further boost to human rights and public health approaches to FP programming. As explained in section 2.2.1, this assessment focuses on these human rights and public health principles.

The EngenderHealth's SEED framework assesses three synergistic components of FP programmes: enabling environment, supply and demand. The analysis in this chapter is therefore grouped under these three elements and also addresses human rights and public health principles of programming at policy, service, community and individual levels.

In recent years, and especially after the FP 2020 conference in London in 2012, voluntary FP programmes that respect, protect, and fulfil human rights have received much attention.

Afghanistan is a focus country under FP 2020, the global partnership to support women's and adolescents' rights to plan their families. For this reason, the findings of the CFPNA are of great significance from a human rights and public health perspective.

**All couples and individuals have the basic right to decide, freely and responsibly, the number, spacing and timing of their children, to have the information and means to do so and to attain the highest standard of sexual and reproductive health (ICPD Programme of Action Principle 8)**

## 3.1 Enabling environment

The SEED framework has identified nine elements under enabling environment:

- Effective leadership and management of the programme;
- Supportive laws, policies and guidelines for FP are operational at all levels;
- Human and financial resources are available for FP and are allocated effectively;
- Programmatic decision-making is evidence-based;
- Contraceptive security measures are in place;
- Advocacy efforts support the programme;
- Champions at all levels advocate for FP;
- Communities are engaged in addressing barriers to FP use; and
- The FP programme works to foster positive social norms and transform gender roles.

For greater visibility of the key issues, the findings described in this section are grouped under three headings: supportiveness of development polices and strategies towards FP, stewardship, and other enabling elements.

The findings derive from key informant interviews conducted at the national level with various divisions of MoPH, Ministry of Women's Affairs, Deputy Ministry of Youth Affairs and the Ministry of Education, as well as professional associations, international NGOs and donors (see section 2.3); with PHDs, RHCs and managers/ officers-in-charge of regional, provincial and district hospitals and CHCs, BHCs and HSCs; and with private sector facilities in the selected five urban areas (see Tables 12a, 12b and 13).

### 3.1.1 Supportiveness of development policies and strategies towards FP

#### Place of FP in national development policies and strategies

Section 1.8 discusses policies and strategies and covers current gaps.

- GIRoA was not a signatory to the ICPD Programme of Action in 1994, as the country was then experiencing conflict. However, through its participation in ICPD review meetings since 2004, Afghanistan has made commitments to the ICPD Programme of Action. In 2004, Afghanistan endorsed the MDGs and subsequently included the MDG 5 target of universal access to RH and its indicators.
- ANDS 2008–2013 identifies FP as a critical intervention for poverty reduction; however, this has not led to the inclusion of fertility and FP into its list of key indicators. The report is structured around the MDGs but the only indicator related to MDG 5 is the maternal mortality rate.
- FP is considered a priority intervention from the perspective of maternal mortality reduction as reflected in the development policies and health policies discussed in section 1.8. This is well justified, based on global evidence and evidence from Afghanistan. Recent studies from Afghanistan have shown that FP is the most effective single intervention for maternal mortality reduction.[71] [72] Studies from elsewhere in the region also point to the role of FP in reducing infant and child mortality, as well as its contribution to reducing stunting and underweight in children from unintended births (section 4.1.1).[73] The contribution of investments in FP to savings in achieving developmental goals is well known.
- Thus, FP deserves to be a standalone key intervention in improving reproductive health (as part of the continuum of reproductive health care) and in socio-economic development.

**Conclusion:** From the review of the policy documents and discussions with key stakeholders, it appears that political commitment to FP as a strategic development factor is an issue, and has an effect on resource allocations to the programme.

#### RH policies and their implementation

- As discussed in section 1.8.3, the National RH Policy and Strategy (2012–2016) both emphasize universal access to FP. All married women, irrespective of age, are entitled to free FP services. However, in reality, the young married are not provided information or services. There is no written law or policy against provision of contraceptives to unmarried adolescents or young married, but no information regarding delaying pregnancy or birth spacing is provided to these groups. There are opportunities during religious premarital education sessions, but no information is provided on the importance of delaying pregnancy.

71. Carvalho N, AS Salehi, SJ Goldie (2013). National and Sub-National Analysis of the Health Benefits and Cost-Effectiveness of Strategies to Reduce Maternal Mortality in Afghanistan. *Health Policy Plan 28* (1) 62–74. DOI: 10.1093/heapol/czs026.

72. Carvalho N, SJ Goldie, AS Salehi (2012). The Value of Family Planning for Improving Maternal Health in Rural Afghanistan: The Example of Kandahar. *Afghanistan J. of Public Health* 1 (1) 12–19.

73. See, for instance, Rahman MM (2015). Is Unwanted Births Associated with Malnutrition in Bangladesh? *International Perspectives on SRH 41* (2) 80-88.

- The RH policy and strategy do not restrict the use of any contraceptive methods and support the expansion of choice through the introduction of implants, postpartum and post-abortion FP, and of emergency contraception. Emergency contraception is not available due to unexplained barriers created by the MoPH.
- The RH strategy emphasizes integration, but there is no evidence this has occurred with child health or STI and HIV/AIDS services. The national guidelines on FP mention screening for STI and HIV/AIDS but, from discussions, this is not common practice. This finding is underscored by observations of counselling and IUCD insertions during field assessment (section 3.2.4).
- The National Strategic Framework on HIV/AIDS does not mention integration with FP services. The guidelines for the prevention of mother-to-child transmission of HIV focuses on prong 3 ('Prevention of HIV transmission from a woman living with HIV to her infant') and prong 4 ('Prevention and appropriate treatment, care and support to women, children living with HIV and their families;). Prongs 1 and 2, relating to preventing HIV amongst women of childbearing age and preventing unintended pregnancies among women living with HIV are not emphasized. This could be because of the concentrated nature of the epidemic, in which surveillance in antenatal clinics is not routine.
- Postpartum FP is a focus of the Maternal and Newborn Health and FP programmes and is promoted through facility-based and community-based approaches but, in reality, only postpartum IUCD insertion (rather than the whole basket of methods) is promoted.
- The QI process for FP includes postpartum IUCD acceptance as an indicator, bringing further focus onto this method. Considering the majority of deliveries occur at home, the focus on postpartum IUCD alone may not be an effective strategy to increase service utilization.
- National FP service guidelines were updated in 2012 to include implants and postpartum IUCD. The guidelines have been translated into Dari and Pashto. The GCMU was made responsible for distributing to BPHC and EPHC implementing partners. However, these have been not distributed and thus are not available in all facilities. The finding was corroborated by the facility assessment.
- A National Strategy for Improving Quality in Health Care exists. National standards for quality assurance specific to FP for district hospitals, CHCs and BHCs have been developed and cover the full range of methods. In addition, an implementation and training guide has been developed.
- WHO's Medical Eligibility Criteria Wheel has been translated into Dari and Pashto and distributed to GCMU for distribution. WHO's Decision-Making Tool for FP clients and providers is currently being translated. This tool is intended to assist providers to provide quality counselling.

**Conclusion:** From the review of the RH policy and strategy documents, FP is highlighted as a key component; however, there are concerns about implementation. The findings from the field assessment highlight some of the issues.

### 3.1.2 Stewardship

Stewardship is one of the six building blocks of the WHO health systems framework and the principles defining stewardship for the health system overall are also applicable to FP. The first element of the enabling environment (leadership and management) is covered under stewardship. The national interviews and literature review conducted as part of this assessment focused on various stewardship tasks described below. The provincial interviews focused mainly on ownership and advocacy as this level is currently not involved in many of the elements.

It is difficult to separate out tasks specifically related to the FP Unit as its functioning is an intrinsic part of the functioning of the RHD. Hence some findings may appear irrelevant in the current context and structure, but are relevant for the FP Unit.

### Overseeing and guiding the overall provision of FP services in the public and private sector

- There is a separate unit for FP under the RHD (section 1.7.1). In line with the MoPH mandate, the RHD is expected to play a stewardship role for RH services including FP, coordinate with the relevant MoPH units and divisions, and provide technical support.[74] Though the roles and responsibilities of the FP Unit are not clear, it is presumed that the unit is expected to play a similar role with regard to the FP programme. From the assessment it appeared that the unit has little decision-making authority or capacity for strategic planning (as with the RHD; as was evident from the earlier assessment). From discussions with various stakeholders, it appears that the unit's activities are mainly influenced by donor requirements, not the needs of the communities. Hence oversight and guidance for FP services appears to be weak.
- Coordination with other relevant units and divisions such as training, safe motherhood, quality assurance, BCC, human resources, midwifery, adolescent health, finance, etc. appears to be through cooperative linkages, not technical support or supervision of FP activities within those divisions.
- Taskforces consisting of internal and external staff have been created to meet technical needs such as the development of guidelines and standards on the introduction of new methods. These taskforces do not have any role in advocacy for increased financial and human resources to implement the guidelines or for the provision of services to adolescents and young people.
- Coordination of activities between various stakeholders appears to not be effectively and efficiently handled, leading to duplicated efforts and wasted resources.
- A policy and strategy for private sector health has been developed, but the role of the FP Unit appears to have been limited. The private sector strategy does not include FP services.
- Communications with the PHD appears to be irregular and largely ad hoc.
- RHD funding (including for the FP Unit) is almost exclusively from donors and not all units are covered, hence it is difficult to create relevant posts.
- There is little to report on the stewardship role of the PHD as administrative powers have not yet been fully devolved and responsibility for fiscal transfers have also not been fully devolved. In the case of FP services, a key factor could be the fact that almost all investments in FP are donor funded. From the in-depth interviews conducted for this assessment, it is evident that PHDs and RHCs recognize FP as an important health intervention for improving maternal and child health, but there is less recognition of its contribution to economic development. The interviews did not give the impression that there was active involvement of PHDs in FP services.

**Conclusion:** The stewardship and leadership role played by the FP Unit is limited due to the structural issues identified above. The stewardship role of PHDs is limited.

74. USAID Afghanistan (2010). *Capacity Assessment of the Reproductive Health Directorate*. HSSP Project..

### Oversight and intelligence

- As with the RHD, the FP Unit does not have a direct mechanism for data collection and the main source of information is the HMIS. As pointed out earlier, the HMIS data does not include all FP indicators. CYP data is available but the indicator primarily reflects distribution, not actual use or impact, and the exact number of individuals using contraception cannot be ascertained.
- The HMIS Department regularly receives reports from BPHS implementing partners, including RH data. These are compiled quarterly by the HMIS but the information is not routinely shared with the various divisions. The RHD or FP Unit has no officer for monitoring and evaluation, affecting capacity to monitor FP trends, access to services and quality of data; hence data cannot be used for planning and programme monitoring.
- There is no regular feedback to implementing partners or PHDs on reports received, either from the HMIS Department or RHD. This is due to capacity and capability gaps in the RHD and FP Unit.
- From the in-depth interviews, facility assessments and focus group discussions with the providers, it appears that the PHDs or RHCs do not actively monitor the data on FP and take corrective action.

**Conclusion:** The oversight and intelligence role appears to be weak or even non-existent.

### Collaboration and coalition building across sectors

- While the taskforces on RH and FP include members from the Ministries of Women's Affairs, Education, Deputy Ministry of Youth Affairs, etc., it is not known whether they influence the promotion of birth spacing in their respective ministries.
- The National Women's Action Plan includes FP as a priority area and it was reported that messages on FP are being promoted through the activities of the Ministry of Women's Affairs, particularly at the community level through women's *shuras*.
- While FP for the married young is mentioned in strategies for birth spacing and to delay the age of first birth, how well this is realized is unknown. Data from the Afghanistan Mortality Survey showed that 7.5 percent of 15–24 year-olds had more than three children. Premarital counselling, including contraception for delaying the first pregnancy, was mentioned in some documents but its implementation is doubtful. Discussions with stakeholders suggested that peer education and other adolescent educational activities do not include much information related to FP.

**Conclusion:** Inter-sectoral collaboration needs strengthening, not only for advocacy, but also for influencing reproductive rights and gender norms.

### Rights-based approaches

- Human rights principles are included as guiding principles of the health policy and RH strategy but it is not known whether this is just rhetoric or if the concerned officials understand the principles as was reported in the assessment of the capacity of the RHD in 2010. Section 3.2 on supply illustrates how duty bearers violate the rights of clients.
- Gender equality is mentioned as a core principle in health and development policy documents.

### 3.1.3 Other enabling elements

The visibility of FP in policies and stewardship are critical first elements of the enabling environment, with an impact on other elements contributing to the enabling environment.

#### Allocation of financial and other resources

- Financial allocation is an indicator of the commitment of the government to a specific programme. There is no separate budget line for FP services or commodities. The Financial Resource Flows for Population Activities report for 2013 showed that 16 percent of the expenditure was for FP activities with 100 percent of funding coming from external sources.
- An action plan for the RH strategy was costed in 2011. Approximately 40 percent was reserved for FP with almost all funding expected to come from United Nations agencies. This raises concerns about the government's commitment to FP.
- There is no system for tracking RH or FP expenditures. The analysis of the RH sub-account in the discussion of health financing (section 1.7.4) showed that the expenditure on maternal and child health and FP was 3 percent and household spending 78.5 percent of THE for RH, with the percentage specifically for FP unknown.
- The RHD has no direct links to the MoPH Finance division as they are not administratively linked.
- RHD posts are not fully filled and those filled are funded by donors. Rapid turnover of staff is another problem.

**Conclusion:** FP does not receive any funding from the government and is 100 percent donor funded. It is not clear if the allocations adequately meet demand.

#### Use of evidence for decision-making

- The FP component of the RH strategies has never been evaluated and its development appears not to be based on evidence.
- As indicated in section 3.1.2 on stewardship, lack of capacity to analyse HMIS data and programme gaps makes it difficult to identify and take corrective action.
- The updating/ development of guidelines is based on international guidelines.
- Generally, operations research is not conducted before introducing new contraceptives or scaling up and introducing new service delivery mechanisms.
- A strategic assessment of FP was completed in 2008 with WHO support (see section 3.2 on supply), but it is not known whether the results were used for developing strategies.
- Behavioural research studies of mothers-in-law and religious leaders have been carried out and the results are being used for training and to develop advocacy materials.
- Aside from a study on its role in reducing maternal mortality, few studies have been undertaken to illustrate the development benefits of FP.[75] [76]

**Conclusion:** While the national standards are based on international standards, the programme elements appear not to be evidence-based. Few studies have been conducted to provide evidence on FP and where these have been done, there is little evidence that the findings have been used.

75. Carvalho N, AS Salehi, SJ Goldie (2013). National and Sub-National Analysis of the Health Benefits and Cost-Effectiveness of Strategies to Reduce Maternal Mortality in Afghanistan. *Health Policy Plan* 28 (1) 62–74. DOI: 10.1093/heapol/czs026.

76. Carvalho N, SJ Goldie, AS Salehi (2012). The Value of Family Planning for Improving Maternal Health in Rural Afghanistan: The Example of Kandahar. *Afghanistan J. of Public Health* 1 (1) 12–19.

## Advocacy and champions

- UNFPA and other international organizations have been advocating with religious leaders and providing them training. Initial evaluations suggest that these religious leaders are advocating for the use of FP. However comprehensive evaluations of the various advocacy activities have not yet been done.
- There is little documentation that shows that senior officials of MoPH publicly speak about FP. While the National Priority Programme and National Health Policy include FP, further high-level multi-sectoral advocacy is required.
- There are no systematic efforts to advocate with policymakers such as ministers, parliamentarians or other leaders at national and provincial levels.
- While media representatives have been trained on the basics of rights-based family planning, radio talks and television debates are lacking. The findings of the studies undertaken by the Health Promotion Department and other studies by social marketing organizations and international NGOs on media reach will be useful in developing appropriate messages.

**Conclusion:** High level advocacy on FP needs strengthening.

## Addressing barriers to FP use through community engagement

- The FP component of the RH strategy includes community engagement in supporting and promoting FP activities through CHWs and health shuras at facility and community levels and FHAGs. Advocacy with religious leaders and other influential people is also emphasized. However, it is not known whether community workers and community-based groups address the barriers to FP use. Focus group discussions indicated that community leaders promoted FP discussions in health shuras.
- In-depth interviews with managers of health facilities found that they engaged with communities and religious leaders in promoting FP (see section 3.3 on demand).
- Focus group discussions with CHWs and midwives also indicated that discussions on FP occurred in health shuras.

**Conclusion:** Community engagement is one of the pivotal elements in creating an enabling environment and requires more attention.

## Reproductive health commodity security

- Most FP commodities are part of the essential drug list (excluding implants, emergency contraceptive pills and female condoms).[77] Discussions are underway to add implants to the list.
- There is no import tax on contraceptives except when a product is imported for social marketing.[78]
- FP commodity security is a serious concern and has several dimensions. The following points cover issues related to policy and programming:
  - There is no strategy or policy in place for FP commodity security. A draft reproductive health commodity security strategic plan has been developed but has not yet been approved.[79] The draft plan does not include elements such as quality assured procurement and quality of distribution.

77. USAID/Deliver Project (2014). Contraceptive Security Indicators Data.
78. Ibid.
79. MoPH. *Reproductive Health Commodity Security Strategic Plan* 2015–2020.

- There is no national policy on procurement of contraceptives. Procurement is a major component under the SEHAT project, and it is possible that FP commodities will be included.
- There are no national standards for warehousing though ASMO has developed standards for its own warehouses.
- The LMIS routinely collects information and reports but there are concerns about the completeness and updating of records. The information gathered and reported is not standardized and does not efficiently capture stock-outs.
- The commodity forecast system for FP (and other RH commodities) is based on consumption during the previous month. It is likely that there is underreporting due to the issues with the LMIS described above, and this has implications for forecasting. Skills in forecasting are limited at national and provincial levels as well as with the partner NGOs. Some training on forecasting has been provided but it is not known whether it was effective. It is not clear whether data on distribution by the social marketing organizations is used by the government.
- The system of requisition and allocation at the health facility level is appears inefficient and practices are not standardized.

The field assessment report provides information on various aspects of commodity security (see section 3.2.1 on availability).

**Conclusion:** The lack of a strong policy/strategy on contraceptive commodity security has serious implications, as discussed in section 3.2 on supply.

### 3.1.4 Conclusion: enabling environment

With more supportive leadership and the allocation of adequate financial resources, positive policies could have been converted to tangible reality. The inadequacy of the government's financial support for promoting reproductive health, particularly for FP, is a concern and has implications for sustainability as donor support decreases.

The commitment of political decision-makers to manage the demographic growth to reap potential dividends appears to be limited.

While policies and strategies support engagement with community leaders and gatekeepers to overcome barriers to the use of FP methods, this engagement appears to be inconsistent and not very effective.

## 3.2 Supply

FP coverage is closely linked to the health system. The quality of services determines the coverage of services. Providing clients with high quality FP services that meet reproductive goals and respect, protect, and fulfil rights will require attention to various elements of health system delivery. Several of the elements related to the enabling environment, covered in section 3.1, such as supportiveness of policies, leadership, financing, monitoring and intelligence, reproductive health commodity security, etc., have a direct bearing on the delivery of FP services.

This section provides findings on the 10 elements of supply identified in the SEED Framework:

- FP is offered through a variety of service delivery modalities;
- Facilities are adequately equipped and staffed to provide quality FP services;
- Facility staff have the necessary skills to provide quality FP services;
- Management, supervision, QA and QI systems are operational;
- A broad mix of FP methods is available;
- FP services are integrated with other health services;
- Referral systems are functional where FP methods or services are unavailable;
- Private sector is involved in the provision of FP methods;
- FP services are inclusive of youth;
- Clients receive high quality FP counselling.

This assessment groups these 10 elements into the four human rights principles of health and public health covering both equity and quality: availability, accessibility, acceptability and quality.[80] Some elements may be relevant to more than one principle.

The figures and tables in the following section do not include data from regional and provincial hospitals (numbering 10 as noted in chapter 2). Data tables, qualitative reports, case studies and field assessment report are available at the UNFPA Country Office, Afghanistan.

### 3.2.1 Availability

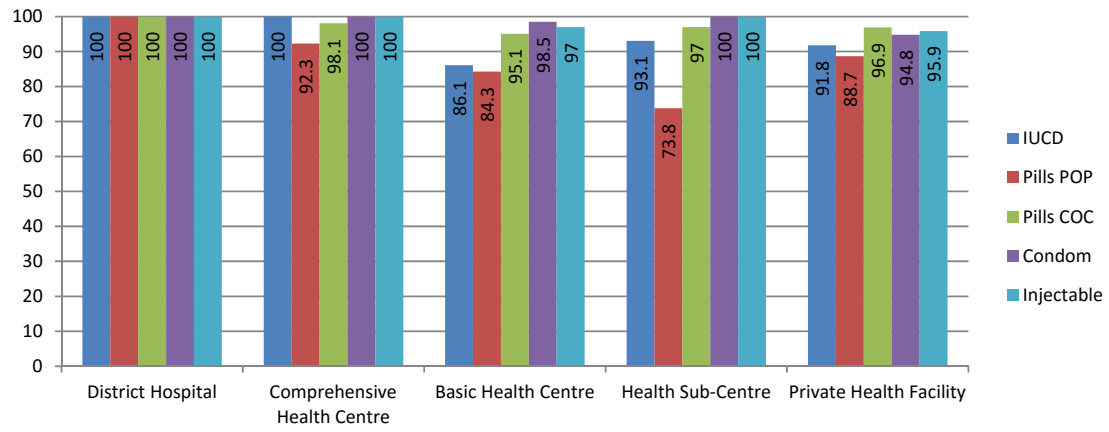
Availability implies functioning facilities with a range of contraceptives and services available in sufficient quantity to enable individuals to exercise full choice. It also includes follow-up and services for removal as needed,[81] and is linked to the following elements: FP is offered through a variety of service delivery modalities; facilities are adequately equipped and staffed; a broad mix of FP methods is available; referral systems are functional; and the private sector is involved in the provision of FP services.

#### Service delivery modalities

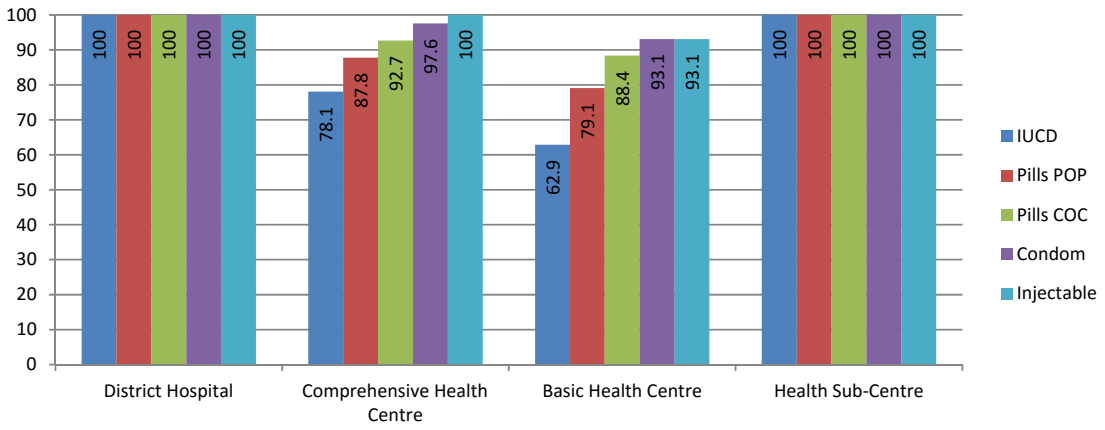
- From literature and policy reviews, it is apparent that at least three FP methods (condom, pill and injectables) were offered in more than 90 percent of the facilities surveyed (see Figure 10a). In the private sector, about 90 percent of facilities provided all three methods. More or less the same pattern was seen in Kabul (Figure 10b). This finding is further corroborated by focus group discussions with women, CHWs and midwives and by in-depth interviews with PHD, RHC and managers of health facilities.

80. Futures. *Voluntary Rights-based FP, FP 2020 Rights and Empowerment Principle of Family Planning.*
81. Ibid.

## Figure 10a: Facilities offering FP services routinely by method – nine provinces + private sector (percent)




## Figure 10b: Facilities offering FP services routinely by method – Kabul (percent)




- Under 90 percent of BHCs provided IUCDs (Figure 10a); this could be related to the availability of trained staff. In the private sector, IUCDs were available in about 90 percent of facilities. In Kabul (Figure 10b), less than 80 percent of CHCs and about 60 percent of BHCs provided IUCDs.
- Tubal ligation figures were less than 20 percent for provincial and district hospitals and around 66 percent for regional hospitals and among provinces.
- Contraceptives were also provided through family health houses (FHH, in Bamiyan, Daikundi and Faryab) and mobile health clinics (in Badakhshan, Bamiyan, Daikundi, Faryab and Herat).

While the above findings indicate there is availability, they do not specify whether the commodities are actually available every day of the week, every month. The stock-outs described in the discussion of commodity security below suggest that commodities may not be available all the time.

- Focus group discussions with women and providers showed that distance is a major barrier in accessing contraceptives. In remote areas and difficult terrain, health posts may not be accessible. Even when these are accessible, the availability of CHWs may be an issue.
- Focus group discussions with women also revealed long waiting times for services due to an inadequate number of female staff, especially midwives.

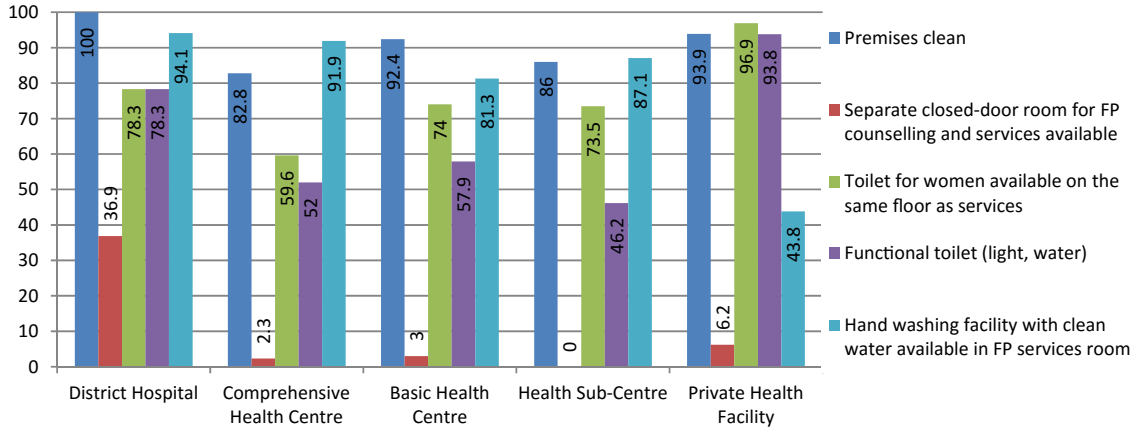
- Social marketing: As described in section 1.7.8, socially marketed contraceptives by ASMO include condoms, pills and injectables distributed through pharmacies in Kabul and major urban areas (Balkh, Faryab, Herat, Mazar-e-Sharif and Nangarhar). MSI does social marketing of condoms and uses community-based distributors trained in counselling in areas where there are no CHWs. The areas covered include Kabul and major urban areas such as Balkh, Faryab and Herat.
- Referral systems: A referral card is used for referrals. The field assessment did not cover referrals in detail except through a few questions under facility assessments and in focus group discussions with midwives and CHWs. The three case studies were expected to cover referral issues in detail but do not provide much information. National level interviews, literature review, case studies and the limited information from the field assessment and client exit interviews suggest that the referral system between BPHS facilities and between BPHS and EPHS facilities is not as effective as was envisaged. Client exit interviews also indicated that the referrals were very few in number. This finding was confirmed by data from in-depth interviews and focus group discussions with health facility managers and providers. Reasons could be distance to a referral facility, lack of skilled providers at referral facilities, etc. The literature review also found that referral systems are not efficient, and inadequate referral practices within the BPHS and between BPHS and EPHS facilities have been a recurring problem and need focused attention. The updated BPHS document (2010) and the QI documents also identified the referral system as a challenge.

**Conclusion:** Availability of contraceptive methods does not appear to be a major problem except in remote areas; however whether the contraceptives are available all the time is not known.

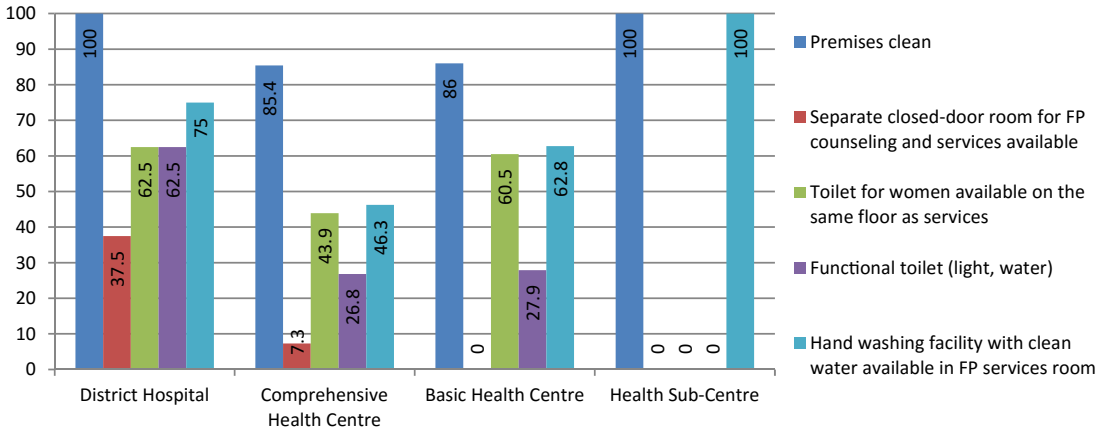
### Adequacy of facilities to provide quality services

- Infrastructure:
  - Cleanliness: Figures 11a and 11b provide information on the cleanliness of BPHS facilities. General cleanliness was good in more than 80 percent of facilities (albeit less good in CHCs and BHCs) in the nine provinces and Kabul.
  - A separate room for FP counselling and services, was available in less than 40 percent of district hospitals, and less than 10 percent of CHCs and BHCs (both in the nine provinces and Kabul). Less than 10 percent of private facilities had a separate room (Figures 11a and 11b). This is a major barrier to accessing FP services according to the respondents in focus group discussions.
  - Availability of a functioning toilet (with light and running water) for females was another gap (Figures 11a and 11b) and could be a major deterrent for clients for IUCD insertion.

## Figure 11a: Facility infrastructure – nine provinces + private sector (percent)

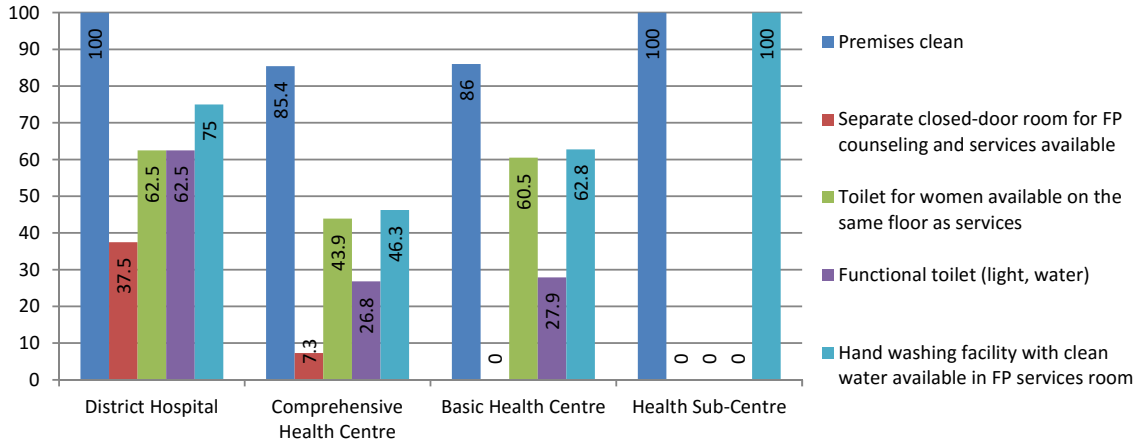



## Figure 11b: Facility infrastructure – Kabul (percent)

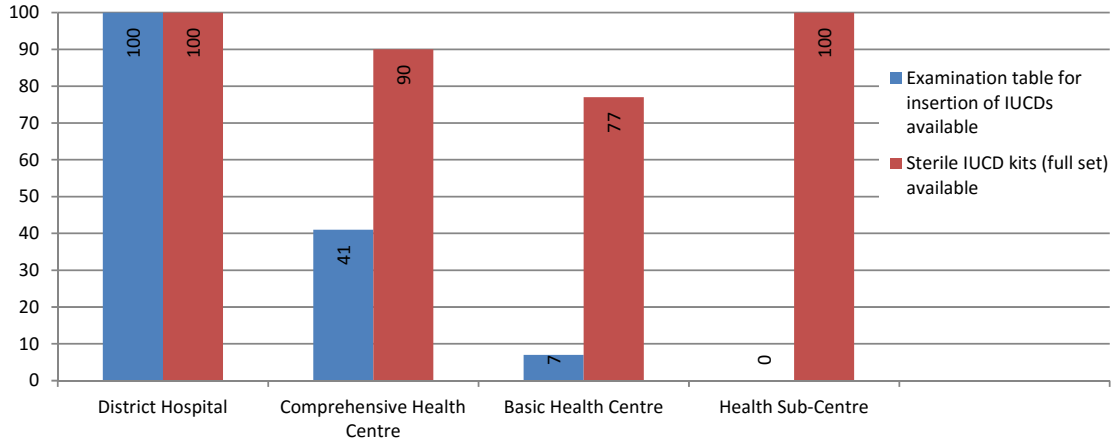



- Figures 12a and 12b show the availability of examination tables and IUCD insertion kits. Examination tables were available in less than 60 percent of facilities, falling to under 30 percent of private facilities. In Kabul while the availability was good in district hospitals, in BHCs and HSCs it was less than 10 percent. The full set of IUCD insertion kits was available in more than 90 percent in the nine provinces but under 80 percent of the private facilities and Kabul BHCs.

## Figure 12a: Facilities with examination table and equipment for IUCD insertion available – nine provinces + private sector (percent)




## Figure 12b: Facilities with examination table and equipment for IUCD insertion available – Kabul (percent)

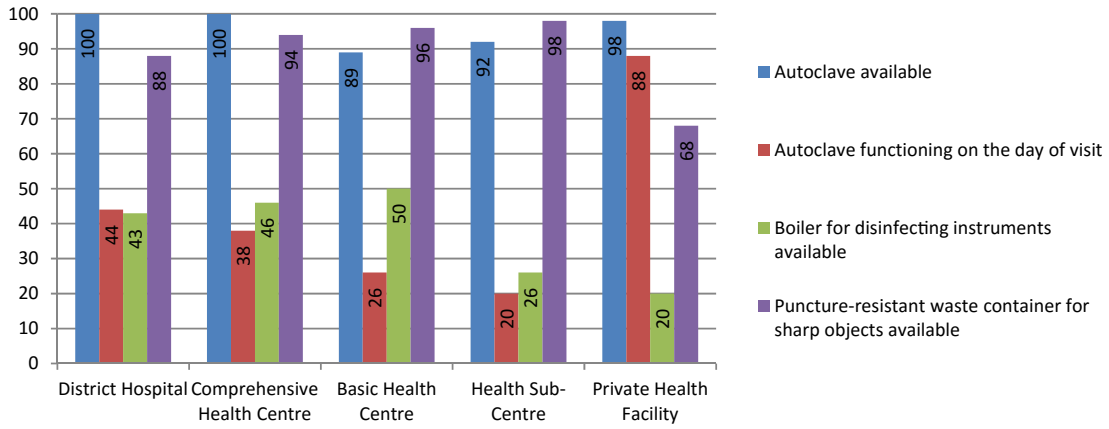



- All EPHS facilities appeared to have functional operating theatres. Not all district hospitals and provincial hospitals had instruments for female sterilization.
- Health posts: From the focus group discussions with CHWs, it appears that there are major gaps in terms of basic furniture needed for provision of services and storage facilities in the health posts.

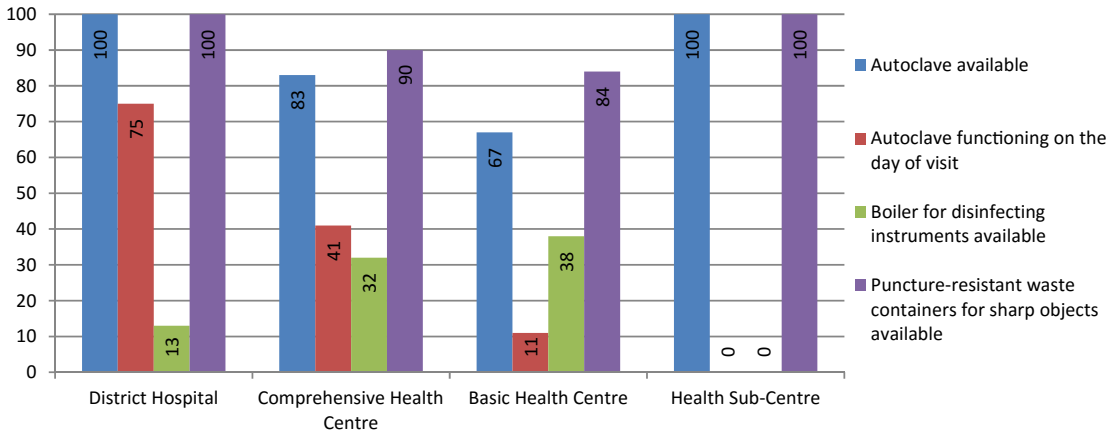
- Infection prevention:
  - Autoclaves were available in almost all facilities but were functional in a very low proportion of facilities including district hospitals (Figures 13a and 13b). This may be related to the lack of reliable electricity and fuel supply. The proportion of private facilities with a functional autoclave was almost 90 percent. Conversely, puncture-proof containers for disposing of sharps were available in the majority of public facilities, while the proportion was much lower in the private sector.

- Visibility of FP services:
  - Figures 14a and 14b show the proportion of facilities with a signboard on the availability of FP services. About 60 percent of district hospitals and 30–40 percent of CHCs, BHCs and HSCs in the nine provinces displayed such signs while less than 5 percent of private facilities had signboards. In Kabul, less than 20 percent of facilities had signboards with no district hospitals displaying signboards on FP services.

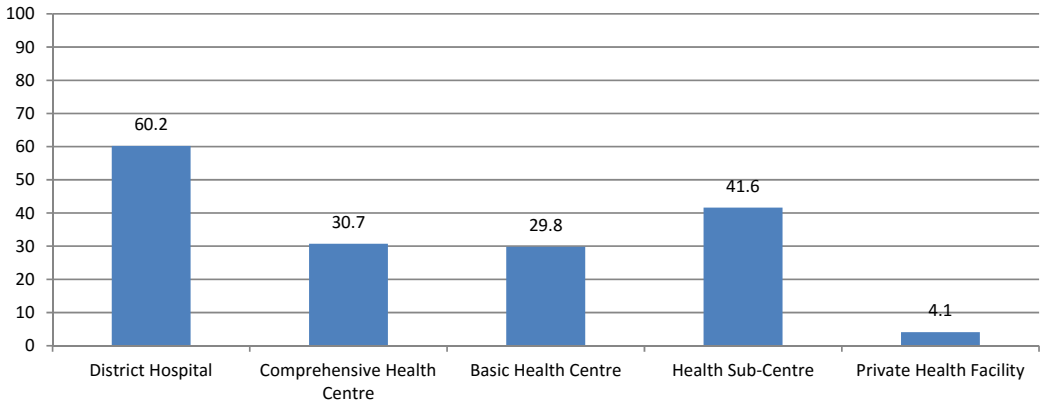
## Figure 13a: Facilities with basic infection prevention measures to support FP services – nine provinces + private sector (percent)



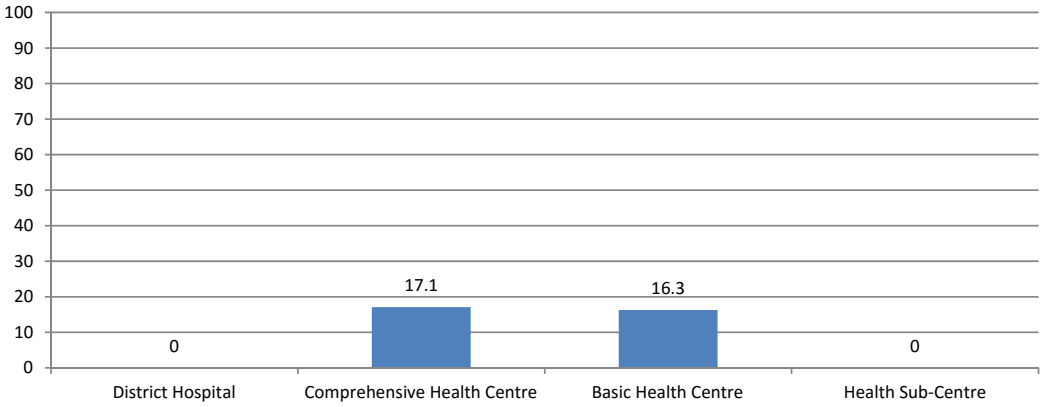

## Figure 13b: Facilities with basic infection prevention measures to support FP services – Kabul (percent)




## Figure 14a: Facilities with visible signboard about available FP services – nine provinces + private sector (percent)

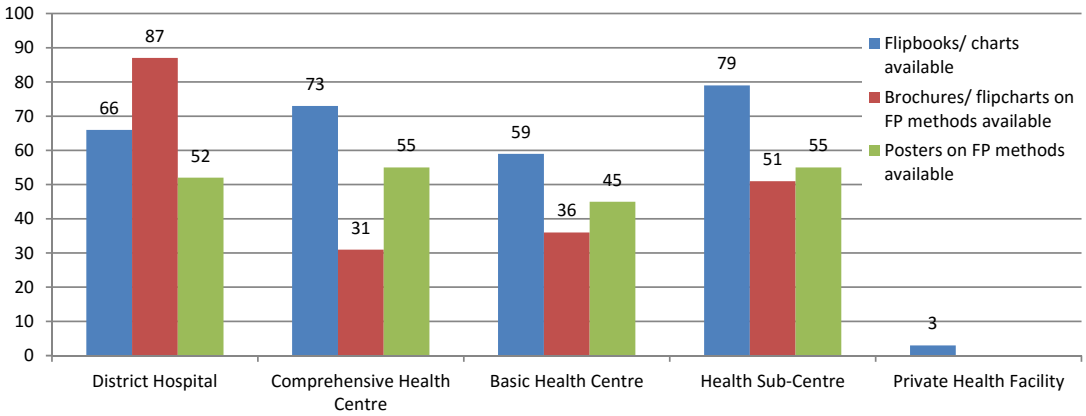


## Figure 14b: Facilities with visible signboard about available FP services – Kabul (percent)

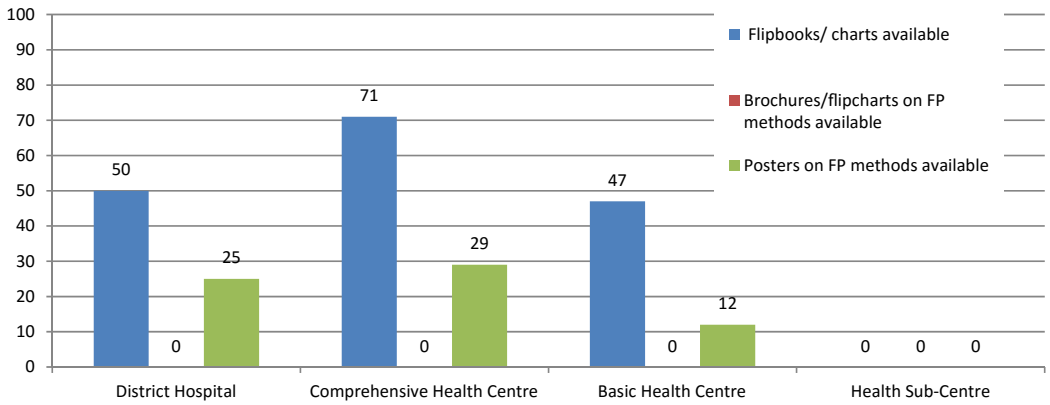



- Client information material:
  - ➢ Educational material in the form of flipbooks, charts and posters were available in only 60–70 percent of public facilities, with comparatively higher proportions among district hospitals (Figures 15a and 15b). In Kabul the availability was lower, and it was negligible in the private sector. Focus group discussions with midwives and CHWs identified the lack of communication materials as a problem in delivering FP services.

## Figure 15a: Facilities with FP informational materials – nine provinces + private sector (percent)



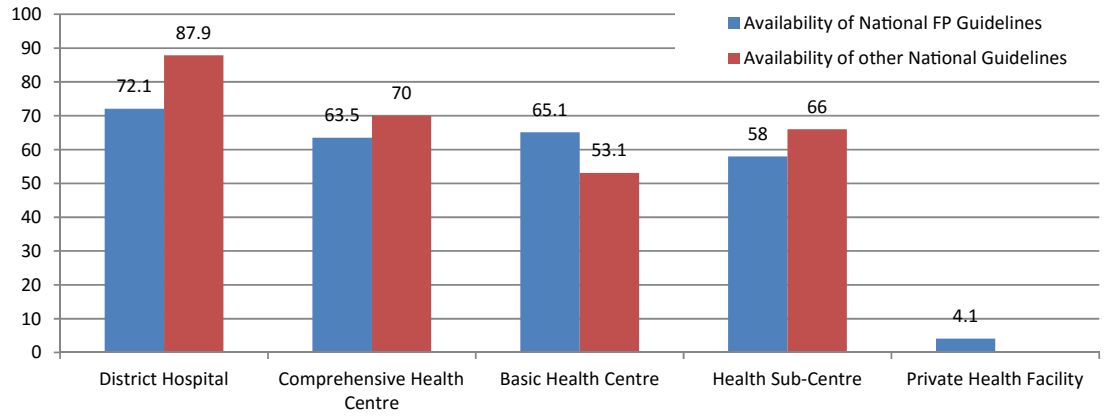

## Figure 15b: Facilities with FP informational materials – Kabul (percent)



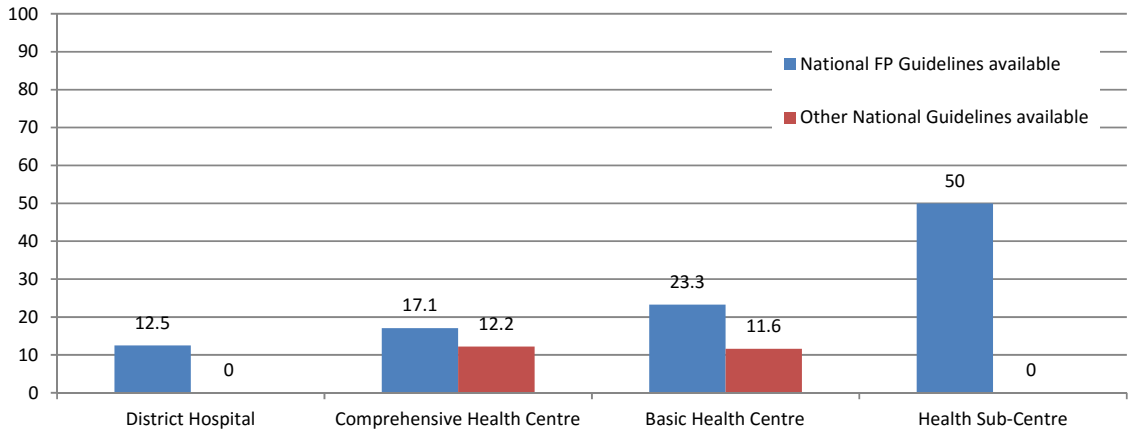
- Availability of FP guidelines:
  - Around 60 percent of public facilities had national guidelines on FP; however in Kabul the proportion was less than 25 percent (Figures 16a and 16b). In private facilities, the proportion was less than 5 percent. This finding was corroborated through observations of IUCD insertion and the provision of injections (see Annex Annex 1.5, Tables FA 1, IUCD 2 and INJ 2).
- The skills of providers are discussed elsewhere in this section, and storage conditions of contraceptives are discussed in section 3.2.1, under contraceptive commodity security.

**Conclusion:** Major gaps in infrastructure include non-availability of separate rooms for FP services and gaps in infection prevention. Non-availability of FP guidelines in all the facilities, particularly in the private sector, is also a concern.

### Figure 16a: Availability of national FP standards and guidelines in facilities – nine provinces + private sector (percent)




### Figure 16b: Availability of national FP standards and guidelines in facilities – Kabul (percent)



## Contraceptive commodity security

- The assessment of the warehouses in Kabul and a visit to Bamiyan province by the RHCS expert revealed several issues including poor quality warehousing, forecasting, LMIS and distribution. Regular monitoring of warehouses, pharmacies and storerooms in health facilities does not appear to be performed. Reports from field observations in warehouses run by NGOs indicated that there were commodities nearing or past their expiry date, but no plans existed for swift distribution or disposal.

The findings of the field assessment discussed below further confirm these findings.

- Stock-outs:
  - Data on stock-outs in the previous months showed that maximum stock-outs were for condoms and IUCDs. In lower level facilities, stock-outs were also reported for injectables and pills. The levels of stock-outs were greater in lower level facilities located closer to the communities (Figure 17a). Compared to the nine provinces, Kabul reported a higher level of stock-outs including in district hospitals (Figure 17b). The situation was worst in private facilities. The situation with stock-outs is corroborated by Figures 18a and 18b.
  - Contrary to the findings in the previous point, the inventory assessment discussed below shows that stocks of contraceptives were available on the day of the facility assessment. Client exit interviews also show that clients got the method they wanted (see Figures 22a and 22b) and focus group discussions with women support this finding. In general, no shortage of supplies was reported from in-depth interviews with managers and focus group discussions with providers; few facilities in Takhar and Nangarhar reported shortages of injectables and condoms. In-depth interviews in Kabul reported shortages. The differences in findings could be due to the time period covered by the questions: client exit interviews report the availability of supplies on the day of the visit.
  - Stock-outs were also reported in the USAID/Deliver project data for Afghanistan for the period 2013.82 The report mentioned that stock-outs in the public sector were generally low, but varied by product. The lowest stock-out was for oral contraceptives and the highest for IUCDs (oral contraceptives: 7 percent; injectables: 9 percent; condoms: 8 percent; IUCDs: 19 percent). Stock-out is here defined as the unavailability of a product even for a day during the month.

- An inventory was done of commodities available in the room where services are provided and in the pharmacy on the day of the assessment. This was compared with physical verification of commodities. The findings below refer to the pharmacy inventory.
  - On the day of the survey the inventory of commodities in the pharmacy showed that stocks of condoms, pills, injectables and IUCDs were available as per records in the register and physical verification by the investigator. Most of the products were nearing expiry, with dates in 2015 and early 2016. Discoloured pills, condoms and IUCD packets and crystallized injectable vials were noted, with a worse situation in CHCs and BHCs (Annex 1.5, Table FA 2)
  - Major inconsistencies were noticed in the numbers recorded in the register and counted. Recording errors or errors in counting could be the reason.

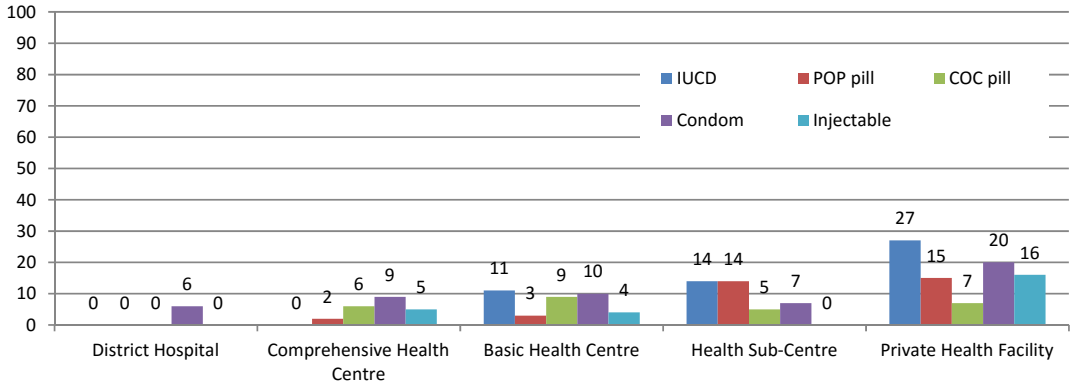
82. USAID/Deliver Project (2014). Contraceptive Security Indicators Data.

- Supply management practices:
  - As shown in Figures 18a and 18b, most facilities had a system for organizing supplies. Supplies were arranged according to expiry date.
  - More than 90 percent of facilities maintained a stock and consumption system. This was also confirmed by in-depth interviews with managers. Current stocks were recorded in 60–70 percent of the facilities. Expiry dates were not recorded in a significant proportion of facilities (see Figures 19a and 19b). The situation in Kabul was worse, and a significant proportion of private facilities did not have a system at all.
  - Indenting was based on the previous month's stock in less than 6 percent of facilities. MoPH guidelines require indenting every three months. In-depth interviews with managers showed that the frequency of indenting varied from one to three months.

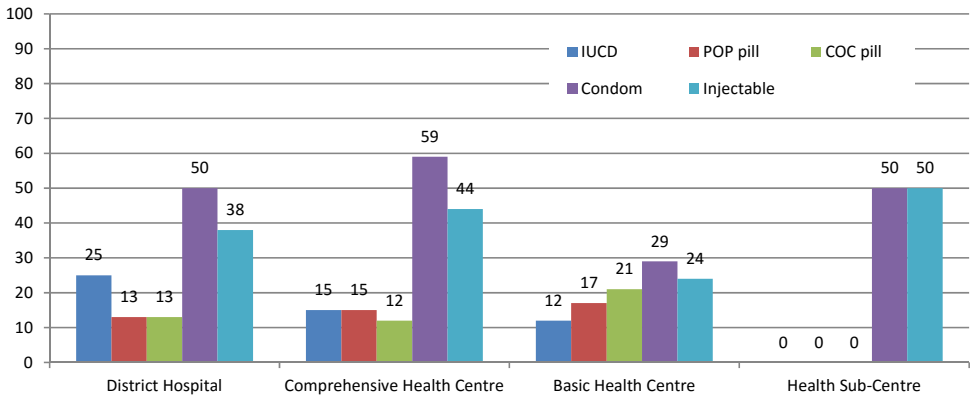
- Quality of storage facilities:
  - Figures 20a and 20b show the condition of stores at various facilities. Storage conditions did not meet recommended standards, which has implications for the quality of contraceptives. The discolouration of contraceptives and crystallization in vials of injectables is evidence of poor storage conditions.

**Conclusion:** Logistics management for contraceptives needs significant improvement. In spite of a functioning stock and indent system, stock-outs of commodities were found and the system of storage does not meet quality standards.

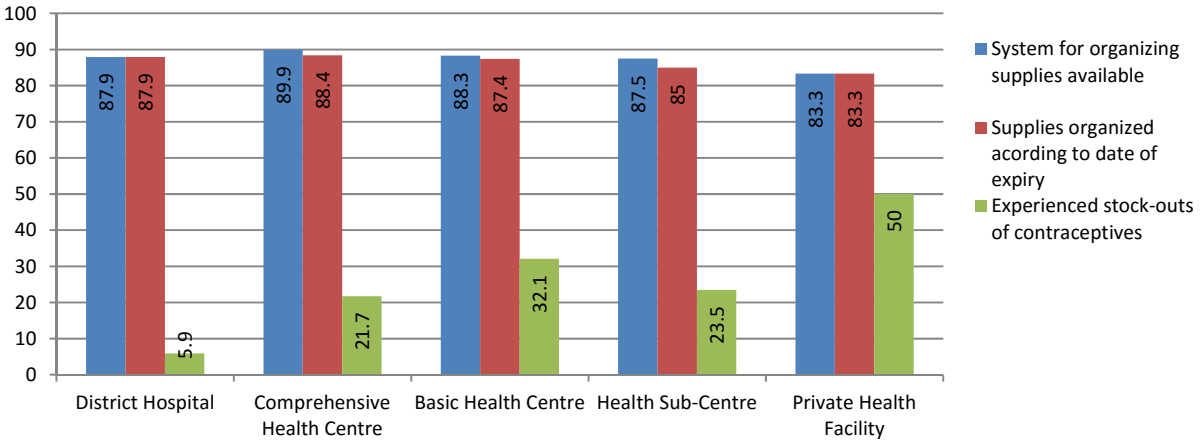
### Figure 17a: Facilities with stock-outs during previous 6 months – nine provinces + private sector (percent)



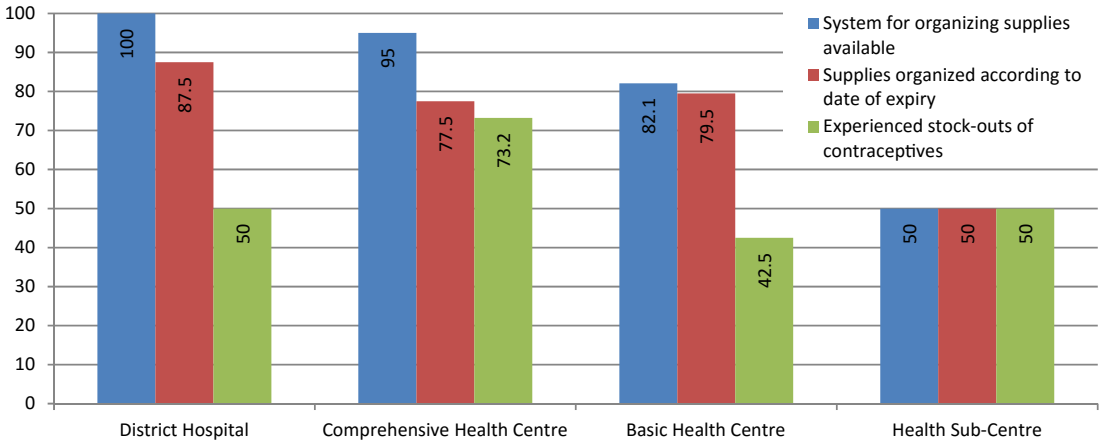

### Figure 17b: Facilities with stock-outs during previous 6 months – Kabul (percent)



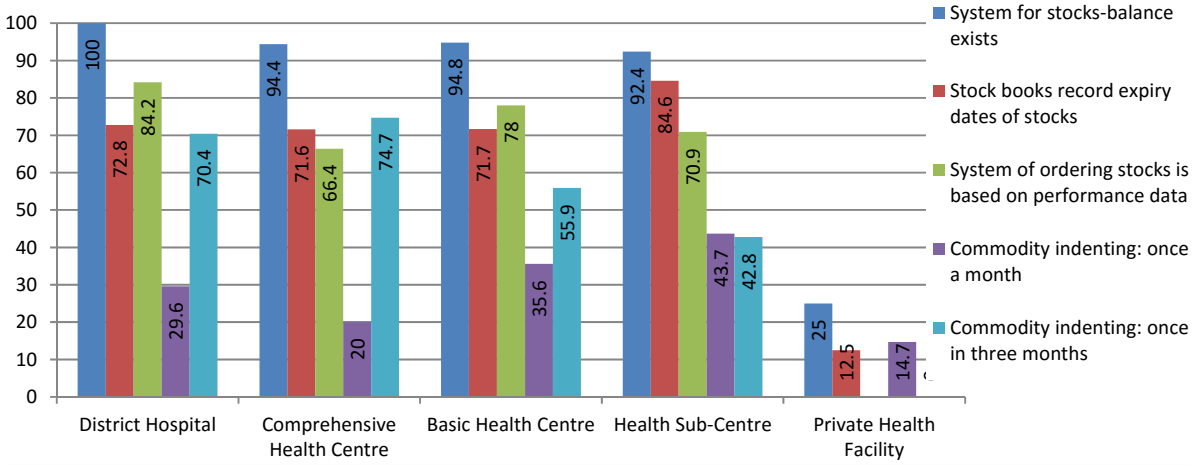
## Figure 18a: Facilities with contraceptive supply systems – nine provinces + private sector (percent)



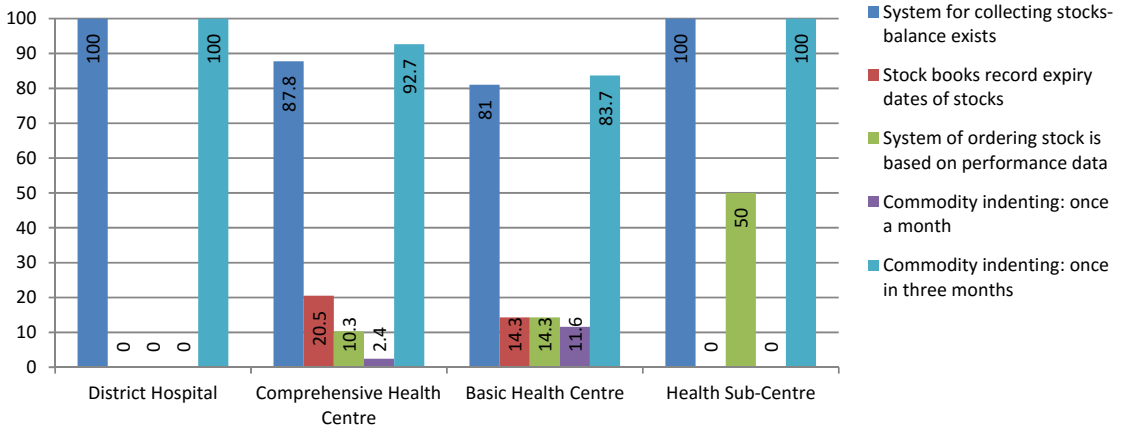

## Figure 18b: Facilities with contraceptive supply systems – Kabul (percent)



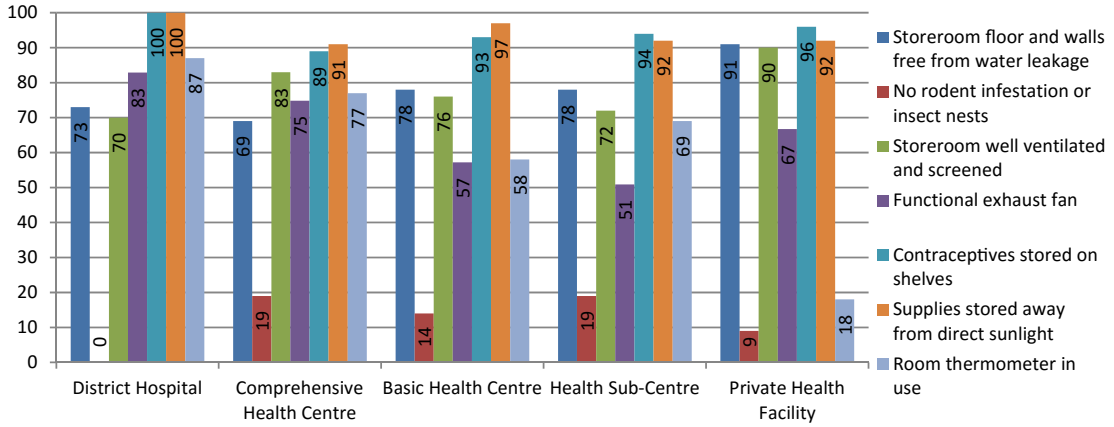

## Figure 19a: Facilities with supply and ordering system – nine provinces + private sector (percent)



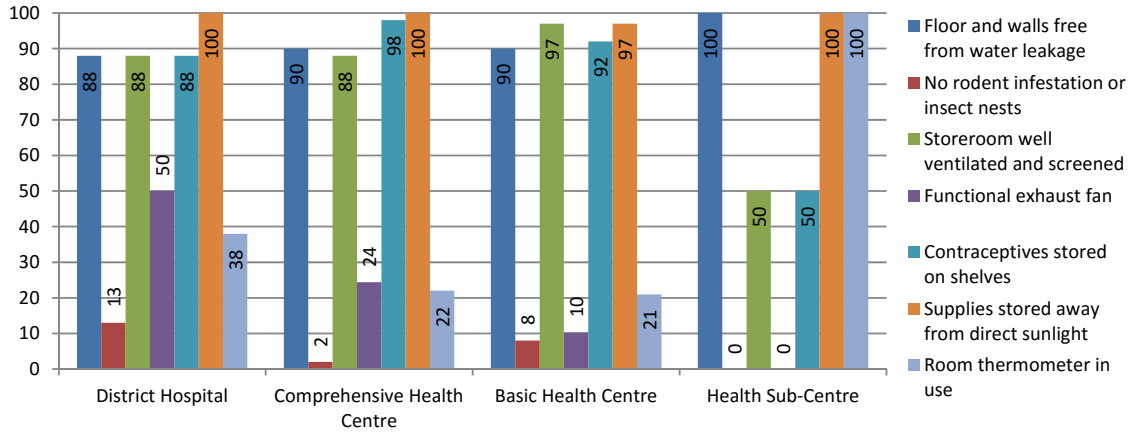
## Figure 19b: Facilities with supply and ordering system – Kabul (percent)




## Figure 20a: Facility storage – nine provinces + private sector (percent)




## Figure 20b: Facility storage – Kabul (percent)



### 3.2.2 Accessibility

Accessibility has four major components: non-discrimination, physical accessibility, economic accessibility, and information accessibility[83] (linked to the element on 'services are inclusive of youth').

- Discrimination: From the literature review, facility assessments, client exit interviews and focus group discussions, it appears that there is no discrimination in providing services. While there are no legal restrictions on providing services to young people, their access to information and services is an issue. The MoPH has developed strategies to provide information and services to young people, these are not yet implemented nationwide. As discussed in section 1.8.5, the National Youth Policy includes an element on providing information on birth spacing but its implementation is not satisfactory. Focus group discussions with young people (female and male) and teachers indicated a need for more information on family planning. Teachers included in the discussions requested to be trained in FP so they could provide information to their students.
    - Afghanistan has a high child marriage rate: 39 percent of women aged 20–24 years were married by 18.[84] By age 19, a third of the women in the 15–19 age group have started childbearing.[85] CPR in this age group is only 8 percent. The specific reasons for this low utilization rate are not known. Limited knowledge about FP, as suggested by focus group discussions, may be a major reason. Studies from other Asian countries have pointed out that the negative attitude of health service providers towards the use of contraception by young married is a major barrier to use. A positive finding from focus group discussions with women, men and young people is that most respondents felt that the best time to have children was after 18 years of age.

- Physical access: With the expansion of BPHS, FHHs and Mobile Health Teams, access to services has improved. However due to the difficult terrain and remoteness, geographical access remains an issue in parts of the country. The focus group discussions suggested that geographical access is a major reason for not accessing FP services.
- Economic access: FP services are free. The focus group discussions and client exit interviews corroborated this; however, clients did pay for transportation which may be a deterrent in using the services.
- Information access: The adult literacy rate among women is 17 percent; the rate among females aged 15–24 years is much higher.[86] Low literacy itself is a barrier to accessing information. As section 3.2.1 suggests, the availability of educational material is limited. The national media, particularly those associated with social marketing organizations, do show messages on birth spacing but only selected channels at provincial levels show messages on FP. Participants in the focus group discussions reported that their major sources of FP information were CHWs, midwives, friends and relatives.

**Conclusion:** While economic access does not appear to be a major barrier, geographical distance and access to youth friendly services for young people are barriers.

83. Futures. *Voluntary Rights-based FP, FP 2020 Rights and Empowerment Principle of Family Planning.*
84. UNFPA (2012). *Marrying Too Young: End Child Marriage.* New York: UNFPA.
85. APHI, CSO, ICF Macro, IIHMR and WHO EMRO. *Afghanistan Mortality Survey. 2010.*
86. Central Statistics Organization (2014). *National Risk and Vulnerability Assessment 2011-12.* Afghanistan Living Condition Survey. Kabul: CSO.

### 3.2.3 Acceptability

Acceptability implies that all health facilities, goods and services are respectful of medical ethics and individual preferences, culturally appropriate, sensitive to gender and life-cycle requirements and respect confidentiality.[87]

- The continued use of a method is an indication of its acceptability; however as discussed in section 3.2.4 on service quality, this information is not available as the HMIS does not provide accurate information on continuation rates.
- Client satisfaction is an indicator of the acceptability of services and appears high, but must be viewed with caution (see the discussion of client rights in section 3.2.4).
- A key finding of the facility assessment in section 3.2.1 is the lack of separate rooms for FP counselling and services. This concern was raised in focus group discussions and could affect acceptability.
- Section 3.2.4 on the quality of care gives more information on other acceptability criteria.

**Conclusion:** Acceptability of services appears to score highly, but not enough information is available to make a definite conclusion.

### 3.2.4 Quality of services

Quality of care implies that individuals have access to information and services of good quality that are scientifically and medically appropriate, a full choice of quality contraceptives, clear and medically accurate information including risks and benefits of a range of methods, presence of equipped and technically competent providers and client provide interaction that respect informed choice, privacy and confidentiality, and client preferences and need.[88]

**The ICPD Programme of Action defines quality of care as follows:**

- Access to information and services for a wide range of FP methods according to the needs of the clients to enable them to exercise free and informed choice.
- Provide accessible, complete and accurate information about various FP methods including their health risks, benefits, possible side effects and their effectiveness including HIV prevention.
- Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical system, a sufficient and continuous supply of essential high quality contraceptive supplies.
- Privacy and confidentiality should be ensured.
- Expand and upgrade training of health care providers, managers and health educators in FP methods and counselling.
- Ensure appropriate follow-up care including treatment for side effects of contraceptives.
- Ensure integration of FP services with related RH services on site or through referral mechanism.
- Monitoring of programme through quantitative and qualitative indicators (focus on quality indicators).

Source: ICPD Programme of Action 7.23

87. Futures. *Voluntary Rights-based FP, FP 2020 Rights and Empowerment Principle of Family Planning.*
88. Ibid.

This section covers the SEED elements related to operational management, supervision, and quality assurance/quality improvement systems, quality assurance/quality improvement, providers have the necessary skills to provide quality FP services, and clients receive high quality FP services.

The findings of the assessment are presented using the International Professional Practices Framework for rights of clients and needs of staff.[89] Clients' rights include rights to information, access, informed choice, safety, privacy, confidentiality, dignity, comfort, continuity, and opinion. The Patients' Charter of Rights discussed in section 1.8.4 covers most of these rights. Providers' needs include training, information, infrastructure, supplies, guidance, back-up, respect, encouragement, feedback and self- expression.

## Findings through the lens of rights of clients

### *Information*

Accurate, appropriate, understandable, unambiguous and unbiased information should be provided to clients. Though these attributes were not specifically assessed, as discussed in section 3.2.1 on infrastructure availability and information accessibility, access to information on FP, both written and visual, is limited, and even more so for young people. Communication and information is included in the MoPH's Patient's Charter of Rights. The impression gained from discussions with various stakeholders is that health education is not a strong component of the services provided in health facilities, and even in situations where health education is provided, FP is not a key message. Birth spacing and FP are not included in discussions with *shuras* at the facility level and community level and by the FHAGs. The information gap in the private sector is also serious as discussed earlier.

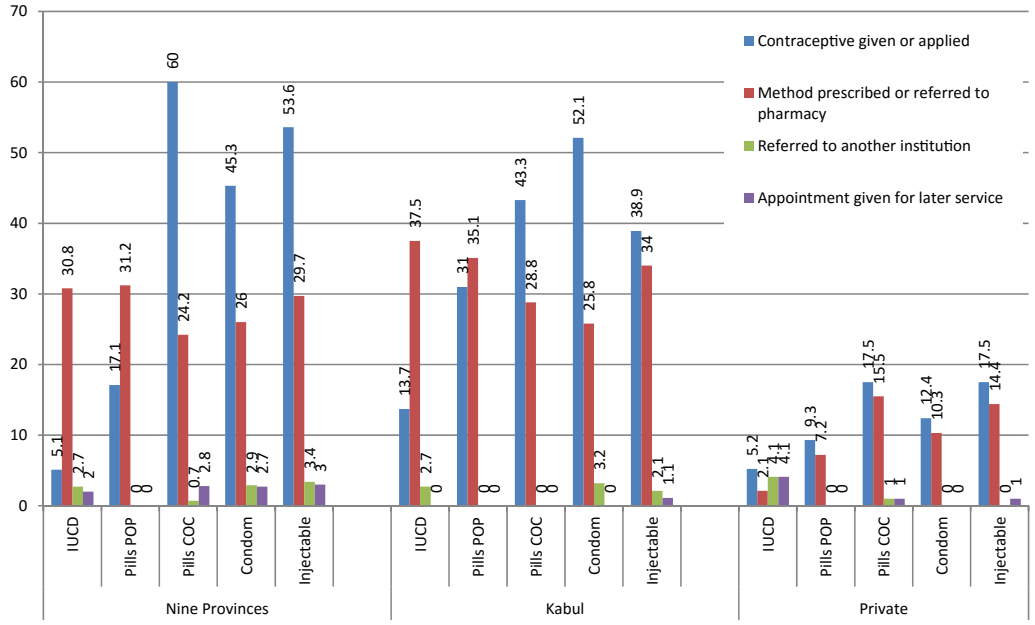
### *Access to services*

Location, promptness, reliability, affordability and lack of barriers are attributes of access to services. Section 3.2.1 on availability pointed out that three methods of contraception (condoms, pills and injectables) were available in most facilities, with a lower proportion in CHCs and BHCs.

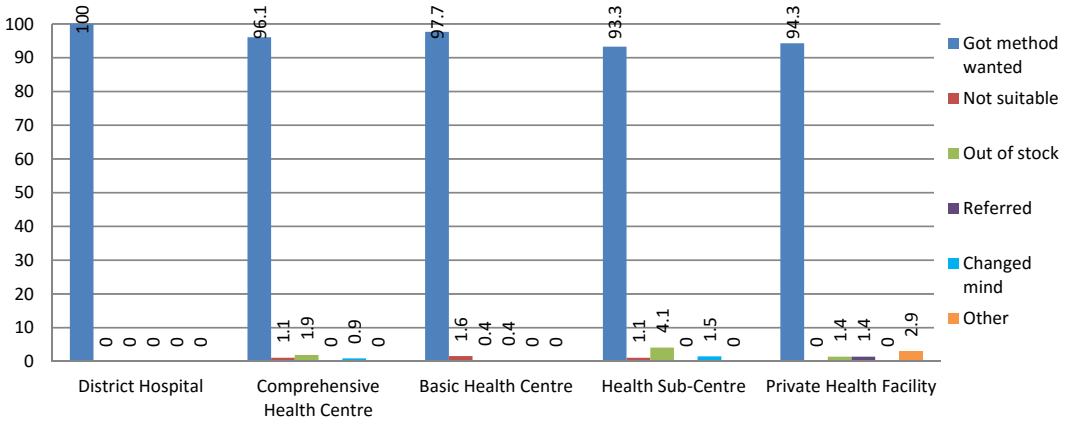
As evident from sections 3.2.1 and 3.2.2 on availability and accessibility, the reliability of services is a concern because of stock-outs. The facility assessment data shows that not all clients were provided FP methods particularly IUCDs (Figure 21). In the private sector, significant numbers were not provided the methods. These findings further corroborate the findings on stock-outs in section 3.2.1. However, it is good to note that the client exit interviews show that continuing users got the contraceptive they wanted on the day of the visit (Figures 22a and 22b).

89. Huezo C, S Diaz (1993). Quality of Care in Family Planning: Clients' Rights and Providers' Needs. *Advances in Contraception* 9 (2) 129–39.

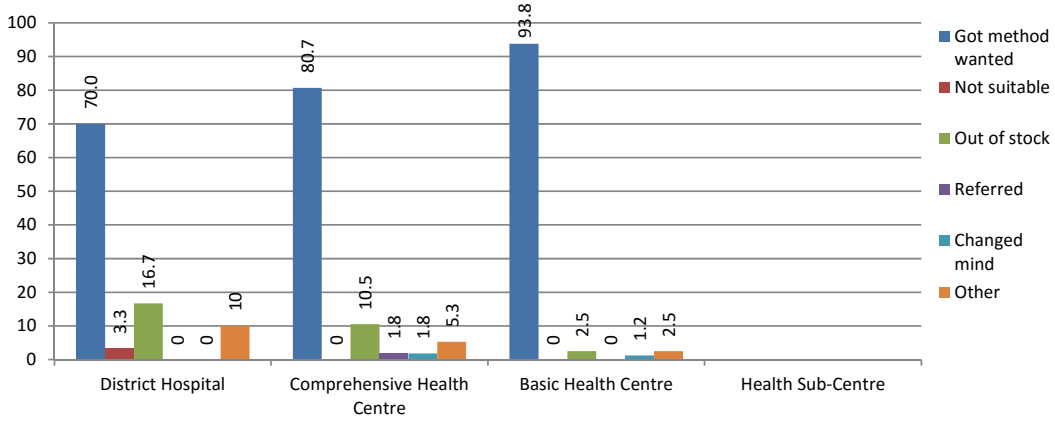
## Figure 21: Facilities providing FP methods to clients on day of visit – nine provinces, Kabul, private sector (percent)




## Figure 22a: Continuing users whose needs were met and reasons for not using method – nine provinces + private sector (percent)




## Figure 22b: Continuing users whose needs were met and reasons for not using method – Kabul (percent)



### *Informed choice*

Voluntary, well considered decisions based on options, information and understanding are attributes of the right to informed choice.

The following sections highlight the concerns related to realizing the right to informed choice.

- Counselling:
  - Observations to assess their skills in counselling of health service providers (more than 90 percent were midwives and the remainder doctors) identified a number of gaps. Table CO 1 (Annex 1.5) provides details of the observations and Figures 23a, 23b and 23c provide the group scores for various components of the observation for both new and continuing clients. The highest scores were in building rapport when counselling new clients, while scores for history taking, providing information on methods, helping to choose and method-specific counselling, screening for medical eligibility criteria and advice on the method chosen were largely below 70 percent. The worst scores were in Kabul and the private sector. Table CO 1 shows that asking about medical problems, side effects, rumours and screening scored the lowest. With regard to continuing clients, finding out about the experience with the method being used and allaying fears about side effects scored lower and was worst in Kabul. Private facilities scores were also low. Scores for follow-up advice and recording were good in the nine provinces but worse in Kabul and the private sector.

**Figure 23a: Observation of counselling skills with new clients – nine provinces, Kabul, private sector (mean group score as percentage of maximum score)**

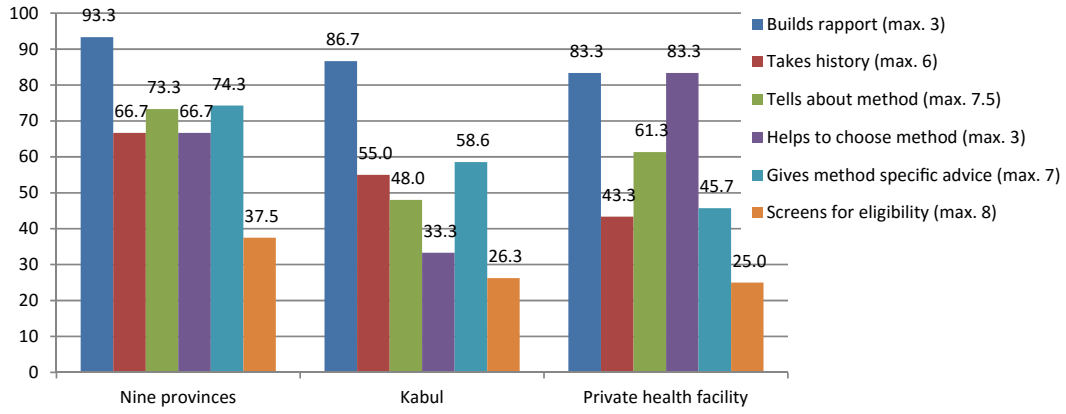
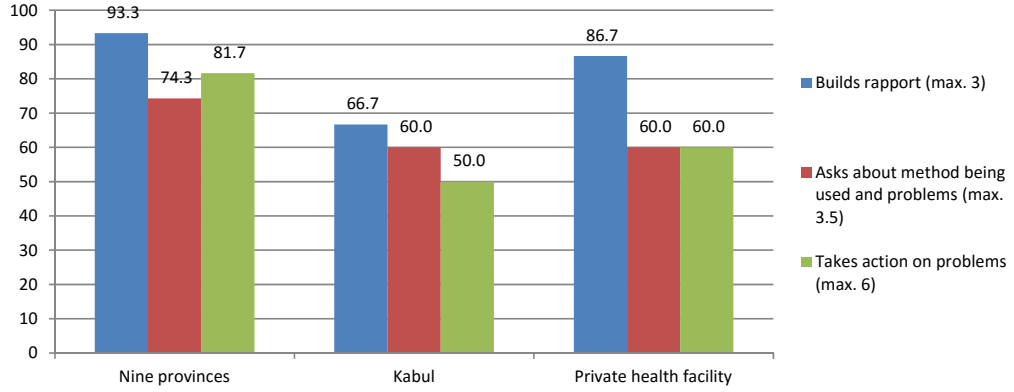
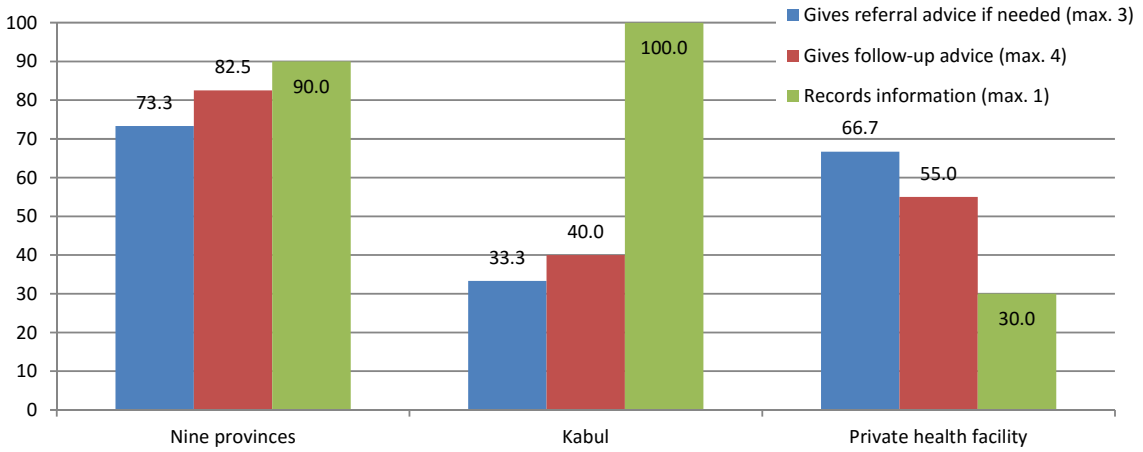



**Figure 23b: Observation of counselling skills with continuing clients – nine provinces, Kabul, private sector (mean group score as percentage of maximum score)**

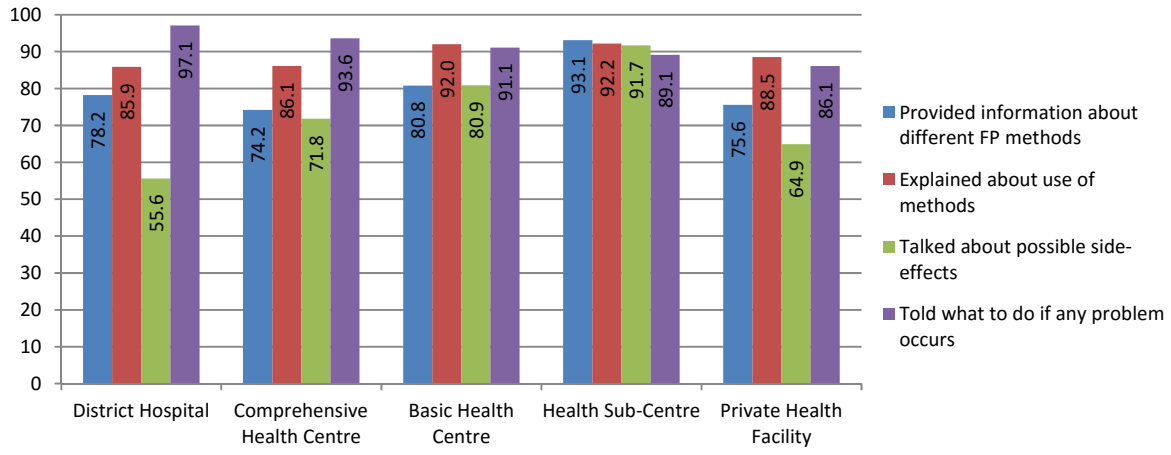


## Figure 23c: Observation of counselling skills with new and continuing clients – nine provinces, Kabul, private sector (mean group score as percentage of maximum score)

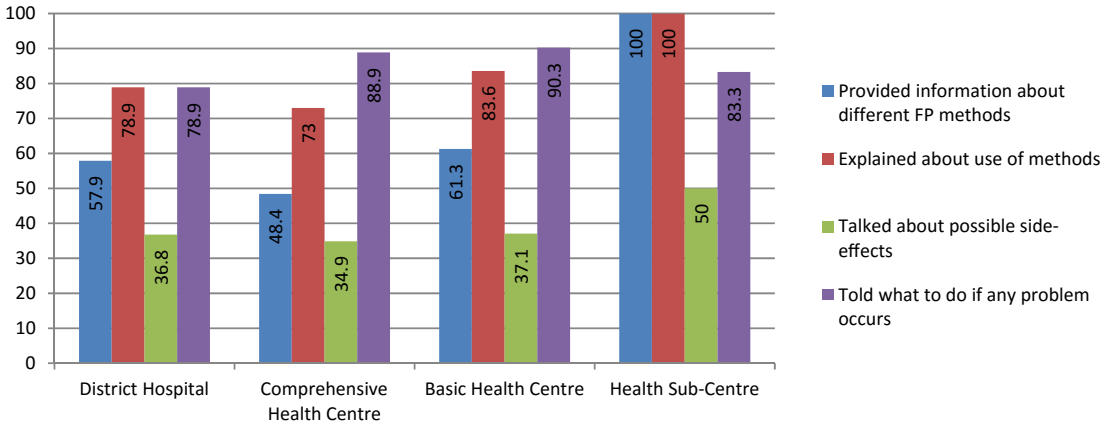



- Client exit interviews further corroborated the findings as shown in Figures 24a–d (new clients), Figures 25a and 25b (continuing clients), and Figures 26a and 26b (clients with problems). In the case of new clients, the gaps identified include information on all methods, side effects, how to use the methods as well as method-specific information; the gaps were greater in the private sector (especially method-specific information) and worst in Kabul. With continuing clients, the gaps are related to enquiry about the experience with the method and related action; gaps were greater in Kabul and worst in the private sector. In the case of clients with problems, the gaps in actions taken were comparatively less in the nine provinces and private sector but significant in Kabul.

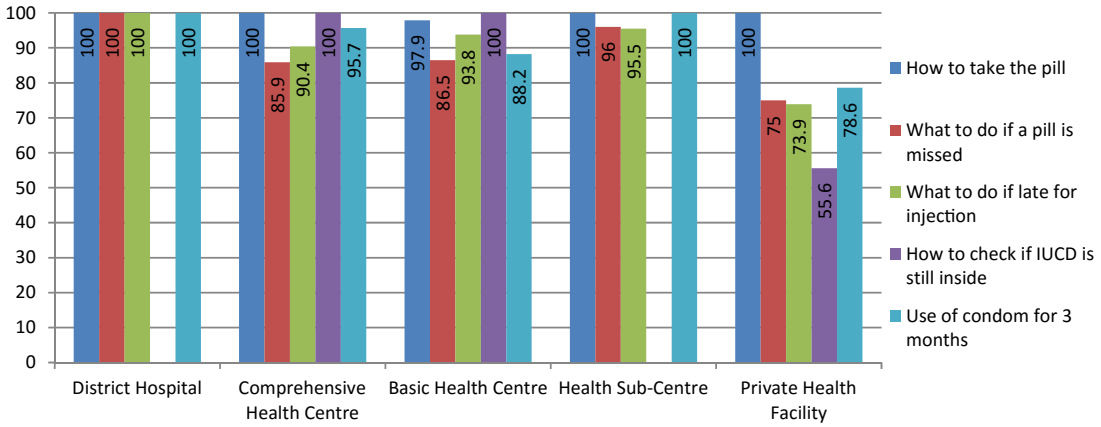
## Figure 24a: New clients who received information on FP methods – client feedback from nine provinces + private sector (percent)



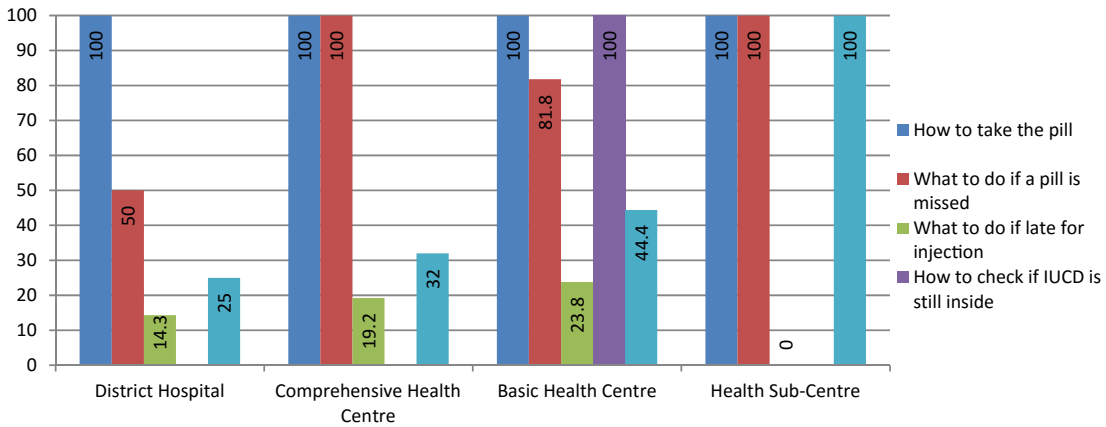
## Figure 24b: New clients who received information on FP methods – client feedback from Kabul (percent)



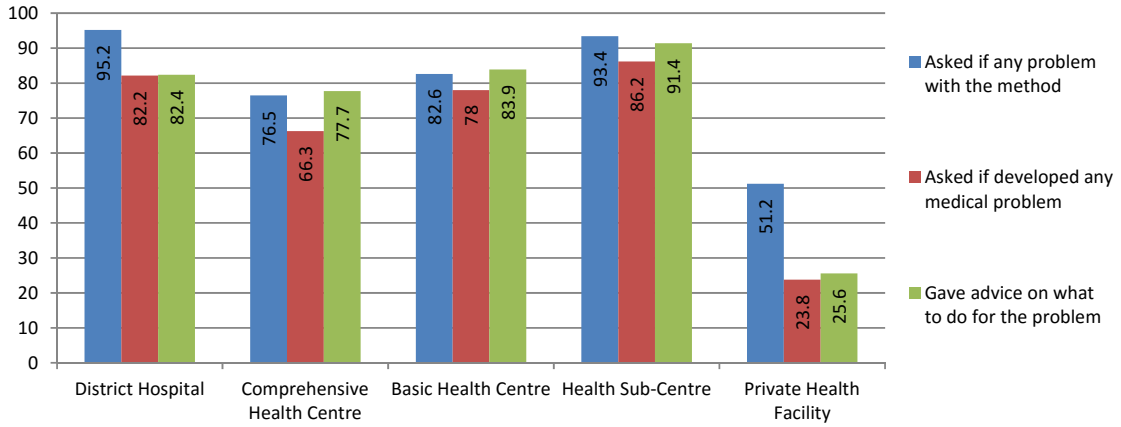

## Figure 24c: New clients who received information on method chosen – client feedback from nine provinces + private sector (percent)



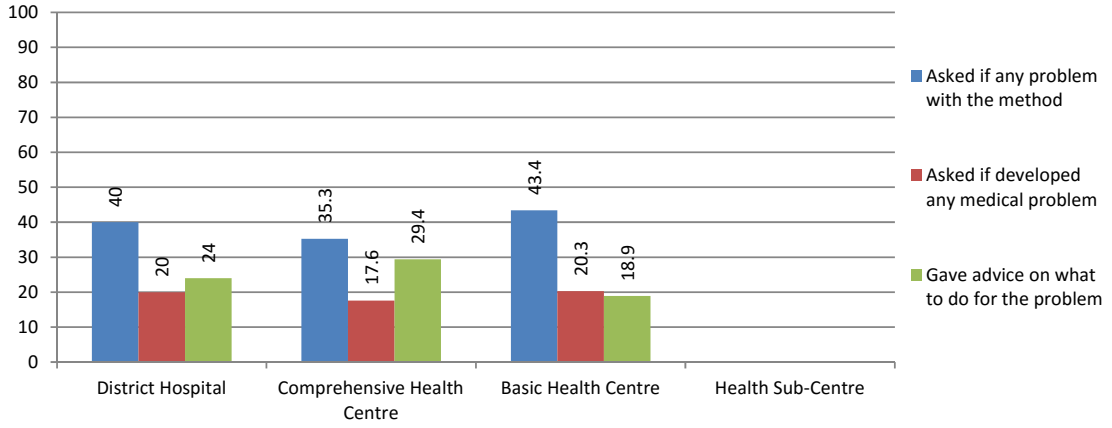

## Figure 24d: New clients who received information on method chosen – client feedback from Kabul (percent)



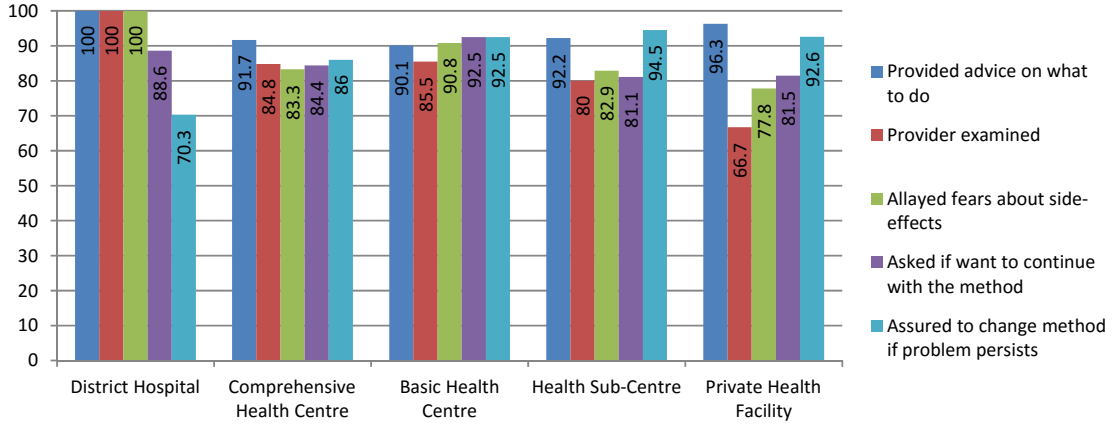
## Figure 25a: Continuing clients who were asked about their experience with the method – client feedback from nine provinces + private sector (percent)



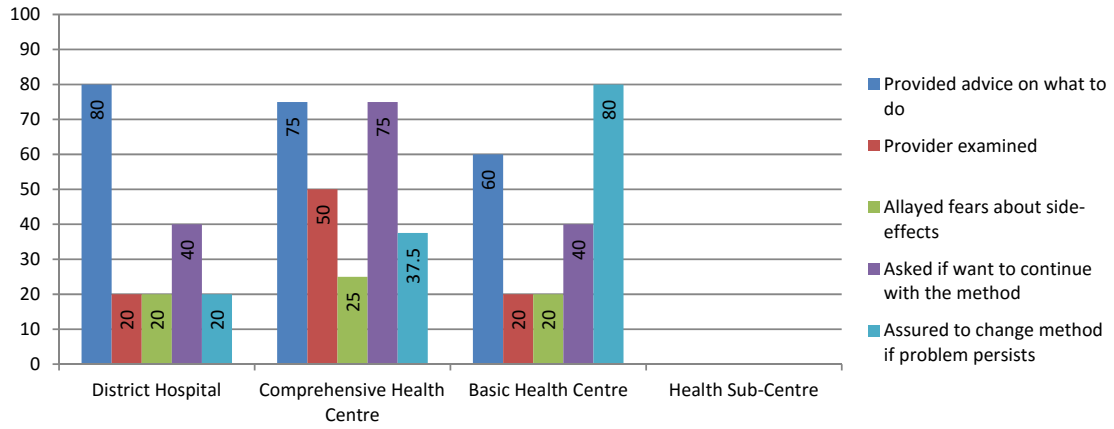

## Figure 25b: Continuing clients who were asked about their experience with the method – client feedback from Kabul (percent)




## Figure 26a: Continuing clients who received care for their problems – client feedback from nine provinces + private sector (percent)



## Figure 26b: Continuing clients who received care for their problems – client feedback from Kabul (percent)




- IUCD:
  - Table IUCD 1 (Annex 1.5) shows details of the observations and Figure 27 shows group scores. Figure 27 shows that pre-insertion counselling scores were generally low, lower still in the private sector and significantly lower in Kabul. More details are discussed below, under safe services.
- Injections:
  - Table INJ 1 (Annex 1.5) shows details of the observations and Figure 28 shows group scores. Pre-injection counselling scores were low, particularly in Kabul. This is further discussed under safe services.

## Figure 27: Observation of IUCD insertion skill – nine provinces, Kabul, private sector (mean group score as percentage of maximum task score)

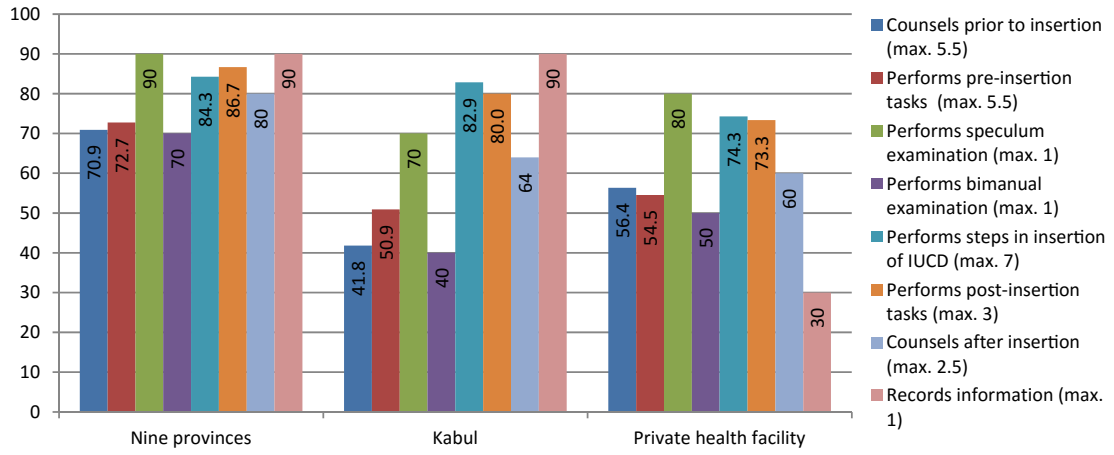
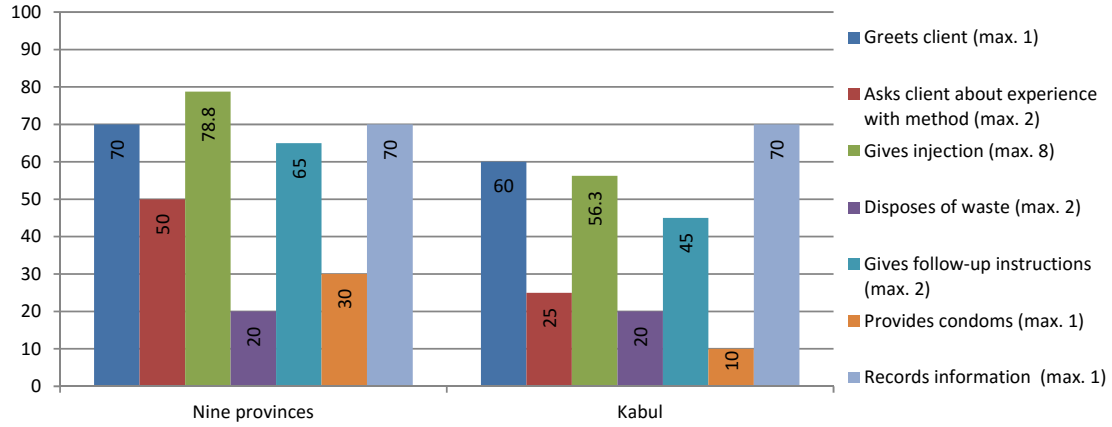


**Figure 28: Observation of injection administration skill – nine provinces, Kabul (mean group score as percentage of maximum task score)**




## *Safe services*

Skilled providers, attention to infection prevention and appropriate and effective medical practices, use of service guidelines, quality assurance mechanisms, counselling and recognition and management of problems are the main attributes of this right.

- Provider skills:
  - IUCD insertion: Figure 27 and Table IUCD 1 (Annex 1.5) show that in general the providers observed were comparatively skilled in insertion and post-insertion tasks, compared to other components of this procedure. Ideally all pre-insertion, insertion and post-insertion steps are critical and should score 100 percent. Major gaps in pre-insertion tasks identified included: screening for reproductive tract infections during pre-insertion counselling (significant gap), emptying the bladder, checking for supra-pubic tenderness and bimanual examination (higher gap in in Kabul). During insertion, major gaps included: applying antiseptics on cervix, uterine sounding, loading Copper T in the sterile pack and the pull and push technique of inserting Copper T (with a higher gap in private sector). Major gaps in post-insertion tasks included: post-insertion infection prevention and post-insertion counselling (especially observing the client for 15 minutes). Recording scores were higher, with the private sector again scoring lowest.
  - Injectables: Figure 28 and Table INJ 1 (Annex 1.5) showed many areas where improvements are needed, including pre-injection counselling, screening clients, injection technique (particularly ensuring the product has not reached expiry, technique of injection and allowing the dose to spread), waste disposal, post-injection counselling and recording. All scores were below 80 percent. The CHWs are provided with disposable syringes and needles, and considering that they operate from their own homes, disposal of waste could be a real concern.
- Infection prevention:
  - As already noted, infection prevention in general needs improvement and specifically after procedures such as IUCD insertion and the administration of injectables.

- Adherence to national standards and medical eligibility criteria:
  - Gaps in practices observed indicate a lack of adherence to national standards. From observations of counselling, IUCD insertion and provision of injectables, gaps in screening for eligibility were noted. Client exit interviews also showed that specific questions on screening were not asked. This could be due to lack of training or gaps in training, particularly with regard to CHWs (discussed further below, under provider needs).
- Identification of problems and their management:
  - Observations and client exit interviews showed gaps in determining whether the client was experiencing any problems with use. As discussed earlier in this section, provision of information related to side effects also scored low which could add to a lack of recognition of problems. As discussed in section 3.2.1 on referrals, very few cases were referred, and the reason could be a lack of recognition of problems with particular methods.

### *Privacy and confidentiality*

Privacy and confidentiality are to be maintained during counselling, physical examination and with regard to personal and medical information. As pointed out in section 3.2.1 on availability, a separate room for counselling was not available which has implications for privacy. The CHWs operate from their own homes where it is difficult to maintain privacy and confidentiality. The lack of privacy was raised as a concern by women during focus group discussions. The confidentiality aspect was not specifically checked during the facility assessments.

### *Dignity, comfort and expression of opinion*

The attributes of this right includes courtesy, comfort and expression of opinion while receiving services and encouraging clients to express their views.

- The scores on building rapport with clients being counselled (see Figures 23a and 23b) were high which indicate that the clients are treated with courtesy.
- The client exit interviews scored high on satisfaction; highest for district hospitals and lowest for CHCs (Figures 29a and 29b). The proportion of satisfied clients was lower for private facilities while a higher proportion of clients in Kabul were satisfied. This high level of satisfaction could be due to lack of understanding of the clients about their entitlements leading to low expectations. Contrary to these findings, the strategic assessment of FP done by MoPH in 2008 reported poor satisfaction with services due to long waiting hours, limited opening hours and poor attitude of the providers.[90]
- In-depth interviews and focus group discussions with providers indicated that client feedback mechanisms exist, but providers did not know if the feedback was used to improve the quality of services.

90. MoPH. *A Strategic Assessment of Family Planning in Afghanistan*, 2008.

**Figure 29a: Users satisfied with FP services – client feedback from nine provinces + private sector (percent)**

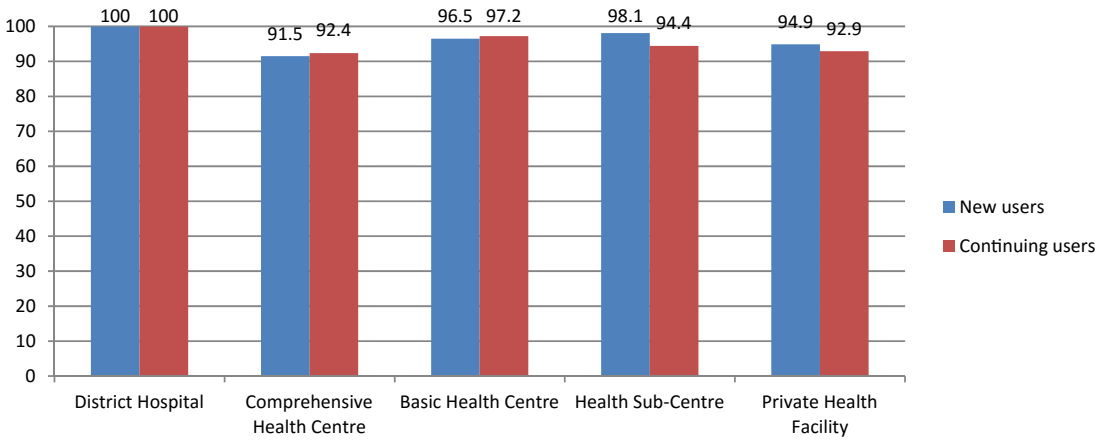
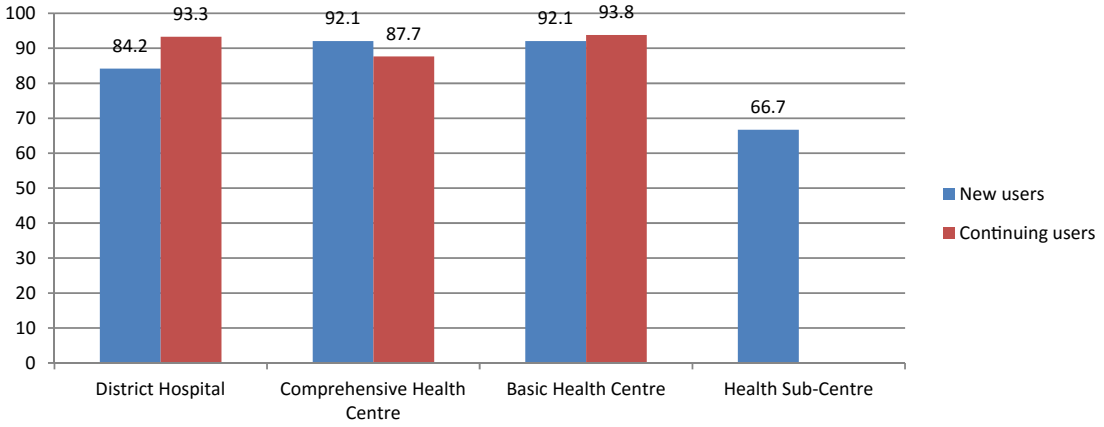



**Figure 29b: Users satisfied with FP services – client feedback from Kabul (percent)**




## *Continuity of care*

The dimensions include continuity of care, supplies, referrals, and follow-up. Issues related to availability of supplies and referrals are covered in earlier sections.

- Continuity of care:
  - In general, the score for follow-up advice was high (see Figures 25a and 25b). Table CO 1 (Annex 1.5) shows that the score for information on timing and location of follow-up was high for counselling observations. The scores for follow-up advice after injections was 60–70 percent (Table INJ 1, Annex 1.5).
  - CHWs are expected to follow up with clients, but there is no system to enable them to their clients.
  - Currently there is no effective system for tracking acceptors which makes it difficult to assess whether there is follow-up with clients. The discussion of the HMIS below provides more information.

**Conclusion:** Despite the QA system and the Balanced Score Card which captures many dimensions of client rights, many of these rights are not actually realized.

## Findings through the lens of provider needs

The providers' needs listed earlier are covered under three main headings.

### *Facilitative supervision and management*

The dimensions discussed under this heading include a supportive environment with supervisors and managers encouraging quality improvements and who value staff.

- In-depth interviews with facility managers and RHD officers indicated that supervision is carried out regularly every month. Managers from facilities in most of the provinces covered by the field assessment mentioned supervision from MoPH and PHD. The implementing NGOs did more regular supervision of the facilities. The supervisors' visits were used as an opportunity to discuss problems and receive guidance.
- Focus group discussions with CHWs suggested that their supervisors interact more frequently with the CHWs and provide them guidance.
- Figures 30a and 30b indicate that more than 50 percent of the facilities had supervisory visits in the last six months. However, written feedback was provided in less than 50 percent. The situation with feedback was worst in Kabul. The quality of the supervision is not known.

**Figure 30a: Providers who received recent feedback and supervision for FP services – nine provinces (percent)**

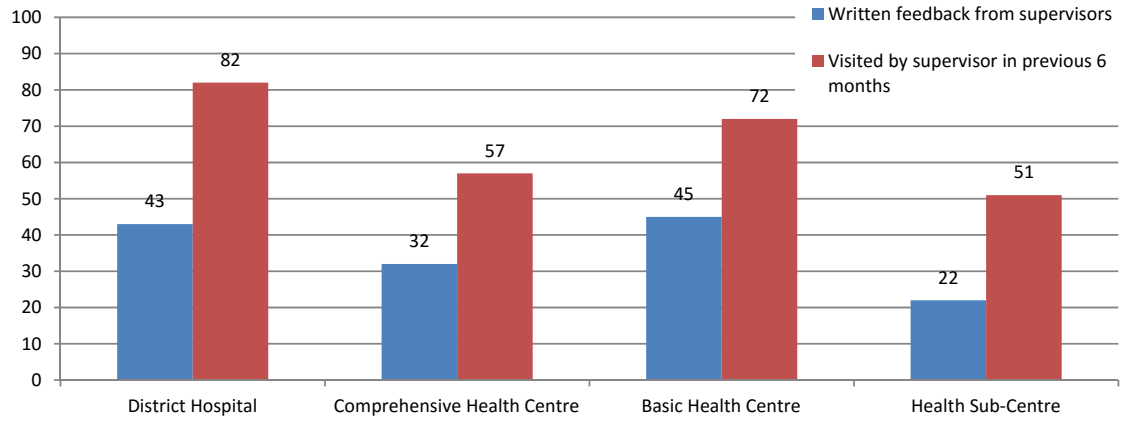
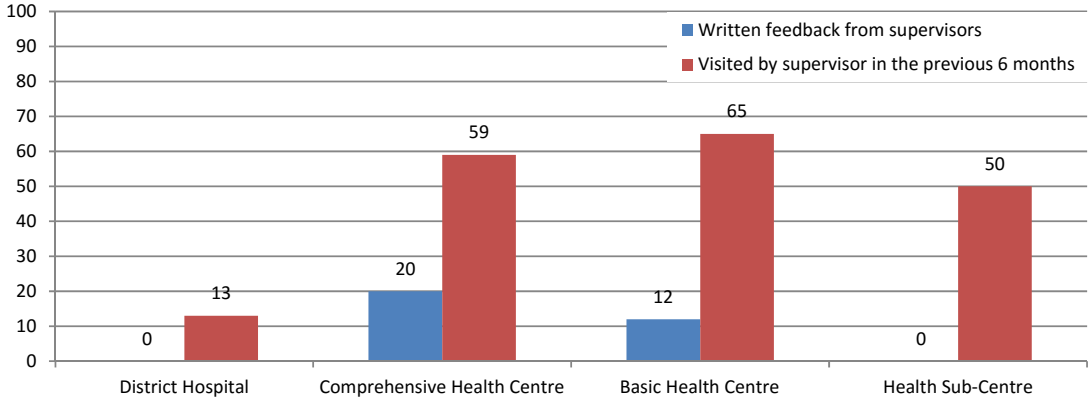



**Figure 30b: Providers who received recent feedback and supervision for FP services – Kabul (percent)**



- HMIS:
  - The in-depth interviews and focus group discussions with midwives and CHWs indicated that reports on FP – users, referrals and drop-outs – are sent regularly to the implementing NGO offices, which in turn send them to Provincial Health Offices and the MoPH. It was also reported that feedback is provided by both supervisors and the Provincial Health Office and MoPH. The content of the feedback is not known.
  - There is no effective system under the HMIS for tracking discontinuation rates, which are not in the list of monitoring indicators. This has implications for contraceptive prevalence as the levels reported may include discontinuing clients and thus artificially inflate the figures. Provision of follow-up care (as discussed under clients' rights in section 3.2.4) is difficult without this information.
  - The CHWs send monthly tally sheets to their supervisors and it is not known whether they receive feedback and of what quality.

### *Information, training and development*

Knowledge, skills and ongoing training and professional development to continuously improve the quality of services they deliver are included under this aspect of providers' needs, and are linked to the SEED element relating to providers and facility staff having the necessary skills to provide quality services.

- The gaps in skills related to provision of FP are discussed under clients' rights to safe services. The skill level of midwives from private sector is a major concern.
- Few midwives from almost all provinces have been trained in FP. In-depth interviews with facility managers indicated that a significant number of midwives and CHWs have been trained and have received refresher training. The need for more training was echoed in the in-depth interviews as well as focus group discussions with providers.
- From the discussions with the staff of the national training centre (Rabia Balkhi), it appears that they provide competency-based training. However, gaps in quantity of training materials, anatomical models and other resources affect the quality of training. The training centre does not follow up with trainees as it is beyond their terms of reference and the trainers do not have time to do so with their responsibilities in the hospital. While this is recognized as a gap, no strategies have been developed to redress this.
- The distribution of providers skilled in FP does not appear to be equitable as the training plans do not focus on achieving systematic full coverage of a geographical area. As indicated in section 1.7.3 on human resources, only two trainings were conducted in permanent methods due to an inadequate number of master trainers. The trainers expressed the need for more skills development.
- The quality of training at the regional training centres is not known; however discussions with stakeholders gave the impression that not many batches are trained in these facilities. There is no coordination between the various training institutions.
- The quality and coverage of training of CHWs is not well documented and no evaluation has been done.
- The RHD training coordinator is expected to coordinate various training activities; however according to feedback from various sources, this coordination does not occur.

- Availability of national FP guidelines in facilities is another concern (as discussed in section 3.2.1 on availability, Figures 16a and 16b). The in-depth interviews with managers of facilities of provinces indicated that guidelines are available, however information on distribution was not available. A shortage of guidelines for trainees has been pointed out earlier.
- The national human resources development strategy has raised concerns about the adequacy of the current job descriptions of BPHS providers. It is not known whether FP is listed as a key function.[91] The in-depth interviews with managers and focus group discussions with providers suggest that a lack of clarity on roles and responsibilities is a major issue with regard to provision of FP services.

### *Supplies, equipment and infrastructure*

Reliable, sufficient inventory of supplies, equipment (in working condition) and infrastructure for uninterrupted delivery of high-quality services are covered under this aspect of providers' needs. The sections on infrastructure and availability (3.2.1) and contraceptive commodity security (3.1.3) also provide information on these aspects.

## Quality assurance

The MoPH has invested heavily in improving quality of services in general, and this is a key component of the Balanced Score Card. The National Strategic Plan for Health and the RH strategy focus on quality of care. Section 1.8 describes strategies specifically related to FP. The completion of the ongoing baseline survey and locale-specific strategies should contribute to the QA process.

## Integration with other services

This is an element of the SEED framework and, as mentioned in the ICPD Programme of Action, is an important aspect of quality of care.

- Section 1.8 on policy discusses the lack of integration of FP into the HIV/AIDS programme. This section also discusses FP as a part of the continuum of maternal health care. The integration with child health is not strong.
- The in-depth interviews indicated that FP is well integrated with primary health care, maternal and child health services as well as HIV/AIDS. Only in two provinces did responses indicate that there was no service integration, as there are no cases of AIDS.
- The national FP guidelines include screening for STIs and HIV, however, observations of counselling, IUCD insertion and injectables suggested that screening for STIs and HIV is not a common element in FP services.
- As discussed in section 3.1.1, the focus of prevention of mother-to-child transmission of HIV guidelines is on prongs 3 and 4 related to transmission and treatment, not on prongs 1 and 2 related to prevention.
- The postpartum and post-abortion guidelines do emphasize FP. As discussed in section 1.8, the focus of postpartum FP is on IUCDs. The impression gained from discussions with stakeholders is that FP is not actively promoted in the maternity wards.

**Conclusion:** The identified health system gaps relate to poor quality of services with regard to informed choice and access to all methods, lack of access of young married, stock-outs of contraceptive commodities and poor quality of commodities and lack of effective monitoring system for FP indicators. The predominant method used is injectables; besides provider bias

91. MoPH. *National Human Resources for Health Strategy*, 2013.

referred to earlier, the reason could be that female CHWs provide services closer to home (though only a few are trained). Sterilization, particularly male sterilization, is not promoted; religious and cultural attitudes towards permanent methods as well as lack of skilled staff are significant barriers.

## 3.3 Demand

### 3.3.1 Current perceptions and barriers

The following findings are derived from in-depth interviews and the analysis of focus group discussions.

- The desired family size was a minimum of four children, irrespective of sex and age of the respondents. The same finding among young people is surprising and is of concern as it can contribute to continuing high fertility. The finding also corresponds to the responses of health service providers about the timing of acceptance of FP methods. It is interesting that the desire for a large family has not changed over the years, as the Strategic Assessment in 2008 reported a similar finding.[92]
- Knowledge about FP: Section 1.6 on RH status points out a high level of knowledge about FP among married women which was also the finding of the Strategic Assessment in 2008.[93] The focus group discussions confirmed that women are knowledgeable about FP and know of at least three methods.
- Preferred method: Injectables appeared to be the preferred method followed by pills among women, while condoms topped the list among men. Increasing preference for injectables was reported to be due to the longer protection these offer. Similar findings were also found in 2008.[94] While providers mentioned that they promoted all methods and supported clients' choices, there appeared to be a bias towards injectables in most provinces. Experience from other countries shows that provider bias towards injectables influences the choice of method. Demand for IUCD and sterilization is limited as these are probably not promoted as heavily as other methods and because of availability: both methods depend on skilled providers.
- Benefits of FP: Almost all the women knew the benefits of FP for the health of mothers and children. Some also mentioned the economic benefits of having fewer children. Focus group discussions with men also pointed out the benefit of FP for maternal and child health. The young women and men interviewed also seemed to be aware of the advantages of FP for maternal and child health; however, young women had comparatively less knowledge.
- Sources of information about FP: Most women heard about FP from CHWs, midwives and relatives while men heard about FP from CHWs, pharmacies, television and radio. The sources of information for young people were CHWs, midwives and television.
- Sources of contraceptives: Women obtained contraceptives from health facilities while men got them from pharmacies and health facilities. From various stakeholder discussions, it was felt that condom use was underreported as men get the supply from pharmacies.
- Barriers:
  - Decision-maker about using FP: From the focus group discussions, it is clear that mothers-in-law play an important role in the decision to use family planning. Some women mentioned religious leaders and elders. Husbands of women who used a method were supportive while mothers-in-law were usually not supportive. Surprisingly, fewer women in Kabul mentioned mothers-in-law as barriers in focus group discussions.

92. MoPH. *A Strategic Assessment of Family Planning in Afghanistan*, 2008.
93. Ibid.
94. Ibid.

- In response to difficulties in obtaining contraceptives, women in focus group discussions pointed out that the lack of permission from husband and senior family members to travel alone to the clinic is a major problem.
- Waiting time in health facilities was identified as another problem.
- The lack of female providers (CHWs or midwives) in health facilities is also an issue.
- As already discussed, distance is a major barrier and involves transportation costs.
- Shortage of supply was mentioned by some.
- Awareness about FP was low among men in some areas.

- Age at marriage: Similar to the 2008 assessment, most suggested above 18 years as the ideal age for marriage. In the focus group discussions with women and men, the community seemed to prefer 16 years as the ideal age at marriage.
- Age at first pregnancy: Most women suggested 18 and above. Most young women and men suggested the same.
- School teachers: Most teachers interviewed said they would like to teach about FP and felt they needed training. With regard to creating awareness among young people about FP, the teachers suggested radio and television as suitable media for communication. Few felt that discussions should be held with community leaders and religious leaders to get their approval for sharing information on FP with young people.
- Community leaders: Focus group discussions indicated that community leaders support FP and advocate with religious leaders and with men and young people in the community. It was reported that they also discuss the issue of FP with health *shuras*. A key finding is that CHWs are well respected and supported by community leaders. Some community leaders and religious leaders had been orientated on FP.

### 3.3.2 Elements of demand

The six elements of demand identified in the SEED's framework are:

- The programme reduces the cost of FP to increase demand;
- A Social and Behaviour Change Communication (SBCC)[95] strategy is in place;
- Commercial and social marketing are used to create demand;
- The FP programme utilizes mass media SBCC approaches;
- The FP programme engages communities and champions in SBCC; and
- The FP programme utilizes peer education.

The first element is not applicable to Afghanistan with regard to FP as services are provided free of cost; this has been confirmed through focus group discussions with community members. However cost of transportation could be an issue found in the 2008 Strategic Assessment.[96]

#### BCC strategy

As discussed in section 1.7.6, a BCC strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health is being developed and includes FP. It is not known whether this includes certain elements: identification of target audiences, barriers, communication channels appropriate for various audiences, dealing with rumours, etc.

95. The SEED framework alludes to Social and Behaviour Change Communication (SBCC), reflecting a renewed emphasis on both individual and group behaviour change, but often used interchangeably with BCC. In the Afghanistan context, the term BCC is more commonly used.
96. MoPH. A Strategic Assessment of Family Planning in Afghanistan, 2008.

- Male involvement is highlighted in the National RH Strategy and national BCC strategy for health; however it is not clear whether any interventions have been implemented or if they are effective.
- As discussed in section 1.7.8, there are two social marketing projects by ASMO and MSI. Their reach is mostly limited to major urban areas. The MoPH supports social marketing programmes. There does not appear to be much coordination in terms of consistent messaging. The MoPH has no mechanisms to continuously monitor the response to social marketing organizations and does not appear to make use of best practices from the implementation of social marketing programmes.
- The rural penetration of the social marketing programmes is less than 20 percent, hence their access to the rural population is limited. One of the reasons quoted by the social marketing organizations is that FP is not something that the rural population will invest in, especially as they can get free services from health posts and BHCs. The organizations are exploring possibilities of increasing their rural coverage.

### Mass media approaches

- While the findings from focus group discussions pointed out that radio and television are a source of information about FP, especially for young people, it appears that the use of mass media for promoting messages on FP by MoPH is limited and unsystematic. No evaluation of the impact of the messages has been carried out.
- A toll-free youth phone line has been established by MoPH to enable young people to ask questions about reproductive health. The youth line is popular and has had a large number of queries related to FP. The youth line also provides counselling to callers and advice to young women on contacting health facilities in their respective provinces.
- There are plans to introduce mobile phone based m-Health approaches. But with mobile coverage currently limited, the reach of such approaches will be restricted.

### Community engagement and use of champions

- The MoPH has been engaging communities through its community based health care policy and strategy. Through the creation of health posts and appointment of CHWs, health *shuras* have been created at facility and health post levels to support health activities and provide feedback on how well these facilities are functioning. Few community leaders have received training in FP promotion. In focus group discussions community leaders pointed out that some of them do discuss the importance of FP in health *shuras*. The in-depth interviews and focus group discussions with providers and community leaders in all provinces indicated that the PHDs, facility managers and CHWs engage community leaders as well as religious leaders in promoting FP. No champions have been identified for FP. The FHAG is another community-based initiative focusing on maternal and child health but it is not known whether it promotes FP.
- The National RH Strategy seeks to promote RH through teachings by religious leaders. To facilitate their involvement, studies of the knowledge, attitude and practices of religious leaders regarding FP were conducted and advocacy workshops on FP were held in collaboration with Ministry of Hajj and Religious Affairs (including some at the provincial level). These studies, and discussions with key stakeholders, suggest that lack of understanding and misinterpretation of religious teachings creates barriers to accepting FP. The model developed by ASMO in advocating and promoting FP to religious leaders appears to be effective.

### Use of peer educators

- There is no specific strategy for utilizing peer educators for FP. The peer educators appointed by the Deputy Ministry of Youth Affairs to promote adolescent sexual and reproductive health programmes in urban areas are not active due to lack of support. As described in section 1.7.8, social marketing programmes use peer educators to promote their FP products and, from reports of the organizations, appear to be successful.

**Conclusion:** Demand creation, while strongly reflected in the policies and strategies, has not translated into actions and national efforts for creating demand are poorly coordinated not strong enough to effect change. This could be partly because of a fear of opposition from religious leaders.

## 3.4 Monitoring

Indicators for monitoring the implementation of the RH strategy include TFR, adolescent fertility rate, crude birth rate, CPR and CYP. However, among the service-related indicators only CYP is monitored regularly. While CYP has its value as a service utilization indicator in terms of commodities distributed, and can be estimated annually, it is not helpful to ascertain the number of actual FP users. The number of new FP users and revisits is not available. Unmet need data is not available, even from the Afghanistan Mortality Survey. There is no information on wanted fertility. As indicated in section 3.2.4 on quality, current HMIS data does not provide information on discontinuing clients. The MoPH has initiated the process of monitoring quality of health services including FP through its QI improvement strategy (section 1.8.4) but there is no effective monitoring of FP activities in the private sector. The NRVA data provides information on access to facilities but it is difficult to assess whether this information is applicable to FP services.

The Balanced Score Card for reproductive, maternal, newborn and child health reported that 88 percent of facilities had FP commodities available and a CYP of 12.[97] However the CYP estimate appears to be incorrect, perhaps due to the method of estimation used.

## 3.5 Human rights perspective

Existing policies and strategies articulate human rights principles, equity, gender sensitivity and sociocultural dimensions. The Balanced Score Card used for monitoring the BPHC includes six domains: client and community, human resources, physical capacity, quality of services, management and overall mission.[98] Though not specific to FP, the six domains of the Balanced Score Card cover all 10 areas of rights. Comparison of scores since the Balanced Score Card was implemented reveals a decrease in the client satisfaction index, worker satisfaction index and infrastructure,[99] which has implications for FP from a rights perspective.

97. MoPH. *Afghanistan Balanced Score Card Reproductive, Maternal, Newborn and Child Health*. 2015.
98. MoPH, JHBSPH, IIHMR: *Basic Package of Health Services Balanced Score Card. National Report* 2012–2013.
99. Ibid.

## 3.6 FP effort index

USAID developed the FP Effort index in 1972 to measure the type and level of efforts by FP programmes in various countries. The index has been revised over the years and the last measurement was done in 2009 in 81 countries including Afghanistan.[100]

The scores constitute a unique resource for understanding FP activities. The index is meant to measure inputs, not outputs and the scores have been used to diagnose programme weaknesses at national levels, assess advocacy efforts to clarify where programmes are performing well, and to indicate what achievements could be expected if efforts are improved. The findings in this report provide evidence for the reasons behind the low scores.

### Table 14: FP effort national component scores 2009

| Total | Policies | Services | Evaluation | Access |
|---|---|---|---|---|
| 50.7% | 56.0% | 51.6% | 53.4% | 41.8% |

100. Ross, John, and Ellen Smith (2010). *The Family Planning Effort Index:* 1999, 2004, and 2009. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

# 4. RECOMMENDATIONS

## 4.1 Context

The London Summit on FP held in July 2012, which led to the FP 2020 partnership, brought together partners from the government, UNFPA, donors, civil society, professional organizations, research and development community and private foundations and organizations to support the right of women and girls to decide, freely and for themselves, whether, when and how many children they have.[101] FP 2020 is an effort to make available affordable, lifesaving contraceptive information, services, and supplies available to an additional 120 million women and girls in the world's poorest countries by 2020. Afghanistan is one of its focus countries and MoPH officials were invited to the summit.

The FP 2020 mechanism builds on the UN Secretary General's Global Strategy for Women's and Children's Health, "Every Woman, Every Child", and other international partnerships such as the Reproductive Health Supplies Coalition (RHSC). In 2010 GIRoA made a commitment to the Global Strategy to increase its CPR to 50 percent.

Afghanistan did not make any commitments at the London Summit. However, the MoPH leadership has constituted a country committee for FP 2020 with UNFPA and USAID as co-chairs.

In order to ensure that FP 2020 and its mechanisms embody ideals grounded in existing rights agreements and frameworks, the rights and empowerment working group developed a set of principles as they relate to ten dimensions of FP: agency and autonomy, availability, accessibility, acceptability, quality, empowerment, equity and non-discrimination, informed choice, transparency and accountability and voice and participation.[102]

Afghanistan is also committed to the ICPD Programme of Action and to achieving the MDGs and their successors, the Sustainable Development Goals.

Afghanistan's commitment to rights-based strategies in health and quality of care is evident from the six Balanced Score Card domains (see Annex 1.4 and section 3.5) and the Patients' Charter of Rights.

101. London Summit on FP July 2012: An overview.

102. Family Planning 2020: Rights and Empowerment Principles for Family Planning. Available at: http://www.familyplanning2020.org/resources/4697

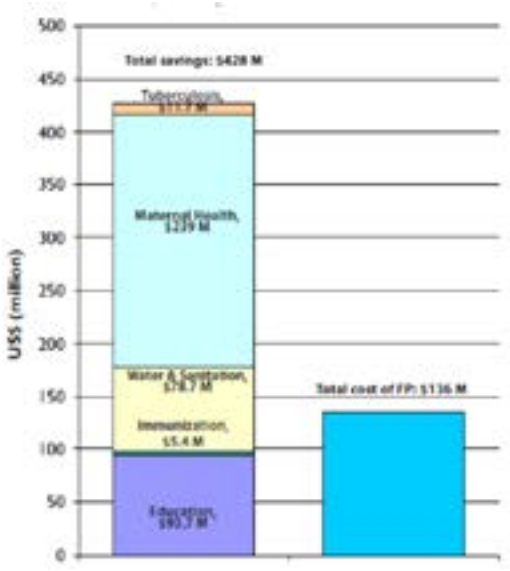
The findings of the CFPNA provide an opportunity to take stock of the implementation of the various policies and strategies and to make mid-course corrections as needed. The early years of implementation of the SEHAT project offers another opportunity to use its findings and recommendations. The CFPNA can also contribute to developing a rights-based strategy for FP to help achieve Afghanistan's developmental goals under the umbrella of the FP 2020 committee.

### 4.1.1 FP and the achievement of Afghanistan's development goals

High fertility and population growth have negative implications for development. The large adolescent and young population have fertility aspirations, which, if unmet, will continue to contribute to high fertility and population growth. The contribution of FP in reducing maternal mortality has been discussed in the section on the enabling environment (3.1.1). There is also evidence to show that if every woman could space births by two years, deaths of children under five would fall by 13 percent. If the gap is three years, such deaths would decrease by 25 percent.[103] If the figures are applied to Afghanistan, the reduction from the current level of 97 deaths per 1,000 live births[104] (UN IEG 2014) would be significant.

As fertility rates fall, pressure on the country's health, education, water, sanitation and social services, and on scarce natural resources is relieved. It is estimated that every US$ 1 invested in FP services yields US$ 2–6 in subsequent social sector cost savings in sub-Saharan Africa, and up to US$ 13 in South Asia.[105] Family planning is one of the best investments for improving health and achieving other national development goals. Figure 31 illustrates the points discussed above using data from the neighbouring country of Pakistan, where fertility and unmet need are also high.

**Figure 31: Social sector cost savings and FP costs in Pakistan**




*Source: USAID/Health Policy Initiative: Achieving the MDGs. The Contribution of FP. Pakistan. 2009*

Studies have shown that policies that slow population growth will probably also have climate-related benefits.[106]

103. Rutstein SO (2008). *Further Evidence of the Effects of Preceding Birth Intervals on Neonatal, Infant, and Under-Five-Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys.* DHS Working Papers No. 41, Calverton, MD, USA: Macro International.

104. United Nations Inter-Agency Group for Child Mortality Estimation [UNICEF, WHO, World Bank, UNFPA] (2014). *Levels and Trends in Child Mortality: Report 2014.* Available at: http://www.unicef.org/media/files/Levels_and_Trends_in_Child_Mortality_2014.pdf

105. Gribble, J and M-L Voss (2009). *Family Planning and Economic Well-Being: New Evidence from Bangladesh.* Population Reference Bureau Policy brief, May 2009.

106. O'Neill BC, Liddle B, et al (2012). Demographic Change and Carbon Dioxide Emissions. *Lancet* 380 (9837) 157-64. DOI: 10.1016/S0140-6736(12)60958-1.

Studies also suggest that enhanced FP efforts under the BPHS will improve public health sector capacity to make necessary investments in other key maternal health interventions. A recent study in Bangladesh showed that unwanted births and mistimed births are associated with stunting, wasting and underweight.[107] It points out that preventing unwanted pregnancies may contribute to decreasing the prevalence of malnutrition, which is currently high in Afghanistan.

With a high fertility, low CPR for modern methods and high unmet needs, it is likely that unintended pregnancies and unintended birth rates are high. In this situation, the population momentum may continue for many years with serious implications for the achievement of development goals. In order to reap the full benefits of the demographic momentum, it is important to ensure that demographic transition takes place, with decreasing birth rates and child mortality. Helping women avoid unintended pregnancies will help achieve this demographic transition. Contraceptive prevalence is an important proximate determinant of fertility reduction. Based on the relationship between unintended pregnancies and malnutrition, the benefits of this demographic bonus and productivity may also be affected by the fact that a significant number of children enter adulthood malnourished.

If the CPR could be increased by 10 percent from 2010 level for modern methods (20 percent), focusing on increasing long-acting and permanent methods (from the 2010 level of 4.4 percent), the numbers below may be significantly reduced (based on estimates using Reality Check tool).[107]

| Indicator | Numbers averted by 2020 |
|---|---|
| Unintended pregnancies | 10,922,434 |
| Abortion | 3,058,282 |
| Unintended births | 6,444,236 |
| Maternal deaths | 23,135 |
| Infant deaths | 206,216 |
| Child deaths | 257, 769 |

*Source: USAID Reality Check Tool*

**Conclusion:** FP deserves its place as a stand-alone key intervention in improving reproductive health (as part of continuum of reproductive health care) and in socio-economic development.

## 4.2. Improving the enabling environment

### 4.2.1 Strengthening policy based on evidence

- Considering the importance of FP in socio-economic development and for reaping the benefits of the demographic bonus, developing a rights-based FP strategy should be considered. The proposed strategy, while emphasising continuum of care, will concentrate on integrating with STI and HIV services, and focus on four areas: availability of equitable and quality FP services, demand creation, enhanced stewardship at all levels of administration and enabling environment for effective, equitable and sustainable FP programming, and fostering and applying

107. Rahman MM (2015). Is Unwanted Births Associated with Malnutrition in Bangladesh? *International Perspectives on SRH 41*(2): 80-88.
108. USAID, Respond. Reality Check: *A Planning and Advocacy Tool for Strengthening FP Programmes.*

innovations and evidence for improving the efficiency and effectiveness of programmes. The strategy should be costed. The strategy document could be used an advocacy document with national and international institutions to increase funding and to ensure a long-term future for the programme. The document should be developed under the leadership of the proposed FP 2020 country committee.

The proposed strategy will cover almost all the recommendations in the following sections.

- While all efforts must be put in place to delay the age at marriage, equal emphasis should be placed on delaying the first pregnancy and developing specific strategies to provide FP to married adolescents. A best practice is the Mayer Hashi project of Bangladesh which targets young married couples using peer-led approaches.
- A review and revision of current indicators in national health and RH strategies should be undertaken to ensure that key FP indicators are included.
- The draft Reproductive Health Commodity Strategy should be reviewed and revised (more details are provided under the specific recommendations on the subject). The procurement policy should be reviewed to assure quality assured procurement and is a focus area under SEHAT. UNFPA, in its global role in quality assured procurement, should support the MoPH in building its capacity.
- The HIV/AIDS and STI strategy should be reviewed to ensure that FP services are provided in STI clinics and HIV/AIDS counselling and testing and treatment facilities. It is well known that a US$ 1 investment in FP could save up to US$ 25 in HIV/AIDS treatment, and reduces the costs of prevention of mother-to-child transmission.

### 4.2.2 Strengthening capacity for stewardship

Chapter 3 identified several areas that need strengthening such as overseeing and guiding the overall provision of FP services in the private and public sector, oversight and intelligence, collaboration and coalition building across sectors.

- The SEHAT project has a component on stewardship and efforts should be made to include FP. In the context of decentralization, capacity of the PHDs for stewardship should be built. Leadership capacity within the RHD should be strengthened and supported to strengthen their stewardship role. Capacity to effectively plan, coordinate and communicate FP and RH programmes should be strengthened.
- The RHD is currently under-resourced and the adequacy of its human and financial resources should be reviewed.
- The oversight mechanism of the RHD should be strengthened through the establishment of a central database for collection and collation of national data on FP and other RH services, closely linked to the HMIS. Indicators should be to be reviewed and revised to include key indicators, disaggregated by age. FP 2020 has identified several core indicators which should be considered and it may be possible to access support for Afghanistan, as a priority country, from the FP 2020 Global Monitoring Group. WHO reviewed the current FP indicators from a rights perspective and the list is available as a resource.[109] In addition, indicators for tracking implementation of policy reforms should be developed. The WHO website on FP High Impact Practices[110] provides examples of such indicators. Annex 1.6 also provides examples.
- An advocacy plan to improve the visibility of the FP programme should be developed with a clear communications plan to reach national institutions such as the Ministry of Planning, Finance and the President's Office as well as international institutions.

109. WHO (2014). Ensuring Rights within the Contraceptive Programmes: A Human Rights Analysis of Existing Quantitative Indicators.
110. Family Planning High Impact Practices. https://www.fphighimpactpractices.org//.

### 4.2.3 Fostering an enabling environment

- Tracking expenditures: The allocations for FP are not known and, as discussed in chapter 3, financing for FP programmes appears to come almost exclusively from donors. A system of tracking FP and RH expenditures to the provincial and district levels should be established by the Health Economics division in collaboration with RHD.
- Performance-based incentives for CHWs should be considered.
- Operations research: The capacity to undertake operations research in FP should be strengthened and technical assistance should be provided to RHD and the Research Division.
- Engaging religious and community leaders: The ongoing activities by the MoPH and Ministry of Hajj and Religion as well as activities supported by donors and social marketing organizations in gathering support for FP through religious leaders should be reviewed to identify best practices and gaps. Consultations between the two ministries, community representatives (including religious and community leaders) as well as political groups should be supported to reconcile religion and the practice of FP as a tool to reduce poverty, reduce maternal mortality and improve family health. Studies should be supported to identify the misinterpretation of religious teachings. Such consultations will require the development of evidence-based documents clearly illustrating the role of FP in improving maternal and child health.

## 4.3 Strengthening supply

### 4.3.1 Reducing unmet needs

The sections on availability (3.2.1) and accessibility (3.2.2) and demand identified several barriers which are also critical for reducing unmet needs. Skilled providers and commodities are essential to reduce unmet needs.

#### Sustained support to users

- Recent evidence of a decline in CPR is an indication of the lack of support to users. Follow-up including counselling and providing support in case of side-effects or problems are important for sustained use. The gaps are listed in section 3.2.4 on quality of care. The counselling skills of CHWs (male and female), midwives and doctors should be strengthened.

#### Overcoming barriers and improving quality of care

Most of the interventions for improving quality of care focus on providers and infrastructure. While these are certainly prerequisites for services, client-related barriers are given little attention. The active participation of clients in selecting a method (i.e. informed choice) and receiving the method they want is important for initiating and continued use.

#### Improving access to information and informed choice

- CHWs and midwives should be provided with client friendly educational material (such as the Decision-making Tool) to provide accurate and unbiased information and be oriented on the use of these materials.
- With an increasing number of women becoming literate, efforts should be made to provide client education materials in health facilities and health posts.
- Best practices are available from other countries on the use of radio to convey messages and the reach of this channel should be expanded.

- The use of mobile phone applications to send messages should be piloted.
- The quality of counselling should be improved through training, emphasizing the importance of informed choice. The training should ensure that counselling of continuing clients and those experiencing problems is included. More details are included in the recommendations dealing with capacity building.

### Improving access to safe services

- Infection prevention including waste disposal should be strengthened. Since the irregular availability of electricity and fuel makes it difficult to use autoclaves, alternate means of sterilization of instruments should be explored.
- Waste disposal in health posts should be reviewed and mechanisms for better disposal of waste (used needles and syringes) should be developed.
- The MoPH should provide support to PHDs to ensure that the standards for facilities and health posts are met by implementing NGOs (several gaps were identified from the facility assessment). The implementation of the SEHAT project should provide such opportunities.
- Possibilities of providing a separate space for FP services that ensures privacy should be explored, e.g. by using curtains or screens, etc. This should be part of monitoring under the MoPH's QA mechanisms.
- Improving the skills of providers is critical and is discussed further in the recommendations of capacity building.

### Continuity of care

- A system (such as tickler files) should be set up in health facilities to enable health service providers to provide follow-up services to clients.
- Regular discussions with CHWs during monthly meetings at BHCs or through CHW supervisors on discontinuing clients should be instituted.
- The training of providers should include the importance of continuity of care.
- Continuity of care is discussed further under recommendations related to the HMIS.

### Improving geographical accessibility

- A mapping of the functionality of facilities (based on criteria to be defined but including the availability of skilled providers) will give a sense of what is currently available.
- Based on the mapping, plans should be developed to improve access through different channels – training of CHWs particularly female, community-based distribution, FHHs, etc.

### Private sector

- Under the private-public sector agreement and through the local and international NGOs working with the private sector, the private sector should be encouraged to follow the recommendations related to informed choice and safe services. Improving skills of providers is discussed in the recommendations on capacity building.

### Integration of services

- It is important to ensure that clients are screened for STI and HIV while providing FP services. The QA mechanisms should include integration as a monitoring indicator.
- Similarly, FP services should be provided as part of voluntary counselling and testing services

for HIV as well as in intervention packages for key populations.

- These recommendations are important to prevent intimate partner transmission of HIV, as evidence from countries with concentrated epidemics among intravenous drug users has shown (however, the current prevalence of intravenous drug users is not high).
- Traditionally, management of victims of intimate partner violence does not include FP services except emergency contraception in some situations. Health service providers should be made aware of the importance of preventing unwanted pregnancy as part of health sector response. NGOs involved in care of victims of violence should provide FP services (directly or through referrals) to victims of violence.

Availability of supplies is crucial for reducing unmet needs and is covered in the relevant sections.

## Contraceptive commodity security

The SEHAT project provides an opportunity to strengthen several elements of contraceptive commodity security. The recommendations below should be considered within the SEHAT improvement plans.

- Revision of the strategy is noted amongst policy recommendations.
- Standards for warehouses and storage places should be developed and standards developed by ASMO and potential partners should be identified and reviewed. Plans for monitoring should be developed.
- Quality assurance of products through adherence to manufacturers' standards for storage should be monitored regularly, as discussed in the section on commodity security (3.2.1).
- The existing LMIS system should be reviewed and improved to avoid stock-outs.
- Inventory practices and records as well as indenting practices should be standardized.
- Plans for capacity building of warehouse managers and store keepers should be developed.

All the recommendations above are also applicable to the private sector.

## Capacity building

### *Health service providers*

- The job descriptions of midwives, nurses and doctors should be reviewed to ensure that FP is a focus area.
- The basic curriculum of midwives should be reviewed as part of the increasing support for midwifery from various agencies to expand the time allotted to FP. Similarly, the basic training curricula for doctors and nurses should be reviewed to include FP.
- In-service training should be reviewed comprehensively, including assessments of training institutions in Kabul and other provinces. The assessment should include the capacity and capability of institutions to provide competency-based training. Gaps in skills identified should be given focus.
- Strategies should be developed to build the capacity of doctors in providing permanent methods of sterilization. As indicated in chapter 3, lack of capacity in facilities could be a reason for lack of demand for these methods.

### *CHWs*

- The current training of CHWs in FP (basic and in-service) should be reviewed and revised as needed. Counselling skills should be a focus.
- The training provided to female CHWs in providing injectables should be reviewed including selection criteria, trainers, whether training is competency-based, etc.
- The training of supervisors should be reviewed in terms of its technical content as well on developing skills in supervision.

### *Supervisors*

- The job descriptions of RHCs should be clarified and they should be trained in supportive supervision as part of the MoPH's QA mechanism.
- The job descriptions of designated supervisors at implementing NGOs should be clarified and training in supportive supervision (including FP) should be provided.

### *Managers of implementing NGOs and health facilities*

- An assessment of the skills in programme management focusing on FP services should be undertaken and capacity building plans developed based on the gaps identified. Management is one of the domains of the Balanced Score Card.

### *Private sector*

- The skills of the private sector providers in FP should be improved.

Capacity building related to RHCS and HMIS is covered in the relevant recommendations.

## HMIS

- The HMIS should be reviewed to see whether CPR data can be collected regularly.
- The recording system of FP services should be modified to capture information on discontinuing clients, for instance, through the use of tickler files as mentioned earlier.
- The quality of the HMIS review and feedback at various levels of service should be reviewed and appropriate action taken.
- Data quality assurance mechanisms should be built at various levels of health care. A good example is the USAID-supported project on 'Strengthening national FP information systems through data quality assessment' in Bangladesh.

The capacity of supervisors at various levels, including CHW supervisors, should be strengthened in taking action based on the reports.

## Adolescents and young people

In addition to ongoing initiatives to provide information and services to young people:

- Pilot projects on premarital counselling should be developed with due cultural and religious sensitivity and technical accuracy. The premarital counselling programme in Iran is recognized as a best practice.

- A training package in birth spacing for teachers – including knowledge and capacity building in conveying the information – should be developed and incorporated into ongoing initiatives involving teachers.
- Peer education activities should include importance of birth spacing/ FP and the importance of delaying first birth.

### Functional accountability system

- The capacities of facility, health post and women's *shuras* should be built by increasing their own knowledge of clients' rights and capacity to increase awareness among women about their rights.
- The capacity of *shuras* to monitor whether these rights are violated should be monitored.
- Existing client feedback mechanisms should be reviewed and strengthened to facilitate regular feedback and actions.

## 4.4 Creating demand

- A comprehensive BCC strategy for FP should be devised as part of the RMNCH communication strategy currently being developed. It should include the involvement of men and young people, community engagement through various channels described below, and monitoring and evaluation.
- Once the strategy is approved, plans for orientation of the provincial health officers and implementing NGOs should be developed.
- As articulated in the national strategies, incorporation of FP messages in antenatal clinics, postpartum and child health clinics should be promoted and monitored.
- Community-specific materials should be developed and disseminated using strategic channels of communication with maximum reach. These materials should be based on core messages which address cultural and religious barriers and rumours about contraceptives, as relevant.
- Community engagement: The role of the FHAGs and women's *shuras* in promoting FP should be reviewed. A plan for promoting FP messages by FHAGs and women's *shuras* (the latter in collaboration with the Ministry of Women's Affairs) and focusing on mothers-in-law and elderly women in the community should be developed and implemented. Women's *shuras* should play an active role in sharing information with young women about the importance of delaying the age of first pregnancy, birth spacing, etc. The groups should also be trained to monitor availability and access to services and become a part of the MoPH's QA initiatives.
- Innovative approaches for male involvement should be developed, implemented and evaluated.
- The use of traditional media for promoting FP messages should be considered.
- The reach of the various channels and impact of messages developed should be regularly reviewed.

# 5. RECOMMENDATIONS FROM VALIDATION WORKSHOP

A workshop to validate the findings of the CFPNA was held in January 2016. Its recommendations are listed below. While some of its recommendations are already in the report, others are not included as they have policy and financial implications and need further consultation with the MoPH. These are presented below for reference.

The participants were divided into four groups to validate the findings and recommendations: (1) Enabling environment including stewardship, (2) Service delivery (supply side), (3) Demand, and (4) Monitoring and evaluation.

### Group 1: Enabling environment

- The National FP Promotion Workshop report (July 2015) should be reviewed and integrated into the CFPNA recommendations.
- Incentives for women to increase FP utilization should be provided, bearing in mind the lessons learned from similar initiatives in other countries.
- A comprehensive advocacy plan at national level for birth spacing should be developed.
- Multi-sectoral collaboration (MoPH, Ministry of Women's Affairs, Ministry of Education, etc.) should be strengthened.
- Coordination and cooperation between public and private (partnership) should be strengthened.
- The quality of counselling should be improved (i.e. psychosocial aspects).
- Analysis of indicators related to FP under the Balanced Score Card should be institutionalized at the national level (i.e. a central database).

### Group 2: Service delivery/ supply

- Waste management training should be conducted for health providers in both public and private sectors.
- IEC materials should be developed and printed for waste management.
- FP counselling should be added into postnatal care health education.
- A database should be created for stock management, showing the approaching expiry dates.
- The availability of buffer stock in every health facility should be assured.
- The involvement of private health associations for improving FP services should be considered.
- National FP guidelines and protocols should be shared with private sector.
- Private sector health providers should be trained on FP guidelines.

- A reporting system from the private sector to MoPH should be established.
- The MoPH should regularly monitor and evaluate the private sector and the results should be used to improve the system countrywide.

### Group 3: Demand

- Plan for distribution of activities for FP demand creation should be developed.
- The policy and strategy for improving FP services through health facilities and communities should be strengthened.
- FP brochures should be distributed to clients.
- A plan for religious leaders' involvement should be developed, with a national training and cascade training in the provinces.
- FP sessions should be included in education for school teachers and other faculty.
- Female-to-female FP education should be initiated.
- FP materials to promote male involvement through male-to-male education should be developed.
- The BCC policy and strategy should focus more on segmenting the audience.
- Women's support groups should focus on awareness raising for influential women (e.g. mothers-in-law).
- Inter-sectoral coordination for FP should be strengthened.
- Role models for FP should be identified and helped to encourage communities regarding the use of FP.
- Gender sensitive multimedia/ television IEC material should be developed.
- South-South cooperation should be established to share lessons learned.

### Group 4: Monitoring and evaluation

- Input, output, outcome level data should be collected (CYP, CPR, TFR, GFR, Crude Birth Rate, Adolescent Fertility Rate).
  - HMIS revision to ensure data collection for these indicators should be considered.
  - Monitoring and evaluation tools should be reviewed for FP indicators.
- Improvements to the current recording system, including:
  - Indicator for counselling sessions.
  - Indicator for discontinuation.
- Data quality assurance should be instituted.
- Capacity building at various levels, especially at the CHW level for monitoring and evaluation, should be initiated.
- Population level data collection for FP indicators should be explored.
- Target setting for FP at the health facility level should be considered, with due regard to lessons learned from the experience of other countries.
- A review of the Balanced Score Card for inclusion of FP indicators should be considered.

# ANNEX 1

ANNEX 1.1: TOR FOR A COMPREHENSIVE FP NEEDS ASSESSMENT IN AFGHANISTAN
ANNEX 1.2. ORGANIZATIONAL STRUCTURE OF MOPH
ANNEX 1.3 ORGANOGRAM REPRODUCTIVE HEALTH DIRECTORATE
ANNEX 1.4: BALANCE SCORE CARD: REVISED DOMAINS
ANNEX 1.5 TABLES
ANNEX 1.6: INDICATORS TO MONITOR FP PROGRAMMES FROM A RIGHTS PERSPECTIVE

## ANNEX 1.1 Terms of reference for a comprehensive Family Planning needs assessment in Afghanistan

### 1.0 INTRODUCTION

This Terms of Reference (ToR) has been developed to facilitate the conduct of a comprehensive FP Needs Assessment in Afghanistan. The assessment is planned to examine FP (FP) needs from supply and demand sides, as well as explore the environment within which FP interventions are implemented. It is planned that the report of such a comprehensive FP assessment will be used to guide development and implementation of a national FP action plan that will address the needs/ gaps identified and contribute to increased utilization of quality FP services in Afghanistan.

### 2.0 BACKGROUND

The background reviews the context within which FP programmes are designed and delivered in Afghanistan. In spite of relatively high levels of knowledge, utilization for FP remains low in Afghanistan (Afghanistan MICs 2012, Afghanistan Mortality Survey 2010). Anecdotal data shows that political commitment, socio-cultural factors, financing issues, etc. affect the provision and use of quality FP services in Afghanistan.

### 2.1 FP in Afghanistan: the facts

Afghanistan has a projected population of 27.5 million people; 72 percent of whom live in rural areas (CSO, 2014). The Total Fertility Rate (TFR) of 5.1 children is influenced by early marriage, polygyny and desire for the male child.

The reproductive health indices remain poor in Afghanistan. In spite of a reported four-fold decrease in the past twelve years, the maternal mortality ratio is 327 per 100,000 live births (Afghanistan Mortality Survey 2010). The infant mortality rate is 77 per 1000 live births; the majority of infant deaths are attributed to neonatal mortality. There is paucity of data on proportion of unintended pregnancies and abortion in Afghanistan.

The percentage of deliveries by skilled birth attendants has increased from 15 percent in 2003 to 40 percent in 2012 with a five-fold increase in rural areas. Similarly, institutional delivery remains low at 40 percent. Although 86 percent of the population has access to health facilities within 2 hours, the difficult terrain, insecurity and inadequate number of female health workers have affected access and utilization of maternal health services, especially in rural areas of Afghanistan.

Similar patterns of low utilization of modern contraception reveal a slow increase over the past ten years, with some evidence of stalling during the past three years. The Contraceptive Prevalence Rate (CPR) increased from a reported low of 5 percent in 2003 to 22 percent for all methods and 18 percent for modern methods in 2012 (Afghanistan MIC Survey 2012). There is significant inequity in the utilization of FP with low use of FP services among those living in rural areas; those without any education; those falling within the lowest wealth quintile and the unmarried. FP use amongst adolescents (15 – 19 years) is low. More than 60 percent of girls are already married by 18 years.

Patterns of use contrast with knowledge of methods. More than 90 percent of married women in Afghanistan know of a modern method of contraception, in particular the pill and injectables (86 and 83 percent, respectively). Knowledge is lowest among married women in the age group of 15 to 19 where only 84.8 percent have heard of any modern method of contraception (AMS 2010). Generally, rural women are less likely to have heard of a contraception method than their urban counterparts (90.4 and 97.6 percent, respectively).

There is no data on demand, percent of demand satisfied or unmet need for FP in Afghanistan. The most common contraceptive method currently used among married women 15-49 years is injectables (6.5 percent), followed by the pill (5.3 percent) and LAM (3.7 percent) male condoms (1.7 percent), female sterilization (1.4 percent) and IUCD (1.3 percent).

Although there are challenges of quality, population-wide representative and valid data in Afghanistan, the recent National Vulnerability and Risk Assessment report (2011/12) showed that FP use was at 13.8%, yet the Afghanistan Mortality Survey (2010) showed a CPR of 22%. Differences in population sampling were observed between the two surveys.

This apparent decline, which may be linked to methodology issues, should be further examined, since a declining trend in use of FP over the period 2010 to 2013 is also observed in the data from the Health Management Information System. Factors surrounding the trend in contraceptive use have yet to be explored. Policy and programmatic decisions are required for repositioning FP to especially reverse this apparent decline and increase rights-based FP services which would contribute to achievement of MDG 5 in the remaining 550 days.

## 2.2 FP in Afghanistan: the response

The Ministry of Public Health of the Government of the Islamic Republic of Afghanistan has developed its Reproductive Health Strategy, within which FP has been integrated.

A review of the depth and extent of the integration of FP related interventions is required to facilitate the development and expansion of adequate and feasible interventions in the context of Afghanistan. Financing for FP commodities is primarily provided by development partners. The percentage of government allocation and expenditure on FP is not known. The benefit of bulk

procurement through a third party arrangement, such as from the RH Access, would benefit the country in terms of timeliness, quality and cost, and is being further explored by UNFPA.

The strong influence of religious and socio-cultural factors on issues of family and family formation needs to be harnessed into a unified and unequivocal voice for a stronger political and socio-cultural support for FP services, while showing the link between Islam and FP. Work of the Ministry of Public Health and Ministry of Haj and Religious Affairs and the Mullahs is beginning to show and create the needed momentum for a FP revolution which is very much needed in Afghanistan, a country in its early phase of a youth bulge.

FP has been integrated in both the Basic and Essential Health Care Packages of the Government health care delivery system. However, the recent HMIS report shows that 79 percent of health facilities had stock outs of essential medicines in the last 6 months. FP is measured amongst the 30+ essential medicines and supplies list, although no specific data on FP status has been analysed separately. Access to and use of FP services is affected by a host of individual, couple, family and societal factors on the demand side. Similarly, availability of female health workers and FP commodities, the quality of FP services provided and other supply side factors are impacting effective coverage of FP services.

The FP Working Group/Task Force has been established by the Ministry of Public Health to improve on coordination of FP actors. A review of the functions, membership and performance of such a working group would guide improvements in quality needed to make services more effective. Such a group would also guide work on estimation, quantification and projection of FP needs for the country into a Contraceptive Procurement Table (CPT) that would guide procurement decisions/planning as well as supply chain management, including FP stock (re) distribution and management.

## 3.0 RATIONALE/JUSTIFICATION

The Comprehensive FP Needs Assessment is vital for Afghanistan. There is need to better understand the factors affecting demand and supply of FP in Afghanistan in order to better design interventions to address them. This is especially important now given the political realization of the need to develop equity based programming as well as due to the growing momentum of mobilized religious leaders and other social and institutional structures to support FP programmes in the country. The religious leaders will in turn mobilize the population and create demand for FP that may outstrip the current supply. Thus the FP Needs Assessment will provide the needed information on what needs to be done to ensure sustainable provision of quality FP services, under the guidance and direction of the Ministry of Public Health. Afghanistan is also experiencing a youth bulge with potential for a demographic dividend. Amongst other services, FP will be a key intervention for such a population if Afghanistan is to harness the potential demographic bonus. To ensure global standards of service delivery are eventually achieved, the assessment will utilize previously tested global assessment methodology adapted for Afghanistan context.

## 4.0 OBJECTIVES

The main objective of the comprehensive FP Needs Assessment is to map the current status of FP in Afghanistan; and determine the supply, demand and environmental needs/gaps that affect sustainable provision of quality FP services.

The specific objectives are:

- Scan and map the current status of FP in Afghanistan
- Assess the needs for effective and sustainable supply/provision of FP services;
- Determine the quality of services provided
- Assess the needs for increased mobilization of the population, especially young people and the rural population to demand and use of FP services
- Assess the needs for conducive policy, financing, political and socio-cultural support for FP programmes

## 4.1 Detailed Scope of Work

The scope of work provides guidance on issues to further examine under each objective, and it is not exhaustive.

**Objective 1: Scan and map the current status of FP in Afghanistan in view of Afghanistan's development challenges.**

This objective will assess the current status of FP in terms of user pattern and profiles.

- Profile the country's demographic and development indicators, and human rights issues that relate to FP interventions.
- Assess and document key RH status, including CPR and user profile for FP in Afghanistan
- Assess the unmet need for FP where the information is available from existing literature.
- Identify the main actors in FP in Afghanistan: policy and decision makers, development partners funding FP programmes, main implementing partners, key/potential adversaries to the FP agenda, etc.

**Objective 2: Assess the needs for effective and sustainable supply/provision of FP services.**

**This objective will analyse the FP needs related to supply of services and commodities, and could include review of the needs in each of the health systems and services delivery as it relates to ensuring provision of FP services to the population.**

- Assess the availability, adequacy and appropriateness of policies on FP in general, and whether they are stand alone or integrated with RH or within the wider National Health Policy. This could also assess the policy for those included or excluded from FP services and any conditions precedent to access and use of FP services.
- Assess the supply chain management system for FP, right from projection and quantification, availability of procurement plan/table and actual procurement and distribution of FP (for both public and private sectors), including FP method mix and stock-out status. This could also examine any link to global third party procurement mechanisms such as RH Access.
- Assess the availability of FP services for the population through both the public and private sector service delivery outlets and its delivery through vertical or integrated services, such as post-partum FP/IUCD in Post Natal Clinics.
- Assess suitable FP services delivery modes for different population groups: static clinics, outreaches and community based services, as well as any elements of total market approach (social, commercial and community based approaches) in FP provision.
- Assess the quality of FP services including counseling and use of aids for discussion
- Determine client satisfaction with FP services

- Determine the level of discontinuation of FP and the main reasons
- Assess availability and use of FP supply chain management system and protocols/guidelines and tools
- Assess the HMIS and LMIS for their content related to FP and how monitoring such information on FP is generated, managed and used to improve FP services delivery
- Assess staff capacity for the leadership and management of FP programmes, and for the provision of the different methods for FP services, including Long Term and Permanent Methods (LTPM) and emergency contraceptives, and any inbuilt supervision, on-going in-service training, provision of job aids for FP and other capacity development measures.
- Assess whether or not FP have been integrated in training programmes for health workers in Afghanistan: medical doctors, nurses/midwives and other auxiliary health care workers.
- Review and determine the extent and effectiveness of social marketing of contraceptives

**Objective 3: Assess the needs for increased mobilization of the population, especially young people and the rural population to demand and use of FP services.**

The focus of the assessment under this objective relates to assessing the needs for increased demand for FP services and commodities and may include:

- Assess the main socio-cultural barriers (beliefs, values and practices) related to FP in Afghanistan
- Assess the availability of relevant advocacy and communication plan, including FP messaging and materials to support FP advocacy work as well as for information and education to create awareness amongst the target population in order to influence their behaviour for use of FP services.
- Assess availability and suitability of the different media of communication for effective social mobilization and communication on FP for the different target groups: young people, rural women, religious structures, etc.
- Assess the extent to which FP has been integrated in school curriculae, especially for secondary and tertiary level of education.
- Assess the level of male involvement in FP programmes

**Objective 4: Assess the needs for conducive policy, financing, political and socio-cultural support for FP programmes.**

This will assess the needs related to creation of an enabling environment for the delivery of FP programmes and services.

- Assess the prevailing legal and regulatory environment and how it relates to FP, including FP commodity registration and customs clearance, tax exemptions, etc.
- Assess the amount of resources allocated and spent from Government budget for FP programmes, including commodities, and whether or not it is adequate to meet the demand for FP.
- Assess the amount of resources allocated and spent by development partners on FP programmes, including commodities, for both on and off budgets; and whether or not it is sustainable.
- Assess the partnership and coordination structure and its functioning for effective FP programme leadership and management. Identify any duplication in funding or programme implementation.

- Assess the level of participation of private sector (private-for-profit and private-not-for profit) in such a coordination mechanism and how such sectors are supported and supervised by the public sector in the delivery of FP programmes/interventions and contraceptive provision.
- Assess the level of political and religious support for FP in Afghanistan and availability of FP champions who are promoting FP.
- Assess the capacity of existing organizations and media networks to advocate for FP programmes in the country.

In addition to the Comprehensive FP Needs Assessment, the consulting firm is also required to:

- Conduct a validation workshop on the draft findings of the assessment, and use the workshop to also brainstorm on draft action plan to address the gaps/needs identified
- Prepare a draft National FP Action Plan in response to the findings in the Comprehensive FP Needs Assessment.

## 5.0 METHODOLOGY

The Comprehensive FP Needs Assessment will use a combination of qualitative and quantitative methods of data collection. The consulting firm will determine the most appropriate methodology and tools for conducting the FP Needs Assessment. Amongst the tools to be considered for use are: Supply Enabled Environment Demand Assessment Guide (SEED) or the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS). They will work with a national institution to train and provide oversight for data collection and analysis.

Methods to consider include:

1. Document reviews – this will include national laws and policies, survey reports, and organizational programmes, plans and reports and budget and expenditure analysis, amongst other documents.

2. Key Informant interviews – This will be undertaken with parliamentarians, policy/decision makers from selected ministries, religious and cultural leaders, development partners and NGOs active in FP programmes, as well as mangers of health facilities.

3. Group interviews – This will be done with health workers in health facilities, community based health workers, staffs of RH directorate and other NGOs working on FP issues. Exit group interviews will also be conducted with clients/patients after they have received services. Major partners will also be called to a validation workshop when draft report is ready.

4. Observations - Field visits to FP clinics run by government, IPPF member associates and other NGOs as well as to the Central Medical Stock, to check on availability of FP and the whole supply chain management and for observation of quality of care in FP services provision.

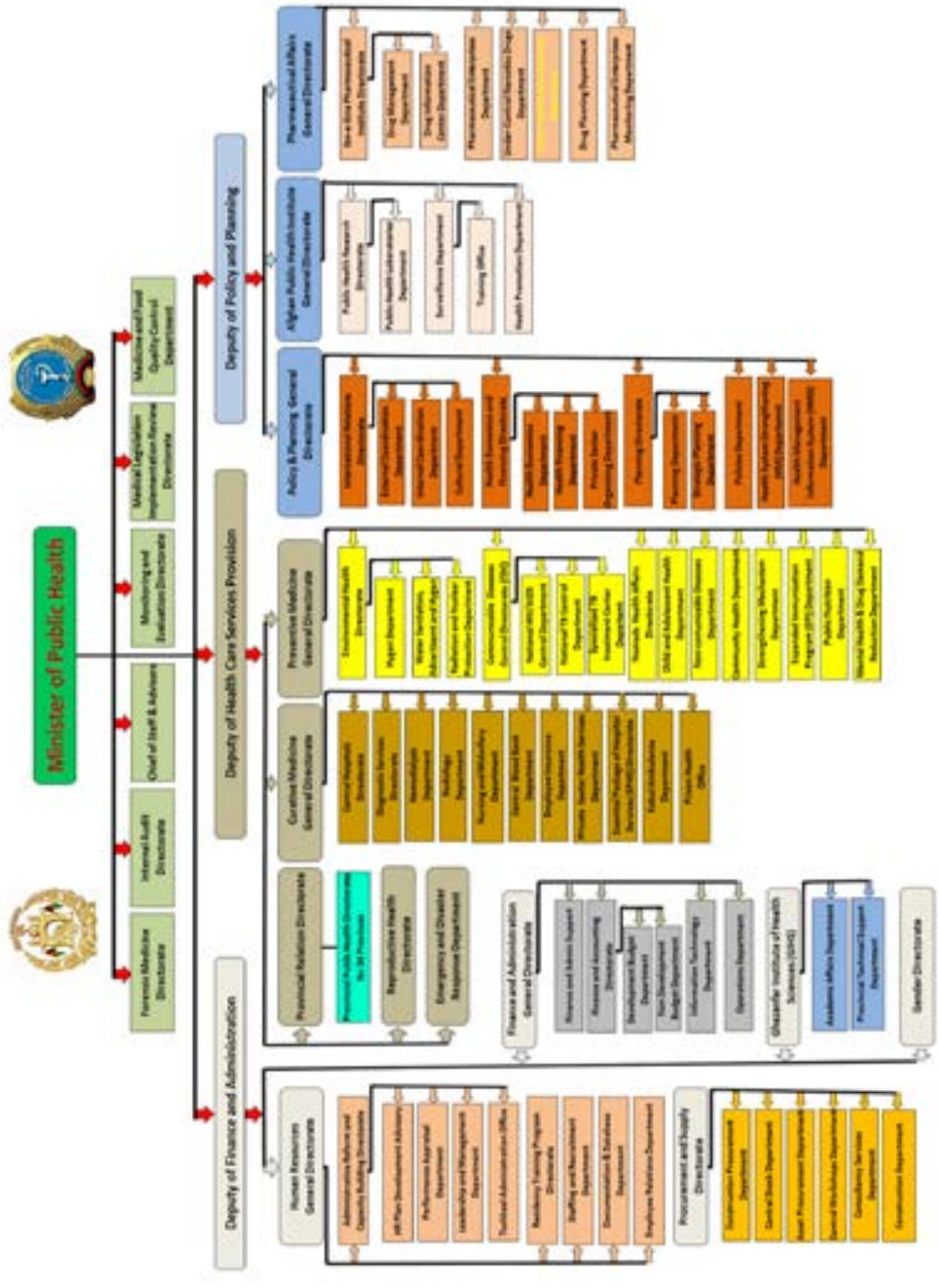
The tools to be used are attached as Annex 1-6. A national institution with significant research capacity will be contracted to also support the data collection and analysis of this survey, with a focus also on capacity building for research in FP. The consulting firm will guide and provide quality assurance in this process.

## 6.0 EXPECTED OUTPUTS

The main expected outputs of the comprehensive FP Needs Assessment are:

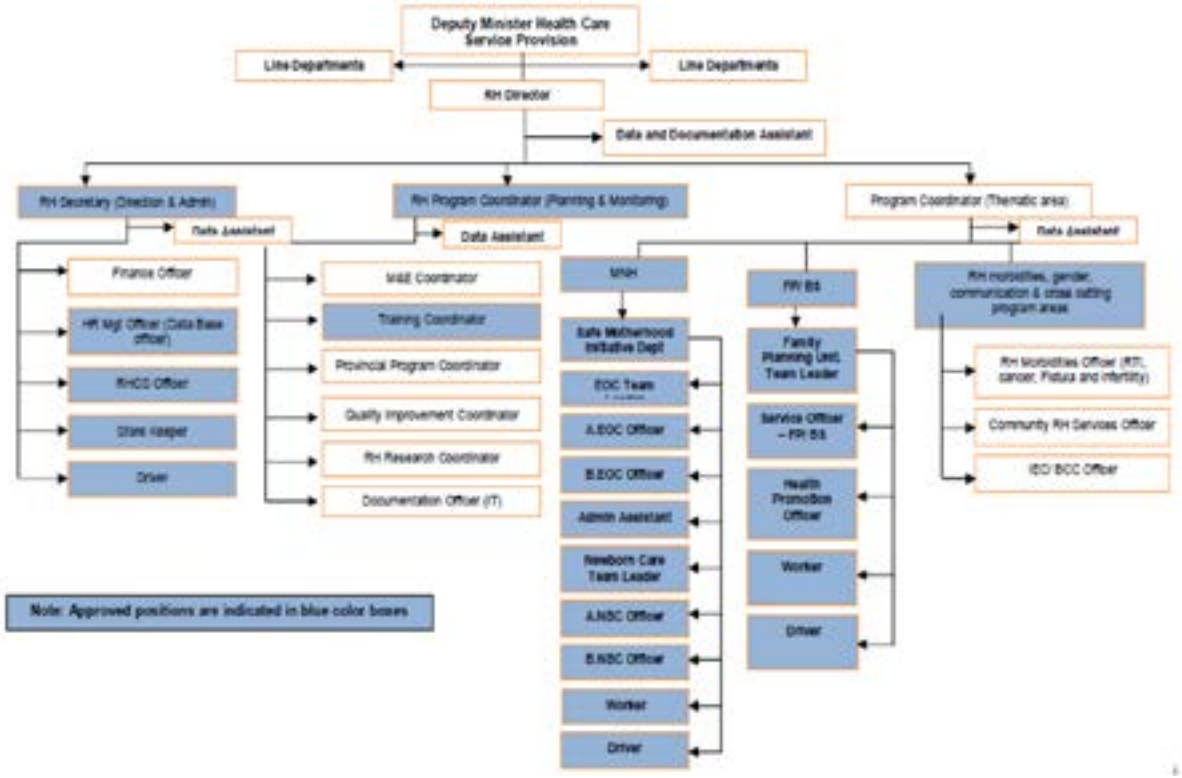
- An inception report, detailing approach, methodology and tools for the Comprehensive FP Needs Assessment Report for Afghanistan
- Consensus built and validated Comprehensive FP Needs Assessment Report for Afghanistan
- A Validation Workshop Report on Comprehensive FP Needs Assessment
- A draft National FP Strategic Action Plan to address the comprehensive FP needs in Afghanistan

# ANNEX 1.2 Ministry of Public Health organizational structure



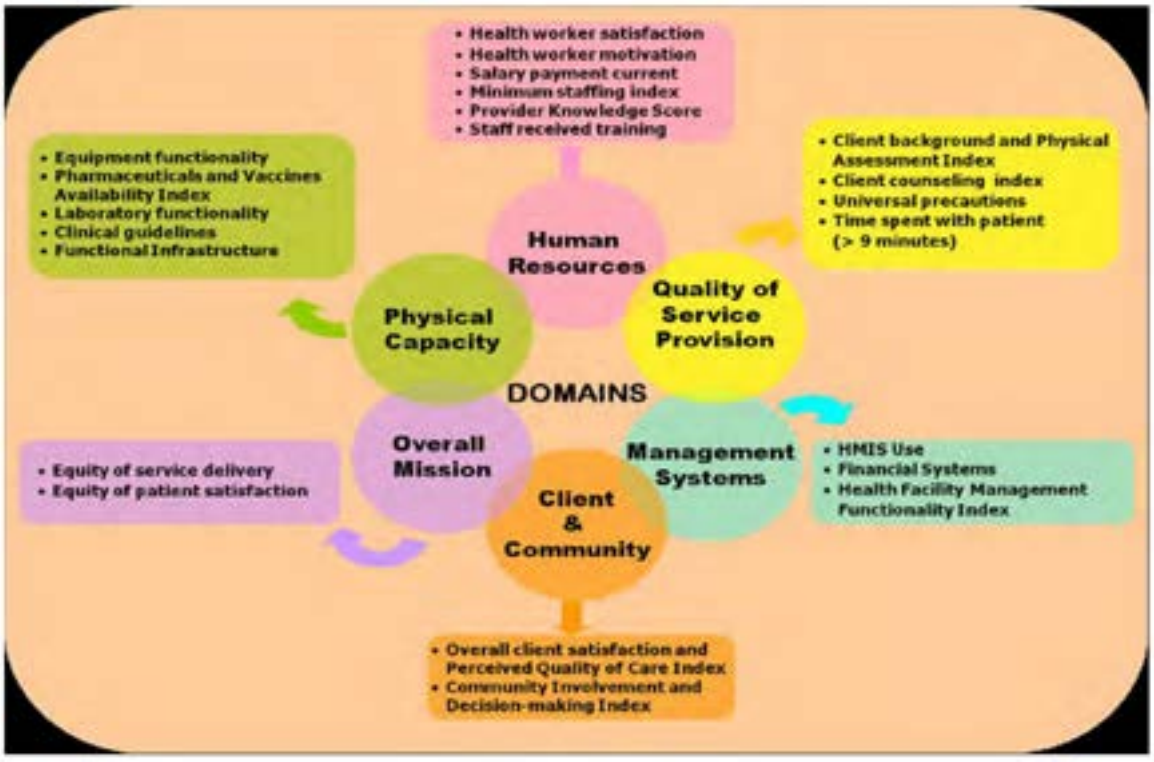

Source: National Strategy on Human Resources for Health Capacity Building with focus on In-service Training, Ministry of Public Health 2014

# ANNEX 1.3 Reproductive Health Directorate organogram




Source: National Reproductive Health Strategy 2012-2016

## ANNEX 1.4 Balanced Score Card: revised domains




Source: Ministry of Public Health, JHBSPH, IIHMR: Basic Package of Health Services Balance Score card. National Report 2012-13.

# ANNEX 1.5 Tables

## Table CO 1: Correct actions for each observed step of counselling by type of health facility – nine provinces, Kabul, private sector (percent)

| | Nine provinces | Kabul | Private facilities |
|---|---|---|---|
| Counselling Observations | | | |
| 1. Greets the client | 94.0 | 70.2 | 91.8 |
| Offers client a seat | 94.0 | 70.2 | 85.6 |
| Listens attentively to client | 92.7 | 87.7 | 97.9 |
| Uses gentle voice and language | 93.9 | 94.7 | 97.9 |
| Assures client about confidentiality | 91.9 | 96.5 | 42.3 |
| | | | |
| 2. Asks about purpose of the visit | | | |
| Start using FP for the first time | 70.5 | 64.9 | 76.3 |
| Resupply/ follow-up | 18.0 | 29.8 | 18.6 |
| Problems | 15.0 | 5.3 | 5.2 |
| | | | |
| 3. History: asks about | | | |
| Age | 82.0 | 70.2 | 50.0 |
| Number of children | 100.0 | | 68.9 |
| Desired number of children | 79.1 | 56.8 | 33.3 |
| Age of last child | 81.5 | 78.4 | 33.8 |
| Breast feeding | 50.3 | 2.7 | 37.8 |
| Menstrual period | 68.3 | 67.6 | 62.2 |
| Any health problems | 67.1 | 59.5 | 44.6 |
| Any reproductive tract infection | 75.8 | 73.0 | 24.3 |
| | | | |
| 4. Tells client about FP methods, including | | | |
| For new clients: | | | |
| Information on methods available | 52.7 | 29.7 | 95.9 |
| Discusses mode of action | 60.8 | 2.7 | 51.4 |
| How to use the method | 95.9 | 73.0 | 82.4 |
| Advantages, effectiveness | 81.5 | 48.6 | 56.8 |
| Disadvantages and | 94.6 | 78.4 | 50.0 |
| Side effects about each method | 81.7 | 48.6 | 63.5 |
| Corrects myths/rumours about methods | 72.3 | 32.4 | 74.3 |
| Informs client about exam/investigations | 68.6 | 45.9 | 21.6 |
| | | | |
| 5. Method of choice | | | |
| Confirms choice and method | 58.7 | 16.2 | 82.4 |
| Client make voluntary/informed choice | 55.8 | 2.7 | 82.4 |
| Obtains informed consent | 86.1 | 75.7 | 85.1 |
| | | | |
| 6. Method-specific counselling | | | |
| Explains to the client about: | | | |
| How to use | 81.1 | 78.4 | 87.8 |
| Side effects and | 83.0 | 83.8 | 75.7 |
| Warning signs of method chosen | 94.4 | 86.5 | 56.8 |
| Makes client repeat information on use | 77.5 | 54.1 | 20.3 |
| If chosen method is pill or injection, instructs: | 76.3 | | |
| On forgotten pill or delayed injection | | 35.1 | 68.6 |
| If chosen method is IUCD, instructs: | | | |
| Checking IUCD is inside after first period | 63.0 | 10.8 | 95.7 |
| If chosen method is vasectomy/ tubal ligation: | | | |
| Instructs on using condoms first three months | 77.9 | 65.5 | . |
| | | | |
| 7. If chosen method is pills: | | | |
| Did the provider ask about: | | | |
| Signs of breast cancer | 89.8 | 80.0 | 33.3 |

| | | | |
|---|---|---|---|
| Any bleeding per vagina | 100.0 | 100.0 | 49.0 |
| History of jaundice | 72.5 | 27.6 | 35.3 |
| Severe headache or blurring vision | 68.6 | 37.9 | 54.9 |
| Severe pain in calves, chest or swollen legs | 69.3 | 37.9 | 47.1 |
| Taking medicines for epilepsy | 72.0 | 44.8 | 31.4 |
| If chosen method is IUCD asked: | | | |
| About vaginal discharge or lower abdominal pain? | 58.8 | 27.6 | 87.0 |
| If chosen method is implant or permanent | | | |
| Did provider refer to an appropriate facility? | 75.8 | 34.5 | . |
| | | | |
| CONTINUING CLIENTS | | | |
| 8. If for resupply/follow up | | | |
| Did the provider asks/give advice on: | | | |
| Which method client is currently using | 98.0 | 88.2 | 94.4 |
| Whether any problems with the method | 53.5 | 47.1 | 38.9 |
| About medical problems/signs of RTI | 53.6 | 35.3 | 22.2 |
| On what to do for the problem | 88.3 | 41.2 | 50.0 |
| If client wants to continue same method | 82.2 | 88.2 | 88.9 |
| Returning for follow up | 85.3 | 70.6 | 94.4 |
| | | | |
| 9. If problems, | | | |
| Did the provider: | | | |
| Find out about problems | 97.0 | 66.7 | 100.0 |
| Provide advice on what to do | 100.0 | 33.3 | 80.0 |
| Do necessary exam as per guidelines | 52.3 | 33.3 | 60.0 |
| Allay fears about the side effects | 83.1 | 33.3 | 40.0 |
| Reconfirms client continues with method | 87.4 | 66.7 | 40.0 |
| Advise method change if problem persists | 71.8 | 66.7 | 40.0 |
| | | | |
| 10. Provides method | | | |
| (1-2 packets of pills) and condoms | 91.7 | 100 | 80.0 |
| Refers with complete information | 55.6 | 0 | 60.0 |
| Provides a referral slip | 74.1 | 0 | 60.0 |
| | | | |
| 11. Follow-up instruction | | | |
| Provides verbal follow-up instructions | 94.7 | 47.4 | 64.9 |
| STI and action if client/partner develops signs | 80.0 | 5.3 | 43.3 |
| When and where to visit for follow-up | 92.8 | 84.2 | 85.6 |
| Provides packet of condoms as back up | 63.7 | 21.1 | 22.7 |
| | | | |
| 12. Records information | | | |
| About method provided as well as referrals | 92.3 | 98.2 | 34.0 |

## Table FA 1: Facilities with the most recent copy of national FP standards – nine provinces, Kabul and private sector (percent)

| Province | District Health Facility | Comprehensive Health Centre | Basic Health Centre | Sub-Health Centre | Total |
|---|---|---|---|---|---|
| Farah | 0 | 66.7 | 0 | 66.7 | 54.5 |
| Nangarhar | 100 | 83.3 | 84.2 | 66.7 | 82.8 |
| Jawzjan | 100 | 0 | 100 | 0 | 90 |
| Paktia | 100 | 66.7 | 60 | 16.7 | 46.7 |
| Kandahar | 0 | 10 | 0 | 0 | 6.3 |
| Bamyan | 100 | 100 | 84.6 | 88.9 | 90.3 |
| Takhar | 100 | 80 | 62.5 | 100 | 75 |
| Parwan | | 50 | 41.7 | 50 | 46.4 |
| Herat | 0 | 81.8 | 54.5 | 0 | 62.5 |
| Total – nine provinces | 72.1 | 63.5 | 65.1 | 58 | 63 |
| Kabul | 12.5 | 17.1 | 23.3 | 50 | 20.2 |
| Private | | | | | 4.1 |

## Table FA 2: Health facilities with buffer stock available and the condition of selected contraceptives – nine provinces, Kabul and private sector (percent)

| Buffer stock and its condition | District Hospital | Comprehensive Health Centre | Basic Health Centre | Sub Health Centre | Total |
|---|---|---|---|---|---|
| Farah | | | | | |
| 15a. Is one month buffer stock available for oral pills | | 100 | 100 | 100 | 100 |
| 15b. Are Pill packets discoloured and appear wet | | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | | 100 | 100 | 100 | 100 |
| 16b. Is the fluid vials crystalized or frozen | | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | | 100 | 100 | 100 | 100 |
| 17b. are packets discoloured, broken / appear sticky | | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | | 100 | 100 | 100 | 100 |
| 18b. Is there any discoloration inside the packets | | 0 | 0 | 0 | 0 |
| | | | | | |
| Nangarhar | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 33.3 | 78.9 | 33.3 | 65.5 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 50 | 68.4 | 33.3 | 62.1 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 50 | 63.2 | 33.3 | 58.6 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 5.3 | 0 | 3.4 |
| 18a. Are there enough IUCDs available | 100 | 83.3 | 73.7 | 66.7 | 75.9 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Jawzjan | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 100 | 87.5 | | 90 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 100 | 87.5 | | 90 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 100 | 87.5 | | 90 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 75 | | 80 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | | 0 |
| | | | | | |
| Paktia | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 100 | 80 | 100 | 93.3 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 66.7 | 80 | 100 | 86.7 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 100 | 80 | 100 | 93.3 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 80 | 100 | 93.3 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Kandahar | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 100 | 100 | 100 | 100 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 100 | 100 | 100 | 100 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 100 | 100 | 100 | 100 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 100 | 100 | 100 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Bamyan | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 100 | 100 | 100 | 100 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 100 | 92.3 | 100 | 96.8 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| 17a. Is one month buffer stock of condoms available | 100 | 100 | 100 | 100 | 100 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 92.3 | 100 | 96.8 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Takhar | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 100 | 100 | 100 | 100 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 100 | 100 | 100 | 100 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 100 | 100 | 100 | 100 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 100 | 100 | 100 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Parwan | | | | | |
| 15a. Is one month buffer stock available for oral pills | | 87.5 | 100 | 75 | 89.3 |
| 15b. Are Pill packets discoloured and appear wet | | 25 | 8.3 | 0 | 10.7 |
| 16a. Is one month buffer stock of injectables available | | 87.5 | 91.7 | 87.5 | 89.3 |
| 16b. Is the fluid vials crystalized or frozen | | 12.5 | 0 | 12.5 | 7.1 |
| 17a. Is one month buffer stock of condoms available | | 87.5 | 83.3 | 62.5 | 78.6 |
| 17b. are packets discoloured, broken / appear sticky | | 25 | 8.3 | 0 | 10.7 |
| 18a. Are there enough IUCDs available | | 87.5 | 91.7 | 75 | 85.7 |
| 18b. Is there any discoloration inside the packets | | 12.5 | 0 | 0 | 3.6 |
| | | | | | |
| Herat | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 90.9 | 81.8 | 100 | 87.5 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 0 | 0 | 0 | 0 |
| 16a. Is one month buffer stock of injectables available | 100 | 90.9 | 81.8 | 100 | 87.5 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 0 | 0 | 0 | 0 |
| 17a. Is one month buffer stock of condoms available | 100 | 90.9 | 81.8 | 100 | 87.5 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 0 | 0 | 0 |
| 18a. Are there enough IUCDs available | 100 | 100 | 81.8 | 100 | 91.7 |
| 18b. Is there any discoloration inside the packets | 0 | 0 | 0 | 0 | 0 |
| | | | | | |
| Total – Nine provinces | | | | | |
| 15a. Is one month buffer stock available for oral pills | 100 | 86.7 | 88.9 | 87.7 | 88.5 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 3 | 1 | 0 | 1.4 |
| 16a. Is one month buffer stock of injectables available | 100 | 87.2 | 84.1 | 90.1 | 86.9 |
| 16b. Is the fluid vials crystalized or frozen | 0 | 1.5 | 0 | 2.4 | 0.9 |
| 17a. Is one month buffer stock of condoms available | 100 | 89 | 82.5 | 85.2 | 85.8 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 3 | 2.5 | 0 | 2.1 |
| 18a. Are there enough IUCDs available | 100 | 96.1 | 84.9 | 91.4 | 90.2 |
| 18b. Is there any discoloration inside the packets | 0 | 1.5 | 0 | 0 | 0.5 |
| | | | | | |
| Kabul | | | | | |
| 15a. Is one month buffer stock available for oral pills | 87.5 | 87.5 | 79.5 | 100 | 84.3 |
| 15b. Are Pill packets discoloured and appear wet | 0 | 27.5 | 5.1 | 50 | 15.7 |
| 16a. Is one month buffer stock of injectables available | 87.5 | 85 | 79.5 | 100 | 83.1 |
| 16b. Is the fluid vials crystalized or frozen | 12.5 | 22.5 | 2.6 | 50 | 13.5 |
| 17a. Is one month buffer stock of condoms available | 75 | 75 | 74.4 | 50 | 74.2 |
| 17b. are packets discoloured, broken / appear sticky | 0 | 0 | 2.6 | 0 | 1.1 |
| 18a. Are there enough IUCDs available | 87.5 | 77.5 | 59 | 100 | 70.8 |
| 18b. Is there any discoloration inside the packets | 0 | 2.5 | 0 | 0 | 1.1 |
| | | | | | |
| Private | | | | | |
| 15a. Is one month buffer stock available for oral pills | | | | | 5.2 |
| 15b. Are Pill packets discoloured and appear wet | | | | | 2.1 |
| 16a. Is one month buffer stock of injectables available | | | | | 52.1 |
| 16b. Is the fluid vials crystalized or frozen | | | | | |
| 17a. Is one month buffer stock of condoms available | | | | | 53.1 |
| 17b. are packets discoloured, broken / appear sticky | | | | | |
| 18a. Are there enough IUCDs available | | | | | 52.1 |
| 18b. Is there any discoloration inside the packets | | | | | |

## Table INJ 1: Observation of infection administration skill by CHWs attached to BPHS facilities – nine provinces and Kabul (number + percent)

| Buffer stock and its condition | Provinces | | Kabul | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| 1. Greets the client | 44 | 70.1 | 21 | 61.9 | 65 | 69.6 |
| Did the provider ask: | | | | | | |
| When was the last injection | 43 | 71.4 | 21 | 57.1 | 64 | 70.5 |
| Whether any problems with the method | 44 | 41.7 | 21 | 19 | 65 | 40.3 |
| About medical problems/signs of RTIs | 44 | 33.2 | 21 | 14.3 | 65 | 32.1 |
| Advise on what to do for the problem | 44 | 61 | 21 | 0 | 65 | 57.3 |
| | | | | | | |
| 2. Injection technique | | | | | | |
| New needle and syringe for each client? | 44 | 87.4 | 21 | 95.2 | 65 | 87.9 |
| Bottle within the expiry date | 44 | 58.1 | 21 | 23.8 | 65 | 56 |
| Bottle shaken before injectable drawn up | 43 | 94.4 | 21 | 47.6 | 64 | 91.5 |
| Injectable contraceptive drawn up correctly | 44 | 88.9 | 21 | 28.6 | 65 | 85.3 |
| Injection site cleaned and air dried | 44 | 77.2 | 21 | 66.7 | 65 | 76.5 |
| Injection given in the correct place | 44 | 86.6 | 21 | 95.2 | 65 | 87.1 |
| Draws plunger back prior to injecting | 44 | 77.2 | 21 | 42.9 | 65 | 75.1 |
| Allow the dose to self-disperse | 44 | 65.3 | 21 | 47.6 | 65 | 64.3 |
| | | | | | | |
| 3. Disposal of waste | | | | | | |
| Needles and syringes disposed of appropriately | 44 | 59.6 | 21 | 81 | 65 | 60.9 |
| Reusable needle/syringe put in container with 5% chlorine solution | 44 | 25.4 | 21 | 4.8 | 65 | 24.1 |
| | | | | | | |
| 4. Follow up instructions | | | | | | |
| Clients given at least: | | | | | | |
| When and where to return for next dose | 44 | 71.3 | 21 | 85.7 | 65 | 72.2 |
| What to do for minor side effects | 44 | 57.3 | 21 | 42.9 | 65 | 56.4 |
| Complications requiring medical attention | 44 | 63 | 21 | 19 | 65 | 60.3 |
| Where to seek help for complications | 43 | 74.9 | 21 | 28.6 | 64 | 72 |
| | | | | | | |
| 5. Post insertion counselling | | | | | | |
| Provides a packet of condoms | 44 | 26.1 | 21 | 9.5 | 65 | 25.1 |
| | | | | | | |
| 6. Records information | | | | | | |
| About method provided as well as referrals | 44 | 74.4 | 21 | 66.7 | 65 | 73.9 |

## Table INJ 2: Providers with access to national FP guidelines and injectable supply – nine provinces and Kabul (percent)

| | District Health Facility | Comprehensive Health Centre | Basic Health Centre | Sub Health Centre | Total |
|---|---|---|---|---|---|
| Farah | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 100 | | 100 |
| 2a. If she has supplies of injectables | | | 100 | | 100 |
| 2b. Has supplies of antiseptic | | | 100 | | 100 |
| 2c. Has supplies of cotton swabs | | | 100 | | 100 |
| 2d. Has supplies of disposable needles and syringes | | | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | | 100 | | 100 |
| 3a. If supplies are adequate | | | 100 | | 100 |
| 3b. Monthly request for supply | | | 0 | | 0 |
| 3b. Quarterly request for supply | | | 100 | | 100 |
| 3c. Are injections stored adequately | | | 100 | | 100 |
| | | | | | |
| Nangarhar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 66.7 | | 66.7 |
| 2a. If she has supplies of injectables | | | 83.3 | | 83.3 |

| | | | | | |
|---|---|---|---|---|---|
| 2b. Has supplies of antiseptic | | | 83.3 | | 83.3 |
| 2c. Has supplies of cotton swabs | | | 83.3 | | 83.3 |
| 2d. Has supplies of disposable needles and syringes | | | 83.3 | | 83.3 |
| 2e. Has sterilized reusable needles and syringes | | | 66.7 | | 66.7 |
| 3a. If supplies are adequate | | | 50 | | 50 |
| 3b. Monthly request for supply | | | 50 | | 50 |
| 3b. Quarterly request for supply | | | 16.7 | | 16.7 |
| 3c. Are injections stored adequately | | | 66.7 | | 66.7 |
| | | | | | |
| Jawzjan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 100 | 100 | | 100 |
| 2a. If she has supplies of injectables | | 100 | 100 | | 100 |
| 2b. Has supplies of antiseptic | | 100 | 100 | | 100 |
| 2c. Has supplies of cotton swabs | | 100 | 100 | | 100 |
| 2d. Has supplies of disposable needles and syringes | | 100 | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | 100 | 75 | | 80 |
| 3a. If supplies are adequate | | 100 | 100 | | 100 |
| 3b. Monthly request for supply | | 0 | 25 | | 20 |
| 3b. Quarterly request for supply | | 100 | 50 | | 60 |
| 3c. Are injections stored adequately | | 100 | 75 | | 80 |
| | | | | | |
| Paktia | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 66.7 | | 66.7 |
| 2a. If she has supplies of injectables | | | 100 | | 100 |
| 2b. Has supplies of antiseptic | | | 100 | | 100 |
| 2c. Has supplies of cotton swabs | | | 100 | | 100 |
| 2d. Has supplies of disposable needles and syringes | | | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | | 100 | | 100 |
| 3a. If supplies are adequate | | | 100 | | 100 |
| 3b. Monthly request for supply | | | 66.7 | | 66.7 |
| 3b. Quarterly request for supply | | | 0 | | 0 |
| 3c. Are injections stored adequately | | | 100 | | 100 |
| | | | | | |
| Kandahar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 100 | 50 | | 66.7 |
| 2a. If she has supplies of injectables | | 100 | 100 | | 100 |
| 2b. Has supplies of antiseptic | | 100 | 100 | | 100 |
| 2c. Has supplies of cotton swabs | | 100 | 100 | | 100 |
| 2d. Has supplies of disposable needles and syringes | | 100 | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | 0 | 50 | | 33.3 |
| 3a. If supplies are adequate | | 100 | 50 | | 66.7 |
| 3b. Monthly request for supply | | 100 | 50 | | 66.7 |
| 3b. Quarterly request for supply | | 0 | 0 | | 0 |
| 3c. Are injections stored adequately | | 100 | 0 | | 33.3 |
| | | | | | |
| Bamyan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 100 | | 100 |
| 2a. If she has supplies of injectables | | | 100 | | 100 |
| 2b. Has supplies of antiseptic | | | 100 | | 100 |
| 2c. Has supplies of cotton swabs | | | 100 | | 100 |
| 2d. Has supplies of disposable needles and syringes | | | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | | 20 | | 20 |
| 3a. If supplies are adequate | | | 60 | | 60 |
| 3b. Monthly request for supply | | | 60 | | 60 |
| 3b. Quarterly request for supply | | | 20 | | 20 |
| 3c. Are injections stored adequately | | | 80 | | 80 |
| | | | | | |
| Takhar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 20 | | 20 |
| 2a. If she has supplies of injectables | | | 100 | | 100 |
| 2b. Has supplies of antiseptic | | | 70 | | 70 |
| 2c. Has supplies of cotton swabs | | | 90 | | 90 |
| 2d. Has supplies of disposable needles and syringes | | | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | | 40 | | 40 |
| 3a. If supplies are adequate | | | 100 | | 100 |

| | | | | | |
|---|---|---|---|---|---|
| 3b. Monthly request for supply | | | 90 | | 90 |
| 3b. Quarterly request for supply | | | 0 | | 0 |
| 3c. Are injections stored adequately | | | 80 | | 80 |
| | | | | | |
| Parwan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 100 | | 100 |
| 2a. If she has supplies of injectables | | | 100 | | 100 |
| 2b. Has supplies of antiseptic | | | 66.7 | | 66.7 |
| 2c. Has supplies of cotton swabs | | | 83.3 | | 83.3 |
| 2d. Has supplies of disposable needles and syringes | | | 100 | | 100 |
| 2e. Has sterilized reusable needles and syringes | | | 0 | | 0 |
| 3a. If supplies are adequate | | | 33.3 | | 33.3 |
| 3b. Monthly request for supply | | | 66.7 | | 66.7 |
| 3b. Quarterly request for supply | | | 33.3 | | 33.3 |
| 3c. Are injections stored adequately | | | 100 | | 100 |
| | | | | | |
| Herat | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 0 | 0 | 0 | 0 |
| 2a. If she has supplies of injectables | | 100 | 100 | 100 | 100 |
| 2b. Has supplies of antiseptic | | 100 | 0 | 100 | 80 |
| 2c. Has supplies of cotton swabs | | 100 | 100 | 100 | 100 |
| 2d. Has supplies of disposable needles and syringes | | 100 | 100 | 100 | 100 |
| 2e. Has sterilized reusable needles and syringes | | 0 | 0 | 0 | 0 |
| 3a. If supplies are adequate | | 33.3 | 100 | 100 | 60 |
| 3b. Monthly request for supply | | 0 | 0 | 0 | 0 |
| 3b. Quarterly request for supply | | 100 | 100 | 100 | 100 |
| 3c. Are injections stored adequately | | 100 | 100 | 100 | 100 |
| | | | | | |
| Total – nine provinces | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 29.1 | 67.9 | 0 | 59.8 |
| 2a. If she has supplies of injectables | | 100 | 95.9 | 100 | 96.6 |
| 2b. Has supplies of antiseptic | | 100 | 81.4 | 100 | 84.8 |
| 2c. Has supplies of cotton swabs | | 100 | 91.6 | 100 | 93.1 |
| 2d. Has supplies of disposable needles and syringes | | 100 | 95.9 | 100 | 96.6 |
| 2e. Has sterilized reusable needles and syringes | | 11 | 47 | 0 | 40 |
| 3a. If supplies are adequate | | 52.7 | 68.9 | 100 | 67.6 |
| 3b. Monthly request for supply | | 18.1 | 56.5 | 0 | 48.8 |
| 3b. Quarterly request for supply | | 81.9 | 22.7 | 100 | 34.2 |
| 3c. Are injections stored adequately | | 100 | 77.6 | 100 | 81.7 |
| | | | | | |
| Kabul | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 0 | 0 | 53.3 | | 38.1 |
| 2a. If she has supplies of injectables | 100 | 100 | 86.7 | | 90.5 |
| 2b. Has supplies of antiseptic | 100 | 60 | 73.3 | | 71.4 |
| 2c. Has supplies of cotton swabs | 100 | 100 | 86.7 | | 90.5 |
| 2d. Has supplies of disposable needles and syringes | 100 | 100 | 80 | | 85.7 |
| 2e. Has sterilized reusable needles and syringes | 0 | 40 | 0 | | 9.5 |
| 3a. If supplies are adequate | 0 | 40 | 40 | | 38.1 |
| 3b. Monthly request for supply | 100 | 20 | 6.7 | | 14.3 |
| 3b. Quarterly request for supply | 0 | 80 | 86.7 | | 81 |
| 3c. Are injections stored adequately | 100 | 80 | 86.7 | | 85.7 |

## Table IUCD 1: Correct actions for each observed step of IUCD insertion – nine provinces, Kabul and private sector (number + percent)

| | Provinces | | Kabul | | Private | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| 1. Pre-insertion counselling | | | | | | | | |
| Greets the client | 151 | 92.4 | 55 | 78.2 | 94 | 91.5 | 300 | 91.7 |
| Treats client with respect and kindness | 151 | 95.2 | 55 | 100 | 94 | 95.7 | 300 | 95.5 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Finds out if she has been counselled | 151 | 85.3 | 55 | 32.7 | 94 | 47.9 | 300 | 80.3 |
| If yes, reviews the notes | 151 | 80.4 | 55 | 20 | 94 | 35.1 | 300 | 74.4 |
| Knowledge of IUCD's/side effects assessed | 151 | 69.5 | 55 | 50.9 | 94 | 47.9 | 300 | 67.1 |
| Makes sure that the client wants an IUCD | 151 | 90.4 | 55 | 65.5 | 94 | 75.5 | 300 | 88.2 |
| Asks re vaginal discharge/lower abdominal pain | 151 | 59.2 | 55 | 43.6 | 94 | 57.4 | 300 | 58.4 |
| Explains procedure/encourages questions | 151 | 73.2 | 55 | 16.4 | 94 | 57.4 | 300 | 69.6 |
| | | | | | | | | |
| 2. Pre-insertion tasks | | | | | | | | |
| Asks client if empty bladder | 151 | 66.7 | 55 | 29.1 | 94 | 28.7 | 300 | 62.2 |
| Ensures everything ready to receive patient | 151 | 71 | 55 | 50.9 | 94 | 56.4 | 300 | 69 |
| Washes hands | 151 | 85.3 | 55 | 56.4 | 94 | 71.3 | 300 | 83 |
| Palpates abdomen - checks if supra pubic tender | 151 | 63.8 | 55 | 76.4 | 94 | 45.7 | 300 | 63 |
| Washes hands thoroughly | 151 | 0.6 | 55 | 0.6 | 94 | 0.4 | 300 | 0.6 |
| Puts on sterile gloves | 151 | 86.5 | 55 | 32.7 | 94 | 61.7 | 300 | 82.3 |
| Arranges instruments and supplies | 151 | 0.9 | 55 | 0.4 | 94 | 0.9 | 300 | 0.9 |
| Speculum exam and checks cervix/vagina | 151 | 85.3 | 55 | 67.3 | 94 | 79.8 | 300 | 84.1 |
| Removes speculum - puts in sterile dish | 151 | 0.7 | 55 | 0.4 | 94 | 0.5 | 300 | 0.6 |
| Performs bimanual examination | 151 | 60.7 | 55 | 52.7 | 94 | 33 | 300 | 58.3 |
| | | | | | | | | |
| 3. Insertion of IUD | | | | | | | | |
| Inserts speculum-applies antiseptic correctly | 151 | 72.6 | 55 | 87.3 | 94 | 84 | 300 | 74.1 |
| Applies antiseptic to cervix and vagina twice | 151 | 90 | 55 | 74.5 | 94 | . | 198 | 89.2 |
| Grasps cervix with vulsellum/ tenaculum | 151 | 82.6 | 55 | 81.8 | 94 | 83 | 300 | 82.6 |
| Sounds uterus using no-touch technique | 151 | 86 | 55 | 78.2 | 94 | 91.5 | 300 | 86.1 |
| Loads Copper T 380 A correctly | 151 | 85.3 | 55 | 74.5 | 94 | 77.7 | 300 | 84.3 |
| Inserts Copper T; uses withdrawal technique | 151 | 80.4 | 55 | 83.6 | 94 | 72.3 | 300 | 80 |
| Plunger removed-ensues high fundal placement | 151 | 85.2 | 55 | 85.5 | 94 | 74.5 | 300 | 84.5 |
| Cuts strings removes forceps and speculum | 151 | 91.7 | 55 | 96.4 | 94 | 80.9 | 300 | 91.1 |
| | | | | | | | | |
| 4. Post insertion tasks | | | | | | | | |
| Decontaminates instruments correctly | 151 | 88.7 | 55 | 90.9 | 94 | 89.4 | 300 | 88.8 |
| Disposes of waste materials correctly | 151 | 83.1 | 55 | 89.1 | 94 | 72.3 | 300 | 82.5 |
| Cleans and removes gloved hands correctly | 151 | 82.1 | 55 | 65.5 | 94 | 58.5 | 300 | 79.6 |
| If re-using gloves, decontaminates correctly | 151 | 78.9 | 55 | 87.3 | 94 | 78.7 | 300 | 79.2 |
| Washes and dries hands correctly | 151 | 90 | 55 | 63.6 | 94 | 47.9 | 300 | 85.7 |
| | | | | | | | | |
| 5. Post insertion counselling | | | | | | | | |
| Discusses side effects or problems | 151 | 82.5 | 55 | 83.6 | 94 | 60.6 | 300 | 80.9 |
| Client assured IUCD can be removed any time | 151 | 76.6 | 55 | 52.7 | 94 | 63.8 | 300 | 74.6 |
| Client observed for 15 minutes | 151 | 79.7 | 55 | 60 | 94 | 44.7 | 300 | 76.2 |
| Explains how to check IUCD after menstruation | 151 | 82.6 | 55 | 65.5 | 94 | 66 | 300 | 80.6 |
| | | | | | | | | |
| 6. Records information | | | | | | | | |
| About method provided as well as referrals | 151 | 87.2 | 55 | 89.1 | 94 | 31.9 | 300 | 83.2 |

## Table IUCD 2: Providers with access to National FP guidelines and IUCD supplies – nine provinces, Kabul and private sector (percent)

| | District Health Facility | Comprehensive Health Centre | Basic Health Centre | Sub Health Centre | Total |
|---|---|---|---|---|---|
| Farah | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | 100 | | 100 |
| 2a. If she has supplies of IUCD | | | 100 | | 100 |
| 2b. If she has supplies of antiseptics | | | 100 | | 100 |
| 2c. If she has table for IUCD insertion | | | 100 | | 100 |
| 2d. if she has supplies of HLD gloves | | | 100 | | 100 |
| 2e. If she has kit with all relevant instruments | | | 100 | | 100 |
| 3a. Supply every three months? | | | 100 | | 100 |
| 3b. Are IUCDs stored satisfactorily? | | | 100 | | 100 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | | 100 | | 100 |

| | | | | | |
|---|---|---|---|---|---|
| Nangarhar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 0 | 80 | 46.7 | 50 | 52.2 |
| 2a. If she has supplies of IUCD | 100 | 100 | 100 | 100 | 100 |
| 2b. If she has supplies of antiseptics | 100 | 100 | 100 | 100 | 100 |
| 2c. If she has table for IUCD insertion | 100 | 100 | 100 | 100 | 100 |
| 2d. if she has supplies of HLD gloves | 100 | 100 | 100 | 100 | 100 |
| 2e. If she has kit with all relevant instruments | 100 | 100 | 93.3 | 100 | 95.7 |
| 3a. Supply every three months? | | 100 | 100 | | 100 |
| 3b. Are IUCDs stored satisfactorily? | | 100 | 92.3 | | 93.8 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 100 | 100 | | 100 |
| | | | | | |
| Jawzjan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 100 | 66.7 | | 75 |
| 2a. If she has supplies of IUCD | | 100 | 100 | | 100 |
| 2b. If she has supplies of antiseptics | | 100 | 100 | | 100 |
| 2c. If she has table for IUCD insertion | | 100 | 100 | | 100 |
| 2d. if she has supplies of HLD gloves | | 100 | 100 | | 100 |
| 2e. If she has kit with all relevant instruments | | 100 | 100 | | 100 |
| 3a. Supply every three months? | | 100 | 100 | | 100 |
| 3b. Are IUCDs stored satisfactorily? | | 100 | 100 | | 100 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 100 | 100 | | 100 |
| | | | | | |
| Paktia | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 100 | 33.3 | 0 | 0 | 16.7 |
| 2a. If she has supplies of IUCD | 0 | 100 | 75 | 75 | 75 |
| 2b. If she has supplies of antiseptics | 100 | 100 | 75 | 75 | 83.3 |
| 2c. If she has table for IUCD insertion | 100 | 100 | 100 | 75 | 91.7 |
| 2d. if she has supplies of HLD gloves | 100 | 100 | 100 | 75 | 91.7 |
| 2e. If she has kit with all relevant instruments | 100 | 100 | 75 | 75 | 83.3 |
| 3a. Supply every three months? | 100 | 100 | 100 | 100 | 100 |
| 3b. Are IUCDs stored satisfactorily? | 100 | 100 | 100 | 100 | 100 |
| 3c. Are IUCD kits packed and stored satisfactorily? | 100 | 100 | 100 | 100 | 100 |
| | | | | | |
| Kandahar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 0 | 40 | 100 | 42.9 |
| 2a. If she has supplies of IUCD | | 100 | 100 | 0 | 85.7 |
| 2b. If she has supplies of antiseptics | | 100 | 80 | 100 | 85.7 |
| 2c. If she has table for IUCD insertion | | 100 | 80 | 100 | 85.7 |
| 2d. if she has supplies of HLD gloves | | 100 | 100 | 100 | 100 |
| 2e. If she has kit with all relevant instruments | | 100 | 80 | 100 | 85.7 |
| 3a. Supply every three months? | | 100 | 60 | 100 | 71.4 |
| 3b. Are IUCDs stored satisfactorily? | | 100 | 80 | 0 | 71.4 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 100 | 80 | 0 | 71.4 |
| | | | | | |
| Bamyan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 100 | 81.8 | 50 | 72 |
| 2a. If she has supplies of IUCD | | 100 | 90.9 | 100 | 96 |
| 2b. If she has supplies of antiseptics | | 100 | 100 | 100 | 100 |
| 2c. If she has table for IUCD insertion | | 100 | 100 | 100 | 100 |
| 2d. if she has supplies of HLD gloves | | 100 | 100 | 100 | 100 |
| 2e. If she has kit with all relevant instruments | | 100 | 90.9 | 100 | 96 |
| 3a. Supply every three months? | | 100 | 81.8 | 100 | 92 |
| 3b. Are IUCDs stored satisfactorily? | | 100 | 100 | 80 | 92 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 75 | 81.8 | 60 | 72 |
| | | | | | |
| Takhar | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 100 | 100 | 90.5 | 57.1 | 85.7 |
| 2a. If she has supplies of IUCD | 100 | 100 | 100 | 100 | 100 |
| 2b. If she has supplies of antiseptics | 100 | 100 | 100 | 100 | 100 |
| 2c. If she has table for IUCD insertion | 0 | 83.3 | 52.4 | 57.1 | 57.1 |
| 2d. if she has supplies of HLD gloves | 100 | 100 | 95.2 | 100 | 97.1 |
| 2e. If she has kit with all relevant instruments | 100 | 100 | 100 | 100 | 100 |
| 3a. Supply every three months? | 100 | 100 | 76.2 | 100 | 85.7 |
| 3b. Are IUCDs stored satisfactorily? | 100 | 100 | 95.2 | 100 | 97.1 |
| 3c. Are IUCD kits packed and stored satisfactorily? | 100 | 100 | 85.7 | 100 | 91.4 |

| | | | | | |
|---|---|---|---|---|---|
| Parwan | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 33.3 | 36.4 | 66.7 | 41.2 |
| 2a. If she has supplies of IUCD | | 100 | 100 | 100 | 100 |
| 2b. If she has supplies of antiseptics | | 100 | 100 | 100 | 100 |
| 2c. If she has table for IUCD insertion | | 100 | 100 | 100 | 100 |
| 2d. if she has supplies of HLD gloves | | 100 | 100 | 100 | 100 |
| 2e. If she has kit with all relevant instruments | | 66.7 | 90.9 | 66.7 | 82.4 |
| 3a. Supply every three months? | | 66.7 | 54.5 | 0 | 47.1 |
| 3b. Are IUCDs stored satisfactorily? | | 66.7 | 45.5 | 66.7 | 52.9 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 66.7 | 45.5 | 66.7 | 52.9 |
| | | | | | |
| Herat | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | 90.9 | 100 | | 93.8 |
| 2a. If she has supplies of IUCD | | 100 | 100 | | 100 |
| 2b. If she has supplies of antiseptics | | 90.9 | 80 | | 87.5 |
| 2c. If she has table for IUCD insertion | | 90.9 | 80 | | 87.5 |
| 2d. if she has supplies of HLD gloves | | 100 | 80 | | 93.8 |
| 2e. If she has kit with all relevant instruments | | 100 | 100 | | 100 |
| 3a. Supply every three months? | | 100 | | | 100 |
| 3b. Are IUCDs stored satisfactorily? | | 100 | | | 100 |
| 3c. Are IUCD kits packed and stored satisfactorily? | | 100 | | | 100 |
| | | | | | |
| Total – nine provinces | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 54.4 | 79.3 | 60.1 | 45.9 | 63 |
| 2a. If she has supplies of IUCD | 63.5 | 100 | 97.5 | 90.2 | 96.2 |
| 2b. If she has supplies of antiseptics | 100 | 96.2 | 95.1 | 95.1 | 95.5 |
| 2c. If she has table for IUCD insertion | 82.1 | 94.8 | 89.3 | 87.9 | 90.5 |
| 2d. if she has supplies of HLD gloves | 100 | 100 | 97.3 | 95.1 | 97.8 |
| 2e. If she has kit with all relevant instruments | 100 | 97.6 | 92.9 | 91.1 | 94.1 |
| 3a. Supply every three months? | 100 | 95.7 | 83 | 86.4 | 86.4 |
| 3b. Are IUCDs stored satisfactorily? | 100 | 95.7 | 87 | 82 | 88 |
| 3c. Are IUCD kits packed and stored satisfactorily? | 100 | 92 | 85 | 74.1 | 84.6 |
| | | | | | |
| Kabul | | | | | |
| 1. If provider has a copy of National Standard Guidelines | 60 | 37.5 | 37.8 | 0 | 39.2 |
| 2a. If she has supplies of IUCD | 80 | 87.5 | 86.5 | 100 | 86.3 |
| 2b. If she has supplies of antiseptics | 80 | 87.5 | 89.2 | 100 | 88.2 |
| 2c. If she has table for IUCD insertion | 100 | 87.5 | 35.1 | 100 | 51 |
| 2d. if she has supplies of HLD gloves | 80 | 100 | 86.5 | 100 | 88.2 |
| 2e. If she has kit with all relevant instruments | 100 | 75 | 75.7 | 100 | 78.4 |
| 3a. Supply every three months? | | | | | |
| 3b. Are IUCDs stored satisfactorily? | | | | | |
| 3c. Are IUCD kits packed and stored satisfactorily? | | | | | |
| | | | | | |
| Private | | | | | |
| 1. If provider has a copy of National Standard Guidelines | | | | | 8.5 |
| 2a. If she has supplies of IUCD | | | | | 93.6 |
| 2b. If she has supplies of antiseptics | | | | | 91.5 |
| 2c. If she has table for IUCD insertion | | | | | 72.3 |
| 2d. if she has supplies of HLD gloves | | | | | 95.7 |
| 2e. If she has kit with all relevant instruments | | | | | 91.5 |
| 3a. Supply every three months? | | | | | |
| 3b. Are IUCDs stored satisfactorily? | | | | | |
| 3c. Are IUCD kits packed and stored satisfactorily? | | | | | |

A Comprehensive

# Family Planning

## Needs Assessment in the Islamic Republic of Afghanistan

January 2016